

No. 19-14387

**IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

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,

Plaintiffs–Appellees,

v.

CITY OF TAMPA, FLORIDA,

Defendant–Appellant

On Appeal from the United States District Court
for the Middle District of Florida
in Case No. 8:17-cv-02896-T-02AAS before the Honorable William F. Jung

**PLAINTIFFS-APPELLEES’ SUPPLEMENTAL APPENDIX
VOLUME I**

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IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF FLORIDA
Tampa Division

ROBERT L. VAZZO, LMFT, <i>et al.</i> ,	)	
	)	Civil Action No.:8:17-cv-02896-CEG-AAS
Plaintiffs,	)	
	)	INJUNCTIVE RELIEF SOUGHT
v.	)	
	)	
CITY OF TAMPA, FLORIDA, <i>et al.</i> ,	)	
	)	
Defendants.	)	

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION
WITH INCORPORATED MEMORANDUM OF LAW**

Pursuant to Fed. R. Civ. P. 65 and M.D. Fla. L.R. 4.06, Plaintiffs, ROBERT L. VAZZO, LMFT, individually and on behalf of his clients ("Vazzo"), DAVID H. PICKUP, LMFT, individually and on behalf of his clients ("Pickup"), and SOLI DEO GLORIA INTERNATIONAL, INC. d/b/a NEW HEARTS OUTREACH TAMPA BAY, individually and on behalf of its members, constituents and clients ("New Hearts") (collectively "Plaintiffs"), by and through counsel, respectfully move this Court to enter a preliminary injunction enjoining Defendants, CITY OF TAMPA, FLORIDA ("City") and SAL RUGGIERO, in his official capacity as Manager of the City of Tampa Neighborhood Enhancement Division ("Ruggiero") (collectively "Defendants"), together with their officers, agents, servants, employees, and others who are in active concert or participation with them, from enforcing CITY OF TAMPA ORDINANCE 2017-47 (the "Ordinance" or "Ordinance 2017-47") and from acting in a manner that violates their First Amendment rights to free speech.

MEMORANDUM OF LAW IN SUPPORT

“We found no empirical research on adolescents who request SOCE.”¹

“[W]hen the government polices the content of professional speech, it can fail to preserve the uninhibited marketplace of ideas in which truth will ultimately prevail. Professionals might have a host of good-faith disagreements, both with each other and with the government, on many topics in their respective fields. . . . The best test of truth is the power of the thought to get itself accepted in the competition in the market, and the people lose when the government is the one deciding which ideas should prevail.”²

By enacting the Ordinance, Defendants are storming the office doors of therapists, thrusting themselves into the sacrosanct relationship of counselor and client, and running roughshod over the clients’ and counselors’ cherished First Amendment liberties. Defendants’ justification for such unconscionable actions is that they do not approve of counseling which addresses the possibility of reducing or eliminating minors’ unwanted same-sex attractions (“SSA”) or desires to “transition to another gender,” **even if the clients desire such change**. Defendants offer no evidence of harm arising from such **voluntary** treatment, but rely upon position papers from advocacy groups, an inconclusive study, and court decisions upholding similar ordinances in other states, which the Eleventh Circuit has dismissed as “dubious,” *Wollschlaeger v. Florida*, 848 F.3d 1293, 1307 (11th Cir. 2017) (en banc), **and which the United States Supreme Court has now gutted**. *NIFLA*, 2018 WL 3116336.

The Ordinance is in gross violation of the Constitution and Florida law, and should be enjoined.

¹ 2009 American Psychological Association Task Force Report on Appropriate Therapeutic Response to Sexual Orientation, on which **Defendants** principally rely. (Verified Complaint, Ex. B at 73) (emphasis added).

² *Nat’l Inst. for Family & Life Advocates v. Becerra* (“*NIFLA*”), No. 16-1140, 2018 WL 3116336, *11 (June 26, 2018) (internal quotations omitted) (emphasis added).

STATEMENT OF FACTS

A. ORDINANCE 2017-47.

On April 6, 2017, the City Council passed Ordinance 2017-47, which was signed into law by Mayor Buckhorn on April 10, 2017, and took immediate effect. (First Amended Verified Complaint, dkt. 78, “FAVC” ¶¶ 24-26). Section 5 of the Ordinance states that “[i]t shall be unlawful for any Provider to practice conversion therapy efforts on any individual who is a minor regardless of whether the Provider receives monetary compensation in exchange for such services.” (*Id.* ¶ 27). Section 4 defines “conversion therapy efforts” (“SOCE counseling”) as:

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

(*Id.* ¶ 28).

All violations of this Ordinance constitute a separate offense and carry a \$1,000.00 fine for the first offense and \$2,000.00 for each and every subsequent violation. (*Id.* ¶ 30). The State of Florida, which is the government body vested with exclusive jurisdiction to regulate licensed mental health professionals has refused to prohibit SOCE counseling despite the numerous attempts of those ideologically opposed to such counseling. (*Id.* ¶¶ 271-273). Despite not being prohibited by the State, Plaintiffs now risk punishment for engaging in SOCE counseling in Tampa. Fla. Stat. Ann. § 491.009(1)(c); Fla. Admin. Code r. 64B4-5.001(c).

B. ROBERT L. VAZZO, LMFT.

Plaintiff, Robert L. Vazzo, LMFT, is a marriage and family therapist and is licensed to practice mental health counseling in California, Florida, Nevada, and Ohio. (FAVC ¶ 100). In his current practice, Vazzo specializes in SOCE counseling, including the areas of unwanted same-sex attractions, pedophilia, hebephilia, ephebophilia, and transvestic fetishism. (*Id.* ¶ 102). His practice includes approximately 17-25 clients each week and ten percent of those clients are minors seeking SOCE counseling. (*Id.*). Many of Vazzo's clients who desire SOCE counseling profess to be Christians with a sincerely held religious belief that homosexuality is harmful and destructive and therefore seek SOCE counseling to live a lifestyle in congruence with their faith and to conform their identity, attractions, and behaviors to their sincerely held religious beliefs. (*Id.* ¶ 104). Vazzo has never received any complaint or report of harm from any of his clients seeking and receiving SOCE counseling, including the many minors that he has counseled. (*Id.* ¶ 105). In fact, all of Vazzo's clients who have engaged in SOCE counseling for at least one year have experienced some degree of positive change with respect to their unwanted SSA. (*Id.*). **Vazzo does not coerce any client to engage in SOCE counseling and would never engage in any counseling unless the client desires such counseling and voluntary consents to it.** (*Id.* ¶ 106).

Vazzo has had numerous clients in Florida, provides counseling to clients in Florida, and constantly receives inquiries from all over the State concerning SOCE counseling. (*Id.* ¶ 108). Vazzo has been contacted by individuals in the City who desire to engage in SOCE counseling with Vazzo, including a fifteen-year-old minor client seeking SOCE counseling from Vazzo. (*Id.* ¶¶ 109-110). Vazzo's client desires to receive SOCE counseling from a licensed professional counselor with expertise in this particular area. (*Id.*). Vazzo's client struggles with unwanted SSA and desires to engage in SOCE counseling with Vazzo to reduce or eliminate the client's unwanted

SSA. (*Id.* ¶111). Vazzo is prohibited from providing SOCE counseling because of the Ordinance, and his client is prohibited from receiving such counseling from a licensed professional. (*Id.* ¶112).

C. PLAINTIFF DAVID H. PICKUP, LMFT.

Plaintiff, David H. Pickup, LMFT, is a licensed marriage and family therapist and is licensed to provide mental health counseling in California and Texas. (FAVC ¶ 113). Pickup is currently seeking licensure in Florida and has only one more requirement to complete to satisfy the requirements for becoming a licensed marriage and family therapist in Florida, which he will complete in August 2018. (*Id.* ¶113-114). Pickup specializes in providing heterosexual minors and adults with authentic Reparative Therapy, which includes the psychological industry standards of Psychodynamic, Cognitive-Behavioral and EMDR methods to help them reduce or eliminate unwanted SSA. (*Id.* ¶ 116). **Pickup only engages in such counseling with clients who voluntarily seek it and desire to and consent to such counseling.** (*Id.* ¶125).

Pickup has particular expertise in SOCE counseling because of his personal experience and success with reparative therapy for unwanted SSA. (*Id.* ¶ 118). When he was 5 years old, he was sexually molested by a 16-year-old high school boy and also suffered severe emotional abuse at the hands of other children. (*Id.*). When he reached puberty and for many years after it, he was sexually attracted to men. (*Id.*). For all of those years, he carried a feeling of immense and crushing shame for his same-sex attractions. (*Id.*). For 20 years following puberty, Pickup became clinically depressed twice, dealt with tremendous anxiety, experienced obsessive compulsive disorder, and knew that he was very confused about his sexual orientation and gender identity. (*Id.* ¶ 119-120). In the latter years of that 20-year period, Pickup found a course of counseling that was tremendously helpful to his mental health issues. (*Id.*). Pickup engaged in authentic Reparative Therapy with the late Dr. Joseph Nicolosi for many years, which he credits for saving his life. (*Id.*).

This counseling, a form of SOCE counseling, helped Pickup get rid of the shame that he had for experiencing unwanted SSA and led to the dissipation of his SSA. (*Id.* at 120). Dr. Nicolosi's counseling helped Pickup solidify his gender identity, which resulted in a profound increase in his self-confidence as a man and in his self-esteem. (*Id.*). Dr. Nicolosi's counseling allowed him to understand the nature and source of his same-sex attractions and allowed him to do the deep emotional work that he needed to do to understand those unwanted feelings. (*Id.* ¶121). As part of the counseling, Pickup learned the importance of healthy male relationships and his sexual attractions to women increased. (*Id.*). Pickup saw a real and profound change in his sexuality that resulted from Dr. Nicolosi's counseling, and he pursued training to offer others the same chance. (*Id.* ¶122).

D. PLAINTIFF NEW HEARTS OUTREACH TAMPA BAY.

New Hearts is a confidential healing and discipleship ministry fostering sexual and relational wholeness in people's lives through the hope of Jesus Christ. (FAVC ¶ 126). New Hearts is an unapologetically Christian organization dedicated to sharing the hope of Jesus Christ to those who choose to pursue sexual and relational wholeness. (*Id.* ¶¶130-131). As part of its ministry, New Hearts offers referrals to individuals, including minors, who are struggling with unwanted SSA, but **only refers these clients to counselors when the client himself or herself voluntarily desires and consents to such counseling.** (*Id.* ¶¶ 133-134). The Ordinance prohibits New Hearts from effectively providing for the needs of its clients because no licensed counselor can provide the SOCE counseling to minors in Tampa who desire to voluntarily engage in such counseling. (*Id.* ¶ 135). New Hearts also provides events and conferences in which its constituents, including minors, hear from licensed professionals concerning topics such as SSA and SOCE counseling, but because of the Ordinance, New Hearts cannot host such events. (*Id.* ¶¶136-143).

E. IRREPARABLE INJURY TO PLAINTIFFS.

Vazzo and Pickup have incurred monetary expense to lease office space in the City to provide SOCE counseling to clients, including minors. (FAVC ¶ 151). Plaintiffs desire to advertise, offer, refer to, and provide SOCE counseling, to clients and potential clients in the City, including minors. (*Id.* ¶¶152-153, 164). Vazzo and Pickup would like to offer religious leaders, organizations, and ministries, such as New Hearts, their expertise and experience in SOCE counseling. (*Id.* ¶155). Plaintiffs have received inquiries from various potential clients in the City, including minors, who desire to receive SOCE counseling. (*Id.* ¶156). Plaintiffs are prohibited from advertising, offering, referring, or providing SOCE counseling to clients and potential clients, including minors, in the City. (*Id.* ¶¶157-159, 164). The Ordinance’s prohibition on SOCE counseling violates Plaintiffs’ cherished First Amendment rights and chills their constitutionally protected expression. (*Id.* ¶¶170-176).

LEGAL ARGUMENT

Injunctive relief is appropriate where, as here, Plaintiffs can establish that (1) they have a substantial likelihood of success on the merits, (2) irreparable injury will result absent injunctive relief, (3) the balance of the equities tips in their favor, and (4) the injunction would serve the public interest. *See, e.g., Siegel v. Lepore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc). Plaintiffs easily satisfy this burden.

I PLAINTIFFS HAVE A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS.

A. The Ordinance Unconstitutionally Discriminates On The Basis Of Viewpoint.

A viewpoint-based restriction on private speech has never been upheld by the Supreme Court or any court. Indeed, a finding of viewpoint discrimination is dispositive. *See Sorrell v. IMS Health*, 131 S. Ct. 2653, 2667 (2011). “It is axiomatic that the government may not regulate speech

based on its substantive content or the message it conveys.” *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 828 (1995); *Good News Club v. Milford Cent. Sch. Dist.*, 533 U.S. 98, 106 (2001) (“The restriction must not discriminate against speech on the basis of viewpoint.”). “When the government targets not subject matter, but particular views taken by speakers on a subject, the violation of the First Amendment is all the more blatant.” *Rosenberger*, 515 U.S. at 829. In fact, **viewpoint-based regulations are always unconstitutional**. See, e.g., *Lamb’s Chapel v. Ctr. Moriches Union Free Sch. Dist.*, 508 U.S. 384, 394 (1993) (“the First Amendment forbids the government to regulate speech in ways that favor some viewpoints or ideas at the expense of others” (quoting *City Council of L.A. v. Taxpayers for Vincent*, 466 U.S. 789, 804 (1984))). See also *Searcy v. Harris*, 888 F.2d 1314, 1324 (11th Cir. 1989) (the government “may not discriminate between speakers who will speak on the topic merely because it disagrees with their views”); *id.* at 1325 (“**The prohibition against viewpoint discrimination is firmly embedded in first amendment analysis.**” (emphasis added)).

The Ordinance is a textbook example of viewpoint discrimination. On its face, the Ordinance purports to allow licensed therapists to discuss the subject of sexual orientation, but explicitly prohibits only one particular viewpoint on that subject, namely that unwanted SSA can be reduced or eliminated to the benefit of the client. The Ordinance defines “conversion therapy” in such a way that it is clear that Defendants are targeting only one viewpoint, *i.e.*, SOCE that seeks to “eliminate or reduce sexual or romantic attractions or feelings **toward individuals of the same gender or sex.**” (FAVC, Ex A at 5, §4 (emphasis added)). Similarly, the Ordinance permits a counselor to accept and facilitate SSA, even if the minor client is merely questioning such feelings, but prohibits a counselor from counseling a minor client to change unwanted SSA, **even when the minor clients themselves request such counseling and seeks that outcome.** (*Id.*).

The Ordinance purports to prohibit licensed counselors from engaging in any practice that seeks to change behaviors, gender identity, or gender expression. But the plain text of the Ordinance demonstrates that it only prohibits such counseling for minor clients who wish to reduce or eliminate behaviors, identity, or expressions that differ from their biological sex. That this is true cannot be questioned because the Ordinance specifically exempts counseling that “provides support and assistance to a person undergoing gender transition.” (FAVC, Ex. A at 5, § 4). To undergo “gender transition,” one has to be – at minimum – seeking to change from one gender to the other. To transition is to change. So, under the Ordinance, if a minor client wants to undergo radical surgery to alter their appearance or genitalia, the City has no problem with a counselor providing counseling to assist in that change. But, if a minor client merely wants to speak with a counselor about unwanted feelings concerning their gender identity or expression, the counselor is absolutely prohibited from engaging in such counseling if it aids the minor in reducing unwanted other-sex identity, behaviors, or expressions. There can be no question that this is viewpoint discrimination.

The Supreme Court and several other courts have invalidated regulations of professional speech as unconstitutional viewpoint discrimination. *See NIFLA*, 2018 WL 3116336, at *15; *Sorrell*, 131 S. Ct. 2653 (2011); *Legal Servs. Corp. v. Valazquez*, 531 U.S. 533 (2001); *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002). In these cases, the courts recognized the axiomatic truth that the government is not permitted to impose its viewpoint on speakers, even professional speakers subject to licensing and regulation.

In *Velazquez*, the Court addressed a federal limitation on the legal profession that operated in materially the same viewpoint-based manner as does the Ordinance and prevented legal aid attorneys from receiving federal funds if their representation involved an “effort to reform” (*i.e.*,

change) welfare laws. *Velazquez*, 531 U.S. at 537-38. Much like the Ordinance here, the limitation permitted attorneys to represent clients involving welfare matters so long as the representation “does not involve an effort to amend” or **change** existing welfare laws. *Id.* at 538. The Court invalidated this provision because it represented “impermissible viewpoint-based discrimination.” *Id.* at 537. In fact, the Court agreed with the Second Circuit’s conclusion that such a prohibition on counseling seeking to **change** existing law was “inescapably viewpoint-biased.” *Velazquez v. Legal Servs. Corp.*, 164 F.3d 757, 769 (2d. Cir. 1999).

In *Conant*, several physicians and their patients brought a First Amendment challenge to a federal policy that punished physicians for communicating with their patients about the benefits or options of marijuana as a potential treatment. *Conant*, 309 F.3d at 633. The Ninth Circuit began its analysis by recognizing that the doctor-patient relationship is entitled to robust First Amendment protection.

An integral component of the practice of medicine is the communication between a doctor and a patient. **Physicians must be able to speak frankly and openly to patients.** That need has been recognized by courts through the application of the common law doctor-patient privilege.

Id. at 636 (emphasis added). Far from being a First Amendment orphan, the court noted that such professional speech “may be entitled to the strongest protection our Constitution has to offer.” *Conant*, 309 F.3d at 637 (quoting *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995)).

The court held that the ban impermissibly regulated physician speech based on viewpoint:

The government’s policy in this case seeks to punish physicians on the basis of the content of doctor-patient communications. Only doctor-patient conversations that include discussions of the medical use of marijuana trigger the policy. Moreover, the **policy does not merely prohibit the discussion of marijuana; it condemns expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient.** Such condemnation of particular views is especially troubling in the First Amendment context.

Id. at 637-38 (emphasis added). The court rejected as inadequate the government’s justification that the policy prevented clients from engaging in harmful behavior, and permanently enjoined enforcement of the policy. *Id.* at 638-39.

The Ordinance operates almost identically to the federal policies enjoined in *Velazquez* and *Conant*. Just as the policy in *Velazquez* permitted counseling concerning welfare laws but prohibited such counsel if it involved efforts to **change** existing welfare laws, so too the Ordinance permits counseling on the subject of SSA but prohibits counseling with minors if it involves efforts to **change** SSA. Just as the policy in *Conant* prohibited physicians from speaking about the benefits of marijuana to a suffering patient, so the Ordinance prohibits counselors from speaking about the benefits of SOCE with a client distressed about his SSA. Moreover, just as in *NIFLA*, the Ordinance “compels individuals to contradict their most deeply held beliefs, beliefs grounded in basic philosophical, ethical, or religious precepts.” *NIFLA*, 2018 WL 3116336, at *15 (Kennedy, J., concurring). This unconstitutionally forces Plaintiffs to “be an instrument for fostering public adherence to an ideological point of view they find unacceptable.” *Id.* The Ordinance’s viewpoint discrimination cannot survive.

B. The Ordinance Unconstitutionally Discriminates Against Content.

1. The Supreme Court’s Precedents in *NIFLA* and *Reed* Mandate that the Ordinance be Subjected to Strict Scrutiny As a Content-Based Restriction on Professional Speech.

“Content-based laws—those that target speech on its communicative content—are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling government interests.” *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226 (2015); *NIFLA*, 2018 WL 3116336 at *7; *R.A.V. v. City of St. Paul*, 505 U.S. 377, 395

(1992) (same). Put simply, *Reed* handed down a firm rule: **laws that are content based on their face must satisfy strict scrutiny.** *Reed*, 135 S. Ct. at 2227.

This firm rule mandating strict scrutiny of facially content-based restrictions of speech applies regardless of the government’s alleged purpose. *Id.* at 2227. “On its face, the [law] is a content-based regulation of speech. We thus have no need to consider the government’s justifications or purposes for enacting the [law] to determine whether it is subject to strict scrutiny.” *Id.* Indeed, “[a] **law that is content based on its face is subject to strict scrutiny regardless of the government’s benign motive, content-neutral justification, or lack of animus toward the ideas contained in the regulated speech.**” *Id.* (emphasis added). “[A]n innocuous justification cannot transform a facially content-based law into one that is content neutral.” *Id.*

The Supreme Court has unequivocally held that content-based restrictions **on the speech of licensed professionals** is also subject to strict scrutiny. *See NIFLA*, 2018 WL 3116336, at *7; *Reed*, 125 S. Ct. at 2229 (“it is no answer to say that the purpose of these regulations was merely to insure high professional standards and not to curtail free expression”). It noted that while “[s]ome Courts of Appeals have recognized ‘professional speech’ as a separate category that is subject to different rules . . . **this Court has not recognized ‘professional speech’ as a separate category of speech. Speech is not unprotected simply because it is uttered by ‘professionals.’**” *NIFLA*, 2018 WL 3116336, at *7 (emphasis added). In so holding, the Supreme Court explicitly named and rejected the decisions in *King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014) and *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014). *Id.* *King* and *Pickup* “except professional speech from the rule that content-based regulations of speech are subject to strict scrutiny,” but “[t]his Court’s precedents do not recognize such a tradition for a category called ‘professional speech’” and thus it must receive the same exacting scrutiny as other content-based laws. *Id.*

In fact, “this Court’s precedents have long protected the First Amendment rights of professionals.” *Id.* at *10 (citing *inter alia Reed*, 135 S. Ct. at 2229; *NAACP v. Button*, 371 U.S. 415, 438-39 (1963), and noting that the Supreme Court has applied strict scrutiny to professional regulations many times). This is true because “regulating the content of professionals’ speech ‘poses the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas and information.’” *Id.* (quoting *Turner Broad. Sys., Inc. v. FCC*, 512 U.S. 622, 641 (1994)).

When the government polices the content of professional speech, it can fail to preserve an uninhibited marketplace of ideas in which truth will ultimately prevail. Professionals might have a host of good-faith disagreements, both with each other and with the government, on many topics in their respective fields. Doctors and nurses might disagree about the ethics of assisted suicide or the benefits of medical marijuana; lawyers and marriage counselors might disagree about the prudence of prenuptial agreements or the wisdom of divorce; bankers and accountants might disagree about the amount of money that should be devoted to savings or the benefits of tax reform. **The best test of truth is the power of the thought to get itself accepted in the competition of the market, and the people lose when the government is the one deciding which ideas should prevail.**

Id. at *10-11 (emphasis added) (quotes, citations and alterations omitted).

Thus, after *NIFLA* and *Reed*, there is no doubt that content-based laws such as the Ordinance must satisfy strict scrutiny, **even if targeted at licensed professionals.** *Id.* at *7; *Reed*, 135 S. Ct. at 2229. “It is rare that a regulation restricting speech because of its content will ever be permissible.” *United States v. Playboy Entm’t Grp.*, 529 U.S. 803, 818 (2000). The burden is on Defendants to prove the Ordinance satisfies strict scrutiny, but they cannot meet that burden here.

2. There is No Compelling Government Interest for the Ordinance.

a. NIFLA demands a finding that King and Pickup cannot and do not constitute a compelling government interest.

Defendants claim that the Ordinance is a justifiable exercise of their interests in protecting their citizens because other federal courts have upheld similar prohibitions enacted in other states.

(FAVC, Ex. A at 4 (citing *Pickup*, 740 F.3d 1208 and *King*, 767 F.3d 216)). However, after *NIFLA*, such reliance is utterly misplaced and cannot support a compelling interest as a matter of law. *See NIFLA*, 2018 WL 3116336, at *7. Indeed, the Supreme Court eviscerated the decisions of the Ninth and Third Circuits in *King* and *Pickup*, *see supra* Section I.B.1, and relegated those erroneous decisions to the dustbin of constitutional history. *NIFLA*, 2018 WL 3116336, at *7 (holding that the Ninth and Third Circuits were incorrect in concluding that content-based regulations of the speech of licensed professionals need to satisfy a lesser standard of scrutiny). Additionally, even if *NIFLA* had not placed the final nail in the coffin of *King* and *Pickup*, which it did, binding Eleventh Circuit precedent rejected such decisions as “dubious constitutional enterprise[s].” *Wollschlaeger*, 848 F.3d at 1309. “[W]e do not think it is appropriate to subject content-based restrictions on speech by those engaged in a certain profession to mere rational basis review,” as the Ninth Circuit had done in *Pickup*. *Id.* at 1311. After *NIFLA*, not only is it inappropriate, but is foreclosed as a matter of settled law. The Ordinance is not supported by any compelling interest.

b. Defendants cannot assert a compelling interest in preventing harm from voluntary SOCE counseling to willing minor clients.

Defendants assert that they have a compelling interest in preventing minors from receiving SOCE counseling because it could potentially be harmful to them. This assertion is not only based on intentional misrepresentations of various studies, *see infra* Section I.B.2.c., but is also insufficient as a matter of settled law to serve as a compelling interest. *NIFLA* and *Wollschlaeger* noted that laws targeting the content of certain doctor-patient or counselor-client communications cannot be justified by the “paternalistic assertion that the policy was valid because patients might otherwise make bad decisions” if left to determine the best course of counseling for themselves. *Wollschlager*, 848 F.3d at 1310. Indeed, “[d]octors help patients make deeply personal decisions, and their candor is crucial.” *NIFLA*, 2018 WL 3116336 at *10 (citing *Wollschlager*, 848 F.3d at

1328 (Pryor, J., concurring)), and “[t]hroughout history, governments have manipulated the content of doctor-patient discourse to increase state power and suppress minorities.” *Id.* But, the First Amendment does not permit such a paternalistic or tyrannical effort to suppress unpopular opinion. *Id.*

Just because Defendants “may generally believe that doctors and medical professionals should not ask about, nor express views hostile to, [a certain topic or course of counseling], [they] ‘may not burden the speech of others in order to tilt the public debate in a preferred direction.’” *Wollschlaeger*, 848 F.3d at 1313-14 (quoting *Sorrell v. IMS Health, Inc.*, 564 U.S. 552, 578-79 (2011)). Where, as here, “[t]he record demonstrates that some patients do not object to questions and advice about [the prohibited content of speech], and some even express gratitude for their doctor’s discussion of the topic,” a law is unconstitutional if it “does not provide for such patients a means by which they can hear from their doctors on the topic.” *Id.* at 1313.

There are no such means provided in the Ordinance. Instead, Defendants assert that they need to protect minors from purported harms they claim would result if licensed professionals talked to willing minors about the possibility that unwanted same-sex attractions or desires to “transition to another gender” can be changed, **even if the clients seek and desire such discussions.** (FAVC, Ex. A at 4-5). No such harm will occur, according to Defendants, if counselors support and affirm minors’ same-sex attractions or desires to “transition to another gender,” (*Id.* at 5), revealing that Defendants are attempting to tilt the debate in favor of those advocating against SOCE counseling, not prevent purported harm. However, Defendants do **“not have carte blanche to restrict the speech of doctors and medical professionals on a certain subject without satisfying the demands [of the First Amendment].”** *Wollschlaeger*, 848 F.3d at 1314 (emphasis added). Indeed, the government “cannot choose the protection that speech

receives under the First Amendment,” and “labels cannot be dispositive of the degree of First Amendment protection.” *NIFLA*, 2018 WL 3116336, at *11. Defendants cannot support the claim that the Ordinance is necessary to protect a purported state interest in preventing harm from a politically undesirable type of counseling.

c. Defendants’ own studies admit that “no empirical research” supports banning voluntary SOCE counseling for willing minor clients, and Defendants cannot manufacture a compelling interest by misrepresenting those studies.

Defendants also attempt to justify the Ordinance by pointing to statements and reports issued by professional associations which supposedly establish that SOCE counseling is harmful to minors. In particular, Defendants cite to the 2009 American Psychological Association Task Force Report on Appropriate Therapeutic Response to Sexual Orientation (“APA Report”), and the subsequent resolution, as justification for prohibiting SOCE counseling. (FAVC, Ex. A at 1-2).

However, the APA Report does not support the conclusion that **voluntary** SOCE counseling is harmful to minor clients **who desire to receive it**. In fact, the APA Report specifically noted that the research is inadequate to draw **any** conclusions concerning SOCE counseling. (FAVC ¶33). Thus, despite the City’s claims that SOCE counseling was found to be harmful to minors, the APA Report specifically noted that “sexual orientation issues in children are **virtually unexamined**.” (FAVC Ex. B at 91 (emphasis added)), and noted that “[t]here is a lack of published research on SOCE among children.” (*Id.* at 72). The APA Report also concluded that “there is a dearth of scientifically sound research on the safety of SOCE. **Early and recent research studies provide no clear indication of the prevalence of harmful outcomes**.” (*Id.* at 42) (emphasis added). The APA Report also noted that it could make no conclusions about SOCE

counseling for those minors who request such counseling because “**We found no empirical research on adolescents who request SOCE.**” (*Id.* at 73 (emphasis added)).

The APA Report also noted that its conclusions were necessarily limited because they are not based on specific studies from individuals, including minors, who request SOCE counseling. (*Id.* at 76). In fact, contrary to Defendants’ representations, the APA Report noted that it found evidence of **benefit** to individuals seeking such counseling. (*Id.* at 43, 85). The APA Report specifically noted that “[s]ome individuals report that they went on to lead outwardly heterosexual lives, developing a sexual relationship with an other-sex partner, and adopting a heterosexual identity.” (*Id.* at 84-85). Since the APA admitted that its report was inconclusive and that there was **no evidence regarding** the effect of SOCE counseling on children, it does not support Defendants’ claim that the Ordinance is necessary to protect children from harm.

3. The Ordinance is Not Narrowly Tailored.

Even if Defendants could substantiate compelling interests for the Ordinance’s prohibition on SOCE counseling, which they cannot, the Ordinance would still fail strict scrutiny because it is not narrowly tailored. “It is not enough to show that the Government’s ends are compelling; the means must be carefully tailored to achieve those ends.” *Sable Commc’ns of Cal., Inc. v. FCC*, 492 U.S. 115, 126 (1989). “There must be a ‘fit between the . . . ends and the means chosen to accomplish those ends.’” *Wollschlaeger*, 848 F.3d at 1312 (quoting *Sorrell*, 564 U.S. 572). Indeed, “precision must be the touchstone when it comes to regulations of speech, which so closely touch our most precious freedoms.” *NIFLA*, 2018 WL 3116336, at *13.

The Supreme Court has clearly established that “The government may not regulate a [‘mode of speech’] based on hostility—or favoritism—towards the underlying message expressed.” *R.A.V.* 505 U.S. at 386. As shown above, the Ordinance is based on political

preferences to ban such counseling, not on scientific evidence of harm. Where, as here, other, content-neutral alternatives exist, government cannot fulfill its narrow tailoring burden by ignoring those alternatives. *See id.* at 395 (“The existence of adequate content-neutral alternatives thus ‘undercut[s] significantly’ any defense of such a statute, casting considerable doubt on the government’s protestations that the ‘asserted justification is in fact an accurate description of the purpose and effect of the law.’” (citations omitted)).

The Ordinance woefully fails this test. The Ordinance is not necessary to prevent harm (which has not been proven) because existing Florida law and the ethical codes of the professions engaging in this form of counseling already prohibit practices that actually harm patients. (FAVC ¶¶ 72-84). Licensed marriage and family therapists are already prohibiting from “[m]aking misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed, registered, or certified” by Florida’s Marriage and Family Therapy Board. *See Fla. Stat. Ann.* § 491.009(1)(l). They are also prohibited from engaging in any practice that is harmful to clients, such as “[f]ailing to meet minimum standards of performance in professional activities when measured against generally prevailing peer performance.” *Fla. Stat. Ann.* 491.009(1)(r).

Existing Florida law regulating professional counselors also imposes upon them a legal obligation to abide by the other ethical requirements of their profession. *See Fla. Stat. Ann.* § 491.001(1)(t). These ethical obligations include ethical codes promulgated by the American Association of Marriage and Family Therapists and its ethics code (“AAMFT Code”). Standard 1 of the AAMFT Code mandates that counselors not harm their clients or engage in practices that might do so. (FAVC ¶79). Standard 1.1 of the AAMFT Code prohibits marriage and family therapists, such as Vazzo and Pickup, from discriminating against clients based on their sexual orientation or gender identity (*Id.* ¶80). If violated, these provisions come with legal sanction under

existing Florida law. *See* Fla. Admin. Code § 64B5-5.001. Thus, Defendants’ assertion that no other alternatives or existing laws prevent the alleged harm they are seeking to prevent (FAVC Ex. A at 4), is demonstrably false. The fact that children are already protected from harmful and dangerous therapies reveals that Defendants’ underlying goal is not about protecting minors. Statutes, regulations and ethical rules already protect minors without suppressing speech. Under *R.A.V.*, if the City had content-neutral avenues of preventing the alleged harm, failing to employ them means the Ordinance is not narrowly tailored. *R.A.V.*, 505 U.S. at 395.

Moreover, if Defendants were concerned with alleged harms resulting to minors who are **involuntarily** subjected to counseling against their will, Defendants could have banned those practices without indiscriminately outlawing **voluntary** SOCE counseling to willing patients. Indeed, informed consent would be another less restrictive means to achieve Defendants’ purported interests. When legislation virtually identical to the Ordinance was being debated in California, several mental health organizations recognized that this type of “legislation is attempting to undertake an unprecedented restriction on psychotherapy.” (*See* FAVC Ex. E at 1). They proposed informed consent language that would have been much more narrowly tailored than the unprecedented intrusion into the relationship between counselor and willing client. (*Id.*). Although this alternative is in the public record, Defendants either never considered it or rejected it for no good reason. In sum, a complete ban a viewpoint regarding SSA is not the least restrictive means to achieve any governmental interest. Total prohibitions on constitutionally protected speech are “hardly an exercise of narrow tailoring.” *Awad v. Ziriax*, 670 F.3d 1111, 1131 (10th Cir. 2012). Absent narrow tailoring the Ordinance cannot survive strict scrutiny.

C. The Ordinance Is An Unconstitutional Prior Restraint.

Prior restraints against constitutionally protected expression are highly suspect and disfavored. *Forsyth Cnty. v. Nationalist Movement*, 505 U.S. 123, 130 (1992). In fact, “any system of prior restraints comes to this Court bearing the heavy presumption against its constitutional validity.” *Bantham Books, Inc. v. Sullivan*, 372 U.S. 58, 70 (1963). This is why “[t]he Supreme Court and [the Eleventh Circuit] consistently have permitted facial challenges to prior restraints without requiring a plaintiff to show that there are no conceivable set of facts where the application of the particular government regulation might or would be constitutional.” *United States v. Frandsen*, 212 F.3d 1231, 1236 (11th Cir. 2000); *Horton v. City of St. Augustine*, 272 F.3d 1318, 1331-32 (11th Cir. 2001) (“the Supreme Court itself in *Salerno* acknowledged [that prior restraints are the] exception to the ‘unconstitutional-in-every-conceivable-application’ rule” (quoting *United States v. Salerno*, 481 U.S. 739, 745 (1987))).

Total prohibitions, such as the Ordinance here, constitute prior restraints. *See, e.g., Howard v. City of Jacksonville*, 109 F. Supp. 2d 1360, 1364 (M.D. Fla. 2000) (“This Court also finds that . . . moratoria are governed by prior restraint analysis in the same manners as permitting schemes.”); *D’Ambra v. City of Providence*, 21 F. Supp. 2d 106, 113-14 (D.R.I. 1998) (same); *ASF, Inc. v. City of Seattle*, 408 F. Supp. 2d 1102, 1108 (W.D. Wash. 2005) (total prohibitions on protected expression fail prior restraint analysis). Here, as in *ASF*, the Ordinance goes “a step further in suppressing protected speech.” *Id.* The Ordinance completely prohibits SOCE counseling, even voluntary counseling, with minors in the City. There is no exception to the Ordinance’s perpetual prohibition on protected expression. As the court held in *Howard*, such bans are subject to prior restraint analysis. *Howard*, 109 F. Supp. 2d at 1364. The Ordinance fails that analysis.

D. The Ordinance Is Unconstitutionally Vague.

A law is unconstitutionally vague if it “either forbids or requires the doing of an act in terms so vague that [persons] of common intelligence must necessarily guess at its meaning and differ as to its application.” *Connally v. Gen. Const. Co.*, 269 U.S. 385, 391 (1926). Government policies “must be so clearly expressed that the ordinary person can intelligently choose, in advance, what course it is lawful for him to take.” *Id.* at 393. “It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined.” *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). While all regulations must be reasonably clear, “laws which threaten to inhibit the exercise of constitutionally protected” expression must satisfy “a more stringent vagueness test.” *Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 499 (1982). Such a law must give “adequate warning of what activities it proscribes” and must “set out explicit standards for those who apply it.” *Broadrick v. Oklahoma*, 413 U.S. 601, 607 (1973) (citing *Grayned*, 408 U.S. at 108).

The Ordinance does not fulfill either requirement and forces both those enforcing the Ordinance and mental health professionals to guess at its meaning and differ as to its application. Because SSA are fluid and changing concepts, Plaintiffs are left to guess about what they are permitted to say to their clients who present with unwanted SSA or unwanted desires to “transition to another gender.” (FAVC ¶¶85-99). The Ordinance leaves Plaintiffs uncertain at what point a particular recommendation or even a particular statement to a minor client will cost them hundreds of dollars in fines and other disciplinary actions. Similarly, officials tasked with enforcing the Ordinance are uncertain at what point a counselor has crossed the line. This does not satisfy the stringent test required for the threat to Plaintiffs’ First Amendment rights. *Vill. of Hoffman*, 455 U.S. at 499.

E. The Ordinance Is Unconstitutionally Overbroad.

The Ordinance is overbroad because it completely bans counseling to any minor that seeks to change or reduce SSA, even when the minor desires and consents to such counseling. Instead of using a scalpel, the City took a chainsaw to the First Amendment. “Because First Amendment freedoms need breathing space to survive, government may regulate in the area only with narrow specificity.” *Button*, 371 U.S. at 433. The Ordinance prohibits licensed counselors under any circumstances from engaging in “any efforts” to reduce or eliminate SSA in minors. The breadth of this prohibition is astounding, and renders the Ordinance unconstitutionally overbroad. Indeed,

it is no answer to the constitutional claims asserted by petitioner to say . . . that the purpose of these regulations was merely to insure high professional standards and not to curtail free expression. **For a State may not, under the guise of prohibiting professional misconduct, ignore constitutional rights.**

Id. at 438-39 (emphasis added). The Ordinance bans Plaintiffs from providing counseling to their clients who knowingly, with informed consent, seek counseling to change SSA. This ban is “an unprecedented restriction of psychotherapy.” (FAVC Ex E at 1). It chills more speech than is permissible and is thus unconstitutionally overbroad.

F. Defendants’ Enactment Of The Ordinance Was *Ultra Vires* And Void *Ab Initio*.

Plaintiffs also have a substantial likelihood of success on the merits because the Ordinance is an *ultra vires* enactment that violate the Florida Constitution and statutes. A local government enactment will be considered inconsistent with state law if “(1) the Legislature has preempted a particular subject area or (2) the local enactment conflicts with a state statute.” *Sarasota Alliance For Fair Elections, Inc. v. Browning*, 28 So.3d 880, 886 (Fla. 2010). The Ordinance violates both prongs.

The State of Florida has impliedly preempted the field of regulation of mental health professionals through enactment of a comprehensive licensing and disciplinary scheme in Florida

Statutes, Title XXXII, Chapter 491. Preemption is implied where, as here, “the state legislative scheme of regulation is pervasive and the local legislation would present the danger of conflict with that pervasive regulatory scheme.” *Sarasota*, 28 So.3d at 886.

When determining if implied preemption applies, the court must look at the provisions of the policy as a whole, the nature of power exercised by the legislature, the object sought to be attained, and the character of the obligations imposed. *Classy Cycles, Inc. v. Bay Cnty.*, 201 So.3d 779, 784 (Fla. 2016). In *Classy Cycles*, an operator of a motor vehicle business sought a declaratory judgement that local ordinances relating to the insurance requirements for certain motor vehicles, and the rental of certain motor vehicles, exceeded the scope of authority of the local government. *Id.* at 781. The court held that the local ordinances were unconstitutional because the insurance requirements imposed by the local ordinances had been impliedly preempted by the State. *Id.* at 788-90. The court reasoned that the State had created a pervasive and extensive scheme of regulation and that the local ordinances were “attempt[s] to regulate in an area well-covered by existing statutes” and thus the local ordinances attempting to mandate insurance were impliedly preempted. *Id.* at 788. Where, as here, the State has not specifically granted any authority to local officials to be involved with certain regulation, the State’s laws extensive law in that particular area demonstrate implied preemption. *Id.* The same is true of the Ordinance here, as Florida has enacted a pervasive scheme for regulating mental health professionals. (FAVC ¶¶268-272).

Moreover, the Ordinance conflicts with Section 491.009 and Rule 64B4-5.001 in purporting to impose additional fees and penalties and, more importantly, attempting to expand upon conduct that would subject a provider to discipline, by purporting to make illegal in Tampa a form of therapy that is legal elsewhere in Florida. (FAVC ¶¶ 195-196). Thus, the Ordinance is

in direct conflict with Florida law that has occupied the field of professional regulation. The Ordinance is void as an *ultra vires* act in violation of Defendants' authority.

II. PLAINTIFFS HAVE SUFFERED, ARE SUFFERING, AND WILL CONTINUE TO SUFFER IRREPARABLE INJURY ABSENT INJUNCTIVE RELIEF.

Plaintiffs are suffering and will continue to suffer immediate and irreparable injury absent injunctive relief. Indeed, "[t]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976); *Cate v. Oldham*, 707 F.2d 1176, 1188 (11th Cir. 1983) (same); *Northeastern Fla. Chapter of the Ass'n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990).

As was true of the law invalidated in *Wollschlaeger*, the Ordinance here discriminates on the basis of content and viewpoint, prohibiting only the viewpoint that SSA and desires to "transition to another gender" can be changed if unwanted. The Ordinance silences Plaintiffs who wish to engage in a course of counseling with consenting minor clients that aligns with the clients' sincerely held religious beliefs. Such a prohibition constitutes a deprivation of First Amendment rights and imposes immediate and irreparable harm on Plaintiffs and their clients.

Plaintiffs are suffering irreparable injury by being silenced in their ability to speak to their willing, minor clients about counseling which is legally available throughout Florida, and which can assist the clients in reducing or eliminating unwanted same-sex attractions. (FAVC ¶¶ 151-176). If Plaintiffs violate the Ordinance's prohibitions, then they are subject to fines and other disciplinary actions. (FAVC ¶ 77). If they follow the Ordinance, then Plaintiffs will be subject to sanctions for violating other provisions of their ethical codes mandating that the clients have the right to self-determination and that counselors should not impose an ideology on the clients. (*Id.* ¶¶ 81-83). The imposition of punishment for discussing a course of counseling desired by the clients is a deprivation of constitutional rights, and constitutes *a priori* irreparable harm.

III. THE BALANCE OF THE EQUITIES FAVORS INJUNCTIVE RELIEF.

An injunction in this matter will protect the very rights the Supreme Court has characterized as “lying at the foundation of a free government of free men.” *Schneider v. New Jersey*, 308 U.S. 147, 151 (1939). The granting of a preliminary injunction that enjoins enforcement of the Ordinance will not impose any harm on Defendants. As noted above, “even a temporary infringement of First Amendment rights constitutes a serious and substantial injury.” *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 72 (11th Cir. 2006). Conversely, “there can be no harm to [the government] when it is prevented from enforcing an unconstitutional statute.” *Joelner v. Vill. of Washington Park*, 378 F.3d 613, 620 (7th Cir. 2004). That is because the government “has no legitimate interest in enforcing an unconstitutional [law].” *KH Outdoor*, 458 F.3d at 1272. As such, there can be no comparison between the irreparable and unconscionable loss of First Amendment freedoms suffered by Plaintiffs and their clients absent injunctive relief, and Defendants’ non-existent interest in enforcing an unconstitutional Ordinance.

IV. INJUNCTIVE RELIEF SERVES THE PUBLIC INTEREST.

The protection of First Amendment rights is of the highest public interest. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976). This protection is *ipso facto* in the interest of the general public because “First Amendment rights are not private rights [but] rights of the general public [for] the benefits of all of us.” *Machesky v. Bizzell*, 414 F.2d 283, 288-90 (5th Cir. 1969) (citing *Time, Inc. v. Hill*, 385 U.S. 374 (1967)). Indeed, “[i]njunctive protection of First Amendment freedoms are **always in the public interest**,” *ACLU of Ill. v. Alvarez*, 679 F.3d 583, 590 (7th Cir. 2012) (emphasis added); *KH Outdoor*, 458 F.3d at 1272.

CONCLUSION

For the foregoing reasons, the preliminary injunction should issue.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 26th day of June, 2018, I caused the foregoing to be electronically filed with this Court through this Court's ECF/electronic filing system. Service will be effectuated on all counsel of record via this Court's ECF/electronic notification system.

/s/ Horatio G. Mihet
Horatio G. Mihet

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IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF FLORIDA
Tampa Division
Civil Action No. 8:17-cv-02896-CEH-AAS

ROBERT L. VAZZO, LMFT, individually
and on behalf of his patients,
DAVID H. PICKUP, 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,

Plaintiffs,

vs.

CITY OF TAMPA, FLORIDA, and
SAL RUGGIERO, in his official capacity as
Manager of the City of Tampa
Neighborhood Enhancement Division,
Defendants.

* * * * *

DEPOSITION OF SAL RUGGIERO
TAKEN AT THE INSTANCE OF THE PLAINTIFFS
* * * * *

DATE: October 30, 2018
PLACE: 201 North Franklin Street
Suite 3200
Tampa, Florida 33603
TIME: 9:56 - 12:59 o'clock p.m.

Florida Court Reporting
561-689-0999

Vazzo v. City of Tampa
Sal Ruggiero

10/30/2018

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Vazzo v. City of Tampa
Sal Ruggiero

10/30/2018

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1 The deposition of SAL RUGGIERO, witness, was taken
2 before me, Rachele Cibula, Notary Public, State of
3 Florida at large, at 201 North Franklin Street, Suite
4 3200, in the City of Tampa, County of Hillsborough,
5 State of Florida, pursuant to notice in said cause for
6 the purpose of taking said deposition at the instance of
7 the Plaintiffs in the above-styled action pending in the
8 above-styled court.

9 THE COURT REPORTER: Raise your right hand,
10 Please, sir.

11 THEREUPON,

12 SAL RUGGIERO,
13 being by me first duly sworn to testify the whole truth
14 as is hereinafter certified, testifies as follows:

15 THE WITNESS: I do.

16 DIRECT EXAMINATION

17 BY MR. MIHET:

18 Q. Good morning. Would you please state your full
19 name for the record.

20 A. Salvatore Ruggiero.

21 Q. Good morning, Mr. Ruggiero. My name is
22 Horatio Mihet, and I represent the Plaintiffs in this
23 lawsuit. And we're here this morning to take your
24 deposition. We always start with a couple of ground
25 rules to make sure that we're all on the same page.

1 Okay?

2 A. (The witness nods head).

3 Q. Number one, everything that you and I are going
4 to be saying today is being transcribed by the court
5 reporter seated next to us, which is why it's important
6 for us to speak clearly and one at a time. Is that
7 okay?

8 A. Uh-huh.

9 Q. Your answer just now leads me to my next ground
10 rule, which is, in order for the court reporter to
11 accurately transcribe your testimony, it's important
12 that you verbalize your answers with a yes or a no or
13 some other way that you feel appropriate because head
14 nods or things like uh-huh don't always make it
15 accurately into the record. Is that okay?

16 A. Yes to both.

17 Q. Great. If you don't understand any one of my
18 questions, will you ask me to repeat it or rephrase it?

19 A. Yes.

20 Q. And, if you don't ask me to repeat or rephrase a
21 question but you answer it, can I understand from that
22 that you understood the question and intended to give
23 the answer that you did?

24 A. Yes.

25 Q. I don't think we'll be together all that long

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1 today. But, should you need a break at any time, please
2 let us know; and we'll be sure to accommodate you so
3 long as there's not a question pending at that time. Is
4 that okay?

5 A. Yes.

6 Q. Great. Throughout the deposition today, for
7 short, I may refer to the City. You'll understand I'm
8 talking about the City of Tampa?

9 A. Yes.

10 Q. And I may also refer for short to the ordinance.
11 You'll understand I'm talking about the ordinance
12 banning conversion therapy that Tampa has enacted which
13 is the subject of this lawsuit?

14 A. Yes.

15 Q. And I may also refer today to SOCE for short.
16 You know that stands for Sexual Orientation Change
17 Efforts?

18 A. Okay.

19 Q. You know now?

20 A. I know now, yeah.

21 Q. Similarly, GICE stands for Gender Identity Change
22 Efforts. Is that okay?

23 A. Okay.

24 Q. Great. Have you ever had your deposition taken
25 before?

1 A. Yes.

2 Q. In what circumstances? About how many times?

3 A. I spent thirty years as a police officer with the
4 City of Tampa.

5 Q. Okay. So we'll just say several dozen
6 depositions?

7 A. Oh, yes. Yes.

8 Q. Okay. What, if anything, did you do to prepare
9 for today's deposition?

10 A. Well, I met with Rob on Friday --

11 Q. Okay.

12 A. -- for a couple hours. It was mainly a
13 meeting-me type thing because I never met him before.

14 Q. Okay. And was anyone else present at that
15 meeting besides you and Rob?

16 A. No.

17 Q. Okay. So --

18 MR. WILLIAMS: "Rob," meaning, Rob Williams,
19 which is me.

20 MR. MIHET: Of course.

21 BY MR. MIHET:

22 Q. Did you review any documents in preparation for
23 today's deposition?

24 A. No.

25 Q. Whether at the meeting with Mr. Williams or at

1 anytime after or before?

2 A. No.

3 Q. What is your current position with the City of
4 Tampa?

5 A. Yeah. I'm the manager for the Neighborhood
6 Empowerment.

7 Q. And what is Neighborhood Empowerment?

8 A. Neighborhood Empowerment is Code Enforcement;
9 Neighborhood Enhancement, which is a clean-up operation;
10 business tax and we have a call center.

11 Q. What does the call center do?

12 A. It takes calls for any clean-up or any code
13 violation that a citizen might have.

14 Q. Okay. And what does the business tax division
15 do?

16 A. Business tax collects tax from businesses within
17 the City of Tampa.

18 Q. Now, you said that. How is Neighborhood
19 Enhancement different from Code Enforcement?

20 MR. WILLIAMS: Empowerment.

21 MR. MIHET: No.

22 BY MR. MIHET:

23 Q. I think you said there's Code Enforcement?

24 A. Yeah.

25 Q. There's Neighborhood Enhancement. There's

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1 business tax, and there's the call center.

2 A. Neighborhood Empowerment is the name of the whole
3 division.

4 Q. Right.

5 A. Code Enforcement handles living condition issues
6 and, you know, any kind of work without permits, things
7 like that. Neighborhood Enhancement is the section that
8 cleans up right-of-ways and removes debris off streets
9 and things like that.

10 Q. With respect to Neighborhood Enhancement, you
11 said it cleans up debris from streets and right-of-ways.
12 Is Neighborhood Enhancement also involved with issues
13 that arise on particular private properties? Or is that
14 Code Enforcement?

15 A. Code Enforcement.

16 Q. Okay. So Neighborhood Enhancement deals with the
17 public streets and right-of-ways?

18 A. Correct.

19 Q. Okay. How long have you been the manager for
20 Neighborhood Empowerment?

21 A. Coming up on five years.

22 Q. So you started sometime in 2013?

23 A. Correct.

24 Q. And is that an appointed, an elected position?
25 How did you get to be the manager there?

1 A. I was appointed.

2 Q. Appointed. By whom?

3 A. The mayor.

4 Q. Who is the mayor that appointed you?

5 A. Buckhorn.

6 Q. Did you have to be approved by a legislative
7 body, or was it just a mayor appointing you --

8 A. Mayor --

9 Q. -- sufficient?

10 A. -- appointing.

11 Q. Were you appointed for a particular finite term,
12 or is it an indefinite appointment?

13 A. Indefinite.

14 Q. Okay. Are there any plans for you to leave this
15 position anytime in the foreseeable future?

16 A. No.

17 Q. Okay. Did you have a position with the City of
18 Tampa prior to being its manager for Neighborhood
19 Empowerment?

20 A. Yes. Well, I actually retired from the Tampa
21 Police as a police commander major in 2011.

22 Q. And how long were you working for Tampa Police?

23 A. Thirty years.

24 Q. Okay. Can you briefly tell me your educational
25 background, not starting with first grade, but say

1 after -- after high school.

2 A. Yeah. So I have a bachelor's degree in
3 administration of justice, and I hold a master's degree
4 in organizational management. And I'm also certified as
5 a professional in -- just drew a blank. In -- you know,
6 employee relations, that type of thing.

7 Q. Like, human resources?

8 A. Human resources. That's the word I was looking
9 for. Yeah, certified as a professional in human
10 resources.

11 Q. Okay. Do you hold any other professional
12 certifications besides human resources?

13 A. No.

14 Q. Do you hold any licensing in counseling or the
15 mental health field?

16 A. No.

17 Q. Have you had any training in the counseling or
18 mental health field?

19 A. No.

20 Q. Have you had any prior experience with -- I'll
21 call them LGBT issues, for lack of a better word, prior
22 to this particular ordinance?

23 A. No.

24 Q. Advocacy in that field or perhaps part of kind of
25 a lawsuit, anything like that?

1 A. Nothing.

2 Q. Okay. Did you have any interaction or dealing
3 with the field of conversion therapy prior to this
4 ordinance?

5 A. No.

6 Q. Were you involved at all in the consideration and
7 the debate of the ordinance prior to it being enacted?

8 A. No.

9 Q. No one solicited your input or your thoughts on,
10 say, enforcement issues relating to the ordinance?

11 A. No.

12 Q. Was anyone in your department involved in the
13 consideration or debate of the ordinance prior to its
14 enactment?

15 A. Not to my knowledge.

16 Q. Okay. When did you first learn that your
17 department was going to be entrusted with enforcement of
18 the ordinance?

19 A. After it passed.

20 Q. And how did you learn that?

21 A. I was told by the legal department.

22 Q. Okay. And was that during a formal meeting? Was
23 it a phone call? Do you recall how that came about?

24 A. It might have been -- I think, when I had to
25 appear at City Council on another matter --

1 Q. Okay.

2 A. -- one of the attorneys told me that we would be
3 enforcing it.

4 Q. Tell me about that discussion.

5 A. You're going to be enforcing this ordinance.

6 Q. Okay. And you said?

7 A. Okay.

8 Q. Okay. All right. Was there any discussion at
9 that point about any particular issues that might arise
10 with respect to enforcement of the ordinance?

11 A. Not at that time, no.

12 Q. Tell me about the -- well, let me ask you this.
13 Is enforcement of the ordinance, does that go underneath
14 the Code Enforcement division; or does it go under the
15 Neighborhood Enhancement division?

16 A. It would be under Code Enforcement.

17 Q. Code Enforcement.

18 And so, tell me a little bit about the Code
19 Enforcement division. Is it appropriate to call it a
20 division? Is it a department? What's the --

21 A. It's fine. The way you're referring to it is
22 fine.

23 Q. Tell me a little bit about the Code Enforcement
24 division in terms of how it's set up, the leadership
25 structure --

1 A. Yeah.

2 Q. -- who works for the division.

3 A. Yeah. So I'm the manager.

4 Q. Okay.

5 A. And then, under me, I have six supervisors. And
6 those six supervisors have a team that's made up of Code
7 Enforcement and Neighborhood Enhancement. So they each
8 have about ten or twelve workers that we supervise. And
9 then, under the supervisors, there's three assistants
10 that we call senior inspectors. And they help out
11 with -- you know, with the supervisor managing these
12 teams. And then they're -- they take over when the
13 supervisor is maybe on vacation or out sick.

14 Q. Okay. So you have the manager, you --

15 A. Uh-huh.

16 Q. -- sitting on top?

17 A. Yes.

18 Q. Under you, you've got six supervisors?

19 A. Correct.

20 Q. And, under them, you have three senior
21 inspectors?

22 A. Correct.

23 Q. And then you have six teams of ten to twelve
24 enforcers each?

25 A. Not -- well, it's a combination of enforcers and

1 clean-up.

2 Q. Okay.

3 A. That's the enhancement.

4 Q. There are distinct individuals that perform
5 enforcing responsibilities, and others that perform
6 clean-up --

7 A. Yes.

8 Q. -- responsibilities?

9 And about how -- how is a team broken down? Is
10 it about half and half enforcers versus clean-up? Or...

11 A. On the east side of the City, there's more than
12 would be in South Tampa because of the call load, you
13 know, the clean-up and all that.

14 Q. Yeah.

15 A. Depending on the workload. So East Tampa might
16 have a little bit more than South Tampa, maybe one or
17 two; but they're pretty close.

18 Q. Are there positions and duties interchangeable?
19 Can somebody today be part of the clean-up team and --
20 and then tomorrow or next week switch over to being an
21 enforcer? Or are they clearly-delineated roles with --

22 A. Right. The first scenario? No, that wouldn't
23 be.

24 Q. Okay. They're clearly delineated --

25 A. Yes.

1 Q. -- roles?

2 A. Yes, sir.

3 Q. And the enforcers do just enforcement, and the
4 clean-up guys do just clean-up?

5 A. Yes.

6 Q. And the clean-up guys then would not have any
7 responsibilities for enforcing this particular ordinance
8 we're talking about?

9 A. Or any ordinance, correct.

10 Q. Okay. So approximately how many code enforcers
11 are there that work for the City? If you've got six
12 teams --

13 A. Uhm.

14 Q. -- and you have maybe a half a dozen each; is
15 that fair?

16 MR. WILLIAMS: Let him finish his question.

17 THE WITNESS: Yeah.

18 BY MR. MIHET:

19 Q. What does the math work out to?

20 A. Forty, forty-five citywide, somewhere around
21 there.

22 Q. Okay. Are the three senior inspectors themselves
23 assigned to these teams, or are they sort of sitting on
24 top of the teams --

25 A. They're -- they're --

1 Q. -- organizationally speaking?

2 A. -- above the team. Yeah. They kind of -- you
3 know, like I said, they're -- they help out with the
4 supervision of the work.

5 Q. Okay. What are your responsibilities within the
6 code enforcement division?

7 A. So, you know, I oversee the whole operation. I
8 have to make sure that, you know, all the work is
9 getting done, that they're following up on complaints
10 and, you know, we're making sure that people are living
11 safe out here. If there's any clean-up issues, I have
12 to, you know, make sure that's being addressed. I
13 oversee, you know -- the supervisory -- like, the
14 business tax supervisor, if there's an issue, he'll come
15 to me; and we'll hash out whatever might happen. The
16 call center might have a problem with something.
17 They'll come to me and -- you know, so, overall, I
18 basically oversee the day-to-day operations of the whole
19 division.

20 Q. Okay. And who do you report to?

21 A. Jake Slater.

22 Q. Who is he?

23 A. He's an administrator.

24 Q. Is that his title?

25 A. Correct.

1 Q. City administrator?

2 A. He's -- yes. Yes, sir.

3 Q. And who does Mr. Slater report to?

4 A. Bob Buckhorn, the mayor.

5 Q. What is the educational requirement for the City
6 of Tampa code enforcers?

7 A. High school.

8 Q. High school diploma or its equivalent, like, a
9 GED?

10 A. Correct. Yes, sir.

11 Q. Okay. Are they required to hold any professional
12 certifications or licenses?

13 A. Yeah, they have to be certified.

14 Q. As what?

15 A. As a certified code inspector. They take a --
16 you know, they read a book; and then they take an exam.

17 Q. Generally, what's the subject matter that the
18 book and the exam cover?

19 A. Yeah. So it would be, like, anything that has to
20 do with construction of a building or living conditions.
21 And then they get into some, you know, legal, you know,
22 search and seizure, that type of thing. Not -- not a
23 lot on that. Mainly, the crux of the exam is basically
24 on buildings, what to look for, you know, structure
25 damage and things like that.

1 Q. Okay. What about, like, grass that's too tall,
2 things of those --

3 A. Well, see, that exam just covers what I just
4 said.

5 Q. Okay.

6 A. Most -- yeah. It doesn't cover the grass and all
7 that.

8 Q. Okay.

9 A. They get that on the job.

10 Q. On-the-job training?

11 A. Yes.

12 Q. Okay. Other than the code inspector's
13 certification, are the code enforcers required to hold
14 any other professional licensing or certification?

15 A. No, that's it.

16 Q. Okay. Does the educational or licensing
17 requirement differ for the three senior inspectors? Are
18 they required to have additional education or
19 certification beyond what we just talked about for the
20 regular code enforcers?

21 A. No.

22 Q. And so what about the six supervisors?

23 A. No.

24 Q. Okay. So, to be a code enforcer in the City of
25 Tampa, including a senior inspector or a supervisor, all

1 you need is a high school diploma or the equivalent and
2 the code inspector certification?

3 A. Correct.

4 Q. Okay. And, just for clarity, from now on when I
5 refer to a code enforcer, I mean to include the three
6 senior inspectors and the six supervisors in that
7 umbrella unless I say otherwise. Okay?

8 A. Understood.

9 Q. Have the City of Tampa code enforcers received
10 any training on any mental health issues?

11 A. No.

12 Q. Have the code enforcers of the City of Tampa
13 received any training on any issues that might arise in
14 family therapy?

15 A. No.

16 Q. Have they received any training with respect to
17 any issues that might arise in the context of
18 counseling?

19 A. No.

20 Q. Okay. And, if I asked the same questions for
21 yourself, would the answer be no, as well?

22 A. Yeah. Correct.

23 Q. You haven't had any training in those fields
24 either?

25 A. No.

1 Q. Okay.

2 MR. WILLIAMS: Harry, just so I'm clear on
3 the line of questioning, you're talking about training
4 that emanates from the City of Tampa as opposed to what
5 someone might obtain on his or her own account? Unless
6 he questioned all of them, he wouldn't know that, of
7 course.

8 MR. MIHET: Of course.

9 BY MR. MIHET:

10 Q. But I think you understood my question?

11 A. Yeah. I'm answering based on what the City might
12 provide.

13 Q. Right. The City hasn't provided any of those
14 trainings?

15 A. No.

16 Q. And the City is not aware of any individual code
17 enforcer going out and getting this kind of training on
18 their own?

19 A. I can answer for myself.

20 Q. Okay.

21 A. And the answer would be, no, I don't know.

22 Q. You, as the manager, as the head of the
23 department, don't know of any such training?

24 A. Correct.

25 Q. Okay. Certainly, the City hasn't required the

1 code enforcers to go out and obtain this kind of
2 training from someone else?

3 A. They have not.

4 Q. Okay. Have the code enforcers, including
5 yourself and the supervisors and the senior inspectors,
6 received any training on how to investigate complaints
7 that might arise under this ordinance, the conversion
8 therapy ordinance?

9 A. Yes.

10 Q. What kind of training have they received?

11 A. Now, I'm going to take myself out of it because I
12 didn't attend. Okay?

13 Q. Okay.

14 A. When this passed, I think it was in April of
15 2017, I directed our legal adviser at that time to
16 develop something. But it was some time that passed by.
17 It didn't happen right away.

18 Q. Okay.

19 A. So, in August of 2017, he -- he trained the
20 troops on --

21 Q. Enforcement?

22 A. -- the ordinance and how we're going to enforce
23 it.

24 Q. Okay. Who are we talking about? Who --

25 A. Jerrod Simpson.

1 Q. And Mr. Simpson is -- what's his function, his
2 title?

3 A. He is an assistant city attorney.

4 Q. Okay. And why did you ask him to provide this
5 training?

6 A. I wanted the division to be prepared in case we
7 did get a complaint --

8 Q. Okay.

9 A. -- on, you know, how to handle the situation.
10 And the bottom line is, if we do get a complaint,
11 everything is going to get run through the legal
12 department before we -- you know, before we make any
13 steps on anything.

14 Q. I take it that's how the City -- how the Code
15 Enforcement department operates with every other
16 complaint? They run it through the legal department?

17 A. Quite a bit. I mean, you know, if it's tall
18 grass or things like that. But, if it starts to get a
19 little complicated, we always bring the legal department
20 involved.

21 MR. WILLIAMS: Harry, for your information,
22 Mr. Simpson is one of our 30(b)(6) witnesses; and he
23 will be here tomorrow, of course.

24 MR. MIHET: Okay.

25 BY MR. MIHET:

1 Q. So what kinds of matters do you typically run
2 through the legal department? You said if it gets a
3 little complicated. Give me an idea.

4 A. Well, if we have a house that may -- you know,
5 may be a candidate for demolition but there's a
6 foreclosure going on, we bring them in -- we get them
7 involved in that. There's been other issues where we've
8 had fencing around a property with a gate lock. You
9 know, get advice on that. You know, just things like
10 that.

11 Q. Okay.

12 A. Sometimes we may need a letter sent to somebody
13 in response to something, and they'll do that.

14 Q. Okay.

15 A. You know, stuff like that.

16 Q. And why is it that complaints under this
17 ordinance would be routed through to the legal
18 department?

19 A. Well, number one, this is a situation where the
20 code investigators, they're not -- they don't handle
21 this type of thing. The legal department would be the
22 ones that would -- if it went to prosecution, you know,
23 they would oversee it. So we would get them involved to
24 see, you know, number one, do we have a complaint here?
25 Does it meet any -- any probable cause under the

1 ordinance? Any other questions that we might have to
2 get involved in, things that he would have -- he could
3 answer that when he comes. But just things that he
4 would have to prove if there was going to be a case
5 made --

6 Q. Okay.

7 A. -- that type of thing.

8 Q. Whose responsibility is it under the -- the City
9 code to issue a notice of a violation when there is a
10 Code Enforcement violation?

11 A. Oh, it's us. Yeah, it would be my folks.

12 Q. Is that terminology appropriate? Is it a notice
13 of violation or a citation? What is issued when a
14 violation --

15 A. Usually, a --

16 Q. -- is detected?

17 A. Yeah. So, usually -- like the example of
18 overgrowth?

19 Q. Yep.

20 A. We would issue a letter saying that you have
21 twenty-one days to cut your grass or -- you know, or
22 further action will be taken.

23 Q. What is the further action in that situation?

24 A. Well, that situation there would be -- it would
25 be a reinspection. And then, if it didn't -- they

1 didn't cut the grass, they would get a ticket.

2 Q. Okay. A ticket?

3 A. A ticket, yes.

4 Q. And the ticket then would start the -- the
5 process of them having to come in and either pay the
6 ticket or -- or do what?

7 A. Or challenge it.

8 Q. Okay. Challenge it where?

9 A. Through -- through the court system.

10 Q. Okay. A special magistrate or...

11 A. The tickets go to Hillsborough County.

12 Q. Okay. Are there special magistrates that are
13 used as part of the Code Enforcement process?

14 A. Yes.

15 Q. In what cases?

16 A. Any type of, like, building violation, like, your
17 house needs to be painted or, you know, you have
18 accumulations on your property, things like that. That
19 can go -- that can go to the magistrate. Any zoning
20 case goes to the magistrate.

21 Q. So, if tickets go to the court, what -- what is
22 issued in a case that goes to the magistrate? Is
23 that --

24 A. Just a court date.

25 Q. Okay.

1 A. Yeah.

2 Q. It's like a notice of violation --

3 A. (The witness nods head).

4 Q. -- or a letter or --

5 A. It's a letter saying that, since you did not, you
6 know, correct the problem --

7 Q. Okay.

8 A. -- you need to appear on such and such a date in
9 front of the magistrate.

10 Q. Okay. And, in both of those instances, whether
11 it's the notice with the court date or the ticket being
12 issued, whose duty is it to -- to determine that a
13 violation has taken place and a notice or a ticket has
14 to be issued?

15 A. It would be the inspector, yeah.

16 Q. The code enforcement official?

17 A. Correct.

18 Q. Okay. And, with respect to enforcement under the
19 conversion therapy ordinance, is it -- is it also the
20 case that it's the code inspector that has to determine
21 whether a violation has taken place and issue a ticket
22 or a notice?

23 A. Ultimately.

24 Q. Okay. When you say, "ultimately," what do you
25 mean?

1 A. Because we're going to review it with the legal
2 department first.

3 Q. Okay.

4 A. But we haven't had a case to review, so I really
5 can't comment.

6 Q. Sure. So the Code Enforcement official receives
7 a complaint. You say they're going to review it with
8 the legal department. And then, based on that review,
9 the Code Enforcement official decides whether a notice
10 of a violation or a ticket has to be issued?

11 A. Well, in that scenario you just, you know,
12 detailed --

13 Q. Yeah.

14 A. -- I would say that they're going to be on the
15 same page, the legal department and the -- and the
16 investigator.

17 Q. Why would you say that?

18 A. Well, because they're going to work in
19 conjunction on that case.

20 Q. Okay. But the ultimate decision belongs with the
21 Code Enforcement person under the code, right?

22 A. Under this particular -- and you can ask
23 Jerrod Simpson. Okay? The decision has been made that
24 they will review. And, to me, that means they're going
25 to direct how the investigation is going to go.

1 Q. "They," being the legal department?

2 A. Correct.

3 Q. So you believe that, with respect to enforcement
4 of the ordinance, the ultimate calls are going to be
5 made in the legal department, not by Code Enforcement?

6 A. I think that it's going to be a common -- they're
7 going to direct our investigator on how to proceed.

8 Q. And the investigator is going to listen to that
9 direction in every instance?

10 A. Yeah.

11 Q. Okay. And in what other instances within the
12 Code Enforcement process does that same thing happen,
13 the decision is made by the legal department as opposed
14 to the Code Enforcement person?

15 MR. WILLIAMS: Before you answer.

16 THE WITNESS: Yes.

17 MR. WILLIAMS: Will you read that question
18 back for me, please.

19 (Requested portion read back by the court reporter)

20 BY MR. MIHET:

21 Q. And by, "the decision," I mean, the decision as
22 to whether or not a violation has occurred such that a
23 ticket or a notice must be issued.

24 MR. WILLIAMS: Harry, I'm going to object to
25 the form of that question because I'm not sure that was

1 the import of his answer. But my objection is on the
2 record.

3 So please go ahead, if you understand it.

4 THE WITNESS: Okay. So you're asking if
5 legal has ever given our folks advice on how to proceed
6 on a case?

7 MR. MIHET: Well, not necessarily advice.

8 BY MR. MIHET:

9 Q. The way I understood you to be testifying -- and
10 correct me if I misunderstood it. But I understood you
11 to say, with respect to the ordinance, legal would be
12 making the determinations. They would be instructing
13 the code enforcers whether or not a notice or a ticket
14 has to be issued; and the code enforcers would listen to
15 legal, correct?

16 A. Correct, yes.

17 Q. So my question is: In what other instances does
18 that scenario happen besides this conversion therapy
19 ordinance?

20 A. Yeah. So -- I mean, I can't give you an exact,
21 you know -- you know, like, a date or something. But
22 it's happened where we may go to them and say -- I'm
23 trying to think of one recently. We may go to them or
24 the inspector might go to them or the supervisor and
25 say, hey look, we have this situation, we can either go

1 take them to Hillsborough County Court or take this case
2 to the magistrate, that type of thing.

3 Q. Okay.

4 A. And they may look at the facts and circumstances
5 and decide, well, we think this belongs in the
6 magistrate. So then that's where we bring it. So
7 there's other instances where they -- where they
8 directed us to, you know, take it somewhere else; and
9 we've done it. Or, you know, like, there's been a
10 couple other cases where they'll -- you know, where
11 they'll direct us on, you know, how to enter a property,
12 things like that --

13 Q. Okay.

14 A. -- you know? There's been other directions. And
15 we're not going to argue with them on it. You know,
16 they're the prosecution of these cases. If Jerrod
17 Simpson or whoever is in that prosecutorial job, he
18 says, hey, we need it to go this way or gather this
19 evidence, we're going to do it. You know? That's the
20 way you build a case.

21 Q. Sure. They get to prosecute a case after the
22 Code Enforcement officials write the ticket or issue the
23 violation notice?

24 A. Or they can -- sometimes we jump -- they jump in.
25 We get them to come in before anything is issued, you

1 know, to kind of get some guidance there.

2 Q. Okay. So I guess that's what I'm trying to get
3 at because the examples you gave me dealt with -- with
4 matters of strategy or procedure, whether to go to one
5 court or another. You know?

6 What I'm -- what I'm asking is, with respect to
7 that initial determination of whether or not a violation
8 has occurred and whether or not a ticket or a notice of
9 the violation should be issued, in what other instances
10 are those calls made by the people in the legal
11 department as opposed to the code enforcers?

12 A. I mean, I would say not a lot.

13 Q. Okay.

14 A. That would be my answer.

15 Q. Okay.

16 A. You know?

17 Q. So has it ever happened?

18 A. Where they've directed us to proceed a certain
19 way?

20 Q. Yeah, to say, hey, there is a violation there.
21 You need to go issue a -- a citation.

22 A. No, no. They're not -- they're not out there on
23 the street looking for violations. Okay? So we can
24 take, you know, that answer -- they're not out there
25 doing that.

1 Q. Okay.

2 A. Most of the time it's us going to them.

3 Q. Okay. And has it ever happened where -- where a
4 Code Enforcement official said, you know what, I've
5 looked at this particular situation, I've looked at the
6 grass on this property, I don't think it's too tall and
7 somebody in the legal department say, well, no,
8 actually, that is too tall, it is a violation of our
9 code, you need to go out and issue a citation for that?

10 A. No.

11 Q. Okay.

12 A. No. That example -- no, I don't have any
13 examples like that.

14 Q. Okay. Can you think of any examples where the
15 initial decision of whether or not a violation has taken
16 place is made by someone in the legal department as
17 opposed to a Code Enforcement official?

18 A. No. Most of the time, it's -- we have a
19 situation, you know, we want some guidance. And -- you
20 know? And then that's when we go to them. But, for
21 them to be out there looking for violations or that type
22 of thing, no.

23 Q. Okay. What if someone were to make a complaint
24 directly to the legal department, what would happen in
25 that situation?

1 MR. WILLIAMS: You're talking about any
2 infraction?

3 MR. MIHET: Yep.

4 THE WITNESS: Well, it would -- they
5 probably would call me and say, hey look, we've got this
6 complaint. Can you look into it? And then I would
7 assign it to the appropriate supervisor, and then it
8 would work its way down from there.

9 BY MR. MIHET:

10 Q. Okay. What did this training that Mr. Simpson
11 provided in August 2017 for the Code Enforcement
12 officials consist of?

13 A. Basically, an overview of the ordinance and then
14 basically the determination that, if we do get a case,
15 bring it to the legal department first.

16 Q. Anything else that was covered at this training?

17 A. That's -- you'd have to ask him. I wasn't
18 present at the training.

19 Q. Okay. Why were you not present at the training?

20 A. I don't know. I might have had something else to
21 do. Could have been -- I don't know.

22 Q. Were there any written materials distributed at
23 the training?

24 A. Not that I know of.

25 Q. Okay. Was the training recorded in any fashion?

1 Audio? Video? Transcribed?

2 A. PowerPoint.

3 Q. Was there a PowerPoint?

4 A. Yeah.

5 Q. Okay. Who would have that PowerPoint?

6 A. Jerrod Simpson.

7 Q. Other than the PowerPoint presentation, was there
8 any recording; audio, video or transcription, of the
9 session?

10 A. I would say, to my knowledge, no.

11 Q. Okay. Have you ever seen the PowerPoint?

12 A. Yes.

13 Q. When?

14 A. I think I looked at it last week.

15 Q. Okay. And what did the PowerPoint consist of?

16 A. What I previously stated.

17 Q. Okay. Which is the overview of the ordinance and
18 an instruction that, when a call is received, to bring
19 it to the legal department?

20 A. Yeah.

21 Q. Did you see anything else in the PowerPoint?

22 A. Not that I recall.

23 Q. Okay. Did you look at the PowerPoint last week
24 in anticipation of your deposition here today?

25 A. Ah...

1 Q. Well, let me ask you this. Let me try it a
2 different way.

3 A. Yeah.

4 Q. Why did you look at the PowerPoint presentation
5 last week?

6 A. I wanted to look and see what date it was
7 actually done. That was my reasoning. But it didn't
8 have a date on it.

9 Q. Okay. And was the reason that you were looking
10 to determine the date because you knew that you would
11 have to come and testify about it here today?

12 A. No. I just -- I -- it was for my own -- you
13 know, I just was trying to put things in my mind, like,
14 when did this thing pass? And then I remember talking
15 about we need to get some training and then just kind of
16 get it in my mind.

17 Q. What prompted you to start thinking about that,
18 if not -- if not knowing that you would be deposed here
19 today?

20 A. Just -- I don't know. I mean, I wasn't -- you
21 know, wasn't --

22 Q. Okay.

23 A. -- trying to, you know, prepare for a test or
24 anything like that. Just wanted to, you know, see what
25 was done.

1 Q. Okay. Did looking at that PowerPoint help to
2 refresh your recollection about the date when the
3 presentation occurred?

4 A. No. I said it didn't.

5 Q. Okay.

6 A. It didn't. And I had to --

7 Q. How is it that you know then that it was around
8 August --

9 A. Because --

10 Q. -- 2017?

11 A. -- I -- when it didn't have a date, I looked -- I
12 called one of the other supervisors and asked if there
13 was a sign-in sheet. And, she said, yes, it was
14 August -- I think it was August 1st.

15 Q. Which supervisor did you speak with about the
16 sign-in sheet?

17 A. Susan Wenrick.

18 Q. Can you spell that last name?

19 A. Yeah. W-e-n-r-i-c-k.

20 Q. And is she one of the six supervisors that we
21 were talking about earlier?

22 A. Yes.

23 Q. Okay. And what is it that you asked Ms. Wenrick?

24 A. About a sign-in sheet for that particular day.

25 Q. And why were you asking her about a sign-in

1 sheet?

2 A. I just wanted to get in my mind what day this all
3 occurred.

4 Q. Okay. And did she provide you with a sign-in
5 sheet?

6 A. She told me the date.

7 Q. Okay. She looked at a sign-in sheet?

8 A. Yeah. She has a sign-in sheet, correct.

9 Q. And she told you the date?

10 A. Correct.

11 Q. And what was the date that she gave you?

12 A. I think it was August 1st of 2017.

13 Q. Was Ms. Wenrick present at this training?

14 A. Yes.

15 Q. And would the sign-in sheet have the names of all
16 the people who were present?

17 A. Yes.

18 Q. And, generally, who were the people that were
19 present there?

20 A. You'd have to see the sheet. But, you know, it
21 would probably be the inspectors and the supervisors and
22 the seniors.

23 Q. Okay.

24 A. Whoever -- unless somebody was on vacation or
25 something.

1 MR. MIHET: Let me just ask your attorney.

2 Mr. Williams, was the PowerPoint
3 presentation and the sign-in sheet produced to us?

4 MR. WILLIAMS: No, because that was not
5 possessed or in the custody of any of the twenty
6 custodians that Magistrate Judge Sansone had in her
7 order. That's the answer. As I told Roger yesterday,
8 as you know, we've had several hearings on that. And
9 we've tried to comply with her order as best we can.
10 And Mr. Simpson is not on that list. Mr. Jerrod's not
11 on that list. Ms. Wenrick's not on that list. And
12 the -- I think the best way to put it, Harry, is that,
13 because the Court was very specific, we had to try to
14 comply with this.

15 Now, having said that, I'll be happy to
16 consider and consult with the City as to whether they're
17 willing to produce that sign-in sheet, if you want it,
18 and the power slide presentation.

19 MR. MIHET: Okay.

20 MR. WILLIAMS: To me, it's innocuous. To
21 you, it may not be. I mean, if you're going into this
22 in some detail, I'm not sure why. I mean, I can
23 speculate; but that's neither here nor there. I will
24 certainly inquire of that, and maybe we can deal with
25 Mr. Simpson tomorrow.

1 MR. MIHET: Okay. Well, you know, just for
2 the record --

3 MR. WILLIAMS: That's the answer to your
4 specific question.

5 MR. MIHET: Great. You know, just for the
6 record, Mr. Ruggiero's name is among the list of twenty
7 custodians.

8 MR. WILLIAMS: Yeah. But he doesn't have a
9 copy of that.

10 MR. MIHET: It's certainly within his
11 custody, possession or control, is it not?

12 MR. WILLIAMS: No, not -- not the slide
13 presentation.

14 MR. MIHET: Okay.

15 MR. WILLIAMS: No. He doesn't have it.

16 MR. MIHET: Well, he just testified he
17 looked at it last week.

18 MR. WILLIAMS: But he -- he didn't look at
19 it prior to December 15, which is the cutoff date. So
20 I'm taking the Court's order literally. Okay?

21 BY MR. MIHET:

22 Q. So, Mr. Ruggiero, do you have a copy of this
23 PowerPoint presentation available to you?

24 A. Yeah. I have it on e-mail.

25 Q. And you had it last week?

1 A. Correct.

2 Q. And who sent the e-mail that you have it on?

3 A. Susan Wenrick.

4 Q. Okay. And when was that e-mail sent to you?

5 A. I think it was Friday.

6 Q. Is Ms. Wenrick a member of the Code Enforcement
7 division then?

8 A. Yes.

9 MR. MIHET: Okay. So, Mr. Williams,
10 obviously, we would -- we would argue that both of those
11 documents are relevant; and they should have been
12 produced. We'd ask you to let us know as early as
13 possible today whether or not you'd be willing to
14 produce them without us going back to the court. We
15 believe that we are and will be further prejudiced by
16 having to question these witnesses without the benefit
17 of those two documents. So I'm hoping we could resolve
18 the issue by you voluntarily providing them to us this
19 afternoon. But, you know, if not, then we'll do what we
20 need to do.

21 MR. WILLIAMS: Here's my position on that
22 question. I disagree with you that they -- we were --
23 the City was obligated to produce those documents. We
24 are trying to comply with the Court's order, and we are
25 reading the Court's order as I articulated earlier.

1 Having said that, again, I disagree that we
2 have not complied with the Court's order. We may have
3 an honest disagreement on that. But, having said that,
4 rather than create an unnecessary kerfuffle on something
5 that I see as, frankly, legally innocuous, it would be
6 my recommendation to the City that we just provide this
7 stuff voluntarily so we can move on. I don't want to
8 get --

9 MR. MIHET: Sure. Would it be your
10 recommendation that they do that this afternoon so that
11 we have a chance to discuss them, if necessary, at
12 tomorrow's deposition?

13 MR. WILLIAMS: Yes.

14 MR. MIHET: Okay. Thank you.

15 MR. WILLIAMS: I assume that sign-in sheet
16 is easily accessible. But -- and why don't we do this.
17 I need to take a break.

18 MR. MIHET: Okay.

19 MR. WILLIAMS: So let me talk to
20 Mr. Ruggiero off the record about the mechanics of all
21 of that, and we can go from there.

22 MR. MIHET: Let's do that.

23 (Recess)

24 MR. WILLIAMS: It is about twelve minutes
25 after eleven on Tuesday, October 30th; and I have handed

1 previously to counsel two documents. One is a
2 handwritten sign-in sheet which is entitled CSC -- I
3 guess that's one p.m. meeting with legal, August 1, '17,
4 that has the signatures of a number of people who
5 apparently were at that meeting. And I also handed a
6 Code Enforcement Update authored by Jerrod Simpson,
7 Assistant City Attorney, to counsel.

8 In accordance with my prior comments, let me
9 formalize my comments. These two documents, as far as
10 the City is concerned, did not come within the ambit of
11 Magistrate Judge Sansone's order. But their existence
12 came up during the course of Mr. Ruggiero's testimony.
13 And the City, based on my recommendation, has agreed to
14 nevertheless produce these documents so that we can have
15 a more efficient process here; and I have done so.

16 But I want to reiterate, as far as I'm
17 concerned and the City is concerned, these were not
18 within the ambit of this Court's order because
19 Mr. Simpson was not one of the custodians. And
20 Mr. Ruggiero didn't have a copy of it during the
21 timeframe that we're talking about, October 1 of '16
22 through December 15 of '17. With that statement on the
23 record, let's proceed with the questions and answers.

24 MR. MIHET: Okay. Just for the record, we
25 just disagree with the City's narrow interpretation and

1 narrow view of its obligation under the Court's various
2 orders. But we will bring those disagreements up with
3 the Court at the appropriate time.

4 (Plaintiffs' Exhibit Nos. 1&2 marked for identification)

5 BY MR. MIHET:

6 Q. All right. Mr. Ruggiero, I've handed you what we
7 have marked as Plaintiffs' Exhibit 1 and Plaintiffs'
8 Exhibit 2. Take a look at Plaintiffs' Exhibit 1,
9 please, and let me know is this the sign-in sheet that
10 you were testifying about prior to the break that is the
11 sign-in sheet that Ms. Wenrick provided to you with
12 respect to the training session that Mr. Simpson
13 conducted for the code enforcers?

14 A. Well, this is the first time I'm seeing this
15 sheet --

16 Q. Okay.

17 A. -- so... But the date is 8/1 of '17. That was
18 the date I was given.

19 Q. Okay. So, when you were discussing this sign-in
20 sheet with Ms. Wenrick, she told you that there was one;
21 and she told you the date that was on the sheet?

22 A. Yes.

23 Q. And the date that she gave you was August 1st of
24 2017?

25 A. Correct.

1 Q. And that's the date that appears on this
2 document, Exhibit 1?

3 A. Yes.

4 Q. So is there any doubt in your mind then that this
5 document is the sign-in sheet that was taken at the
6 meeting that you testified about in August 2017 where
7 Mr. Simpson provided training to the code enforcers with
8 respect to the ordinance?

9 A. No doubt.

10 Q. Okay. I'm counting twenty-eight signatures on
11 the first page and eight signatures on the second page
12 of Exhibit 1. So, if my math serves me right, it's
13 thirty-six attendees, right?

14 A. Correct.

15 Q. Was this a mandatory meeting for the code
16 enforcers?

17 A. Yes.

18 Q. And so I think you testified earlier that there
19 were between forty and forty-five enforcers. Is it fair
20 to say that some of them then did not -- were not able
21 to attend this meeting?

22 A. Yes.

23 Q. Was there any kind of a make-up session for them
24 or a requirement for them to fulfill -- to obtain this
25 training some other way?

1 A. No.

2 Q. Okay. When you take a look at the names on this
3 sheet, these are part of the forty or forty-five code
4 enforcers that the City of Tampa has?

5 A. Yes.

6 Q. Is there any name among these thirty-six that you
7 do not recognize?

8 A. The only one I can't really make out is this
9 scribble right here.

10 Q. For the record, you're pointing to the eighth
11 signature from the bottom of the first page; is that
12 right?

13 A. Correct.

14 Q. Okay. Other than that one entry, is there any
15 other entry that you cannot recognize?

16 A. Yes, I got -- everybody else is identified.

17 Q. And is everybody else a code enforcer -- well,
18 let me ask you that a different way. Are there any
19 names among the thirty-five that you do recognize who
20 are not code enforcers for the City of Tampa?

21 A. No, they all are. McLeish is now retired,
22 though. He's on the second page.

23 Q. Okay.

24 A. Second one down from the top.

25 Q. Okay. All the other ones are code enforcers for

1 the City of Tampa?

2 A. Yes.

3 Q. Are you able to tell me whether all six
4 supervisors and all three senior inspectors were in
5 attendance? Why don't we just -- as you go down, when
6 you spot a supervisor or an inspector, tell me; and
7 we'll identify them. Okay?

8 A. Yeah. So, right at the top, you've got Bowmer,
9 senior inspector.

10 Q. That's the first entry on the first page?

11 A. Yes.

12 Jerry Williams.

13 Q. Is what?

14 A. He's a supervisor.

15 Q. And that's the second entry on the first page?

16 A. Yes.

17 Carlos Rios, supervisor.

18 Q. Is that -- I see it.

19 A. Right below, Rasmussen.

20 Q. I see it.

21 Carlos Rios is a supervisor.

22 A. Ciucio, he's a senior inspector.

23 Q. And where do you see that name?

24 A. You see Alan Villa?

25 Q. Yep.

1 A. Right below Alan Villa.

2 Q. Jack Ciucio?

3 A. Ciucio.

4 Q. He's a senior inspector?

5 A. Correct.

6 Q. Okay.

7 A. Billie -- Billie J -- Jo Slatton, supervisor.

8 Q. Where do you see that?

9 A. Right at the bottom of the first page.

10 Q. Got it. Supervisor.

11 A. Susan Wenrick, supervisor. And then the last --
12 the second page, the last name, Randel Smith, that's a
13 senior inspector.

14 Q. Okay. So I'm counting about four of the six
15 supervisors and --

16 A. Right.

17 Q. -- and three -- all three senior inspectors. Is
18 that about right?

19 A. Correct.

20 Q. Can you tell which two supervisors were not in
21 attendance?

22 A. Right. Mike Peterson. Let me just double check
23 here. The other one would be Kevin Amos.

24 Q. Do you know why either one of those gentlemen did
25 not attend?

1 A. No.

2 Q. Okay. Looking at Exhibit 2, is this the
3 PowerPoint presentation that you testified about earlier
4 which is the one that you looked at last week from the
5 presentation that Mr. Simpson provided to the code
6 enforcers regarding the ordinance?

7 A. So the only part that I looked at was in the --
8 like, in the middle here.

9 Q. Okay.

10 A. That was it.

11 Q. For the record, you are pointing to a page that
12 has -- within Plaintiffs' Exhibit 2 that has Conversion
13 Therapy as a title at the top. And then the next entry
14 says, what is the violation, question mark. Do you see
15 that? That's what you're pointing to?

16 A. Correct.

17 Q. Okay.

18 A. Yes. And then the second page --

19 Q. And then the next page, same title, Conversion
20 Therapy with the subtitle, how is it enforced, correct?

21 A. Correct. And then this page here.

22 Q. And then the next page is the same title,
23 Conversion Therapy; and it's got an entry that says, all
24 possible conversion therapy cases must be referred to
25 legal for review, dash, prior to the issuance of a

1 notice of violation. Those are the three pages you
2 looked at?

3 A. Yes.

4 Q. Are those the only three pages you looked at?

5 A. Yes.

6 Q. But, to get to those three pages, you had to open
7 up a PowerPoint presentation, right?

8 A. The PowerPoint that I opened up only had those
9 three pages on it.

10 Q. Oh, it did?

11 A. Yeah.

12 Q. Okay. Where did the PowerPoint come from that
13 you opened up?

14 A. I think I answered earlier. Susan Wenrick sent
15 me an e-mail.

16 Q. Okay. There were only three slides in that
17 PowerPoint?

18 A. To the best of my knowledge, correct.

19 Q. Okay. Do you still have that e-mail in your
20 in-box?

21 A. I could look.

22 Q. Okay. Do you have a mobile device that you can
23 look on?

24 A. Yes.

25 MR. MIHET: Why don't we go off the record.

1 What I'd like to know is --

2 THE COURT REPORTER: Are we still on the
3 record?

4 MR. MIHET: Yes.

5 BY MR. MIHET:

6 Q. Just so you know, what I'd like for you to try to
7 determine, if you can, is to what extent that document
8 was different -- the document that you received by
9 e-mail was different from this Plaintiffs' Exhibit 2.
10 Okay? We're going to go off the record and give you a
11 chance to do that.

12 MR. WILLIAMS: And that's okay, Sal. I
13 don't want to make a big deal out of this. Let's move
14 on.

15 (Recess)

16 (Plaintiffs' Exhibit No. 3 marked for identification)

17 MR. WILLIAMS: We're back on the record.

18 During the colloquy between Mr. Mihet and
19 Mr. Ruggiero prior to this short break, the issue of
20 whether or not Mr. Ruggiero had seen a portion of the
21 slide presentation, which is Plaintiffs' Exhibit 2 to
22 this deposition, that topic came up. In order to
23 refresh Mr. Ruggiero's deposition, counsel asked him to
24 look at his iPhone; and he did. And we were able to
25 print off of the iPhone the portion of the slide show

1 that Mr. Ruggiero apparently had access to a week ago.

2 Now, all of this, as far as I'm concerned,
3 again, is outside of the parameters of the Court's
4 order. But, in an effort to move along and make sure
5 that there's no misunderstanding or difficulty regarding
6 this, I have made a decision to go ahead and produce
7 this. We're not going to produce the e-mail, itself,
8 because that's not relevant. And this is necessary, I
9 think, for Mr. Ruggiero to refresh his recollection.
10 And that's the basis upon which I'm producing it. Okay?

11 MR. MIHET: Okay.

12 MR. WILLIAMS: So please proceed.

13 MR. MIHET: So, obviously, we disagree with
14 just about all of that. But we'll resolve that at
15 another time.

16 BY MR. MIHET:

17 Q. Mr. Ruggiero, now you've been handed a document
18 that we have marked as Plaintiffs' Exhibit 3. Is this
19 the PowerPoint presentation that Ms. Wenrick e-mailed to
20 you that you reviewed last week regarding the conversion
21 therapy ordinance training that was provided by
22 Mr. Simpson to your code enforcers in August of 2017?

23 A. Yeah. That is what I just e-mailed, correct.

24 Q. Okay. And you mentioned that this was provided
25 to you in an e-mail by Ms. Wenrick?

1 A. Yes.

2 Q. And when did that e-mail arrive to you?

3 A. Friday.

4 Q. This past Friday?

5 A. Correct.

6 Q. And she was responding to a request that you had
7 made of her to send this to you or something else?

8 A. No, first part. Yes.

9 Q. You had asked her to send it to you, and she was
10 responding to that request?

11 A. Yes.

12 Q. Your request to her was conveyed by what means?

13 A. Phone call.

14 Q. So when did that phone call take place?

15 A. Friday.

16 Q. Okay. And so you called her, and you -- you
17 asked her what exactly?

18 A. I don't remember the exact words.

19 Q. Okay.

20 A. But, obviously, the gist of it was I'd like to
21 see, you know, what the training was.

22 Q. And did you tell her why you wanted to see it?

23 A. I don't recall.

24 Q. Okay. How long was your conversation with her?

25 A. Maybe a minute.

1 Q. Okay. What did she say when you told her that
2 you wanted to see what was provided to your code
3 enforcers?

4 A. Okay.

5 Q. And she said she would send it to you?

6 A. Yes.

7 Q. Okay. And why was it on Friday that you wanted
8 to take a look at this?

9 A. No particular reason. You know, I mean, no -- no
10 particular reason. That would be my answer.

11 Q. Okay. The e-mail message that came from
12 Ms. Wenrick attaching this presentation, was that the
13 first message in a string of communication; or was there
14 another e-mail below that she was responding to?

15 A. I don't know.

16 Q. Okay.

17 A. I don't know.

18 Q. Can you -- can you look and tell me, please.

19 MR. WILLIAMS: Take a look. I don't think
20 there's --

21 THE WITNESS: I don't --

22 BY MR. MIHET:

23 Q. Do you understand my question?

24 A. Let me pull it up, first.

25 Q. Yeah.

1 MR. WILLIAMS: Harry, I'm allowing this line
2 of questioning simply to help the witness refresh his
3 recollection. But I'm not going to get into the
4 e-mails. They're certainly outside of the boundaries of
5 the Court's order.

6 THE WITNESS: Okay. What was the question?

7 BY MR. MIHET:

8 Q. The e-mail communication from Ms. Wenrick
9 attaching this PowerPoint presentation, was it a -- an
10 original e-mail that she began or a communication that
11 she began; or was she responding to another e-mail
12 that's visible in that chain?

13 A. No, I don't -- you have to get specific with me
14 because -- you know what, I need -- it was actually on
15 Thursday. I thought it was Friday.

16 Q. That's fine. We can correct that.

17 A. Yeah. I thought it was Friday.

18 Q. That's okay.

19 A. It was actually Thursday.

20 Q. Memories are not always perfect.

21 So, now that you're looking at the e-mail, you
22 see that it actually took place on Thursday, not Friday?

23 A. Correct.

24 Q. And the date -- Thursday was what? October?

25 A. 25th.

1 Q. 25th of 2018.

2 So really what I'm asking is, you know, when --
3 when you send an e-mail to somebody, usually you do it
4 in one or two ways. You can click new e-mail; and you
5 start an e-mail, right? Or you can reply or respond to
6 a previous e-mail that had been sent. In that case, you
7 usually have the previous communication at the bottom
8 and what it is that you're going to say at the top. Are
9 you familiar with what I'm talking about?

10 A. Not really. But this is an e-mail from her to me
11 directly.

12 Q. Okay. And, at the bottom of her e-mail, are
13 there other previous communications?

14 A. I don't see any.

15 Q. Okay. And did -- in the e-mail that she sent
16 you, did she say anything about the attachment; or did
17 she only attach the attachment?

18 A. No. She says, as requested, please see attached
19 presentation --

20 Q. Okay.

21 A. -- provided to our department by the legal
22 department.

23 Q. Okay.

24 A. That's it, period.

25 Q. Okay. That's the only thing that she says?

1 A. Yes.

2 Q. Okay. And did you respond to that e-mail?

3 A. It doesn't look like I did.

4 Q. Okay. All right. Let's work off of Exhibit 3
5 since this is the one that you -- you saw.

6 A. All right.

7 Q. And so, just so we're clear, Exhibit 3 is what
8 you looked at last week. Exhibit 2 you hadn't seen
9 prior to today --

10 A. Correct.

11 Q. -- correct?

12 Now, Exhibit 3 does have more than three pages,
13 it looks like. I'm counting -- the pages aren't
14 numbered, but I'm counting approximately ten pages in
15 this. I think, earlier, you testified that you thought
16 there were only three pages in the presentation that --
17 that you looked at. Do you know what -- what the
18 discrepancy is there?

19 A. Well, it was probably my fault because, to me,
20 when I look on the iPhone, it looks different than this.

21 Q. I gotcha.

22 A. So that's the discrepancy.

23 Q. Okay.

24 A. So everything that's in this exhibit is on this
25 e-mail.

1 Q. Is on that e-mail. Okay.

2 So you identified earlier one of the pages that
3 you looked at which was the one that had the title
4 Conversion Therapy at the top. It's towards the end of
5 the document. I believe, for the record, it's the next
6 to the last page. Do you see that it says Conversion
7 Therapy at the top; and then it says, all possible
8 conversion therapy cases must be referred to legal for
9 review, dash, prior to the issuance of a notice of
10 violation. Do you see that?

11 A. Yes.

12 Q. That was one of the pages you looked at last
13 week?

14 A. Yes.

15 Q. Okay. Who is it that came up with this directive
16 that all possible conversion therapy cases have to be
17 referred -- must be referred to legal for review prior
18 to the issuance of a notice of violation?

19 A. I'm trying to remember conversations that you're
20 asking me, you know, about a year ago. So... I know --
21 I think we came to an agreement, myself and Simpson,
22 that this is the way it would be handled.

23 Q. Okay. Now, you had never seen this document
24 prior to last week --

25 A. Correct.

1 Q. -- correct?

2 And so it's fair to say you didn't write this
3 directive?

4 A. No.

5 Q. Okay. Do you know who wrote this directive?

6 A. Jerrod Simpson, I'm assuming, wrote it based on
7 the fact that he prepared the PowerPoint.

8 Q. Okay. And this would have been sometime in 2017
9 prior to August 1st --

10 A. Correct.

11 Q. -- correct?

12 When did you discuss this issue with him prior to
13 August 1st of 2017?

14 MR. WILLIAMS: Which issue?

15 MR. MIHET: The issue of the enforcement of
16 the conversion therapy ordinance.

17 THE WITNESS: I don't know the exact date.
18 And, I mean, the only thing that I could probably tell
19 you about that is that it probably happened in our
20 weekly staff meeting --

21 MR. MIHET: Okay.

22 THE WITNESS: -- at some time after -- after
23 we found out that it was passed.

24 MR. MIHET: Okay.

25 THE WITNESS: Sometime after that and prior

1 to August 1st, we had some type of discussion.

2 MR. MIHET: Okay.

3 THE WITNESS: I can't tell you exactly what
4 was said. I don't remember.

5 BY MR. MIHET:

6 Q. Okay. Why was it Mr. Simpson who provided
7 this -- this training as opposed to someone else in the
8 legal department?

9 A. He's our -- at the time -- he still is. But, at
10 the time, he was our direct legal adviser.

11 Q. For the Code Enforcement?

12 A. Correct.

13 Q. Okay.

14 A. He's now -- he's still -- we still have contact
15 with him because he handles the Hillsborough County
16 courtroom. Okay? So, at the time, he was our direct
17 legal adviser; so that's why he prepared it.

18 Q. Okay. What was his involvement in the drafting
19 or consideration of the ordinance? Do you know?

20 A. You'd have to ask him.

21 Q. Okay. What do you think he means here where he
22 says, all possible conversion therapy cases must be
23 referred to legal for review? He puts "all" in all
24 caps.

25 A. You'd have --

1 MR. WILLIAMS: Object to the form of the
2 question because it clearly calls for speculation.

3 MR. MIHET: Okay.

4 BY MR. MIHET:

5 Q. Go ahead.

6 MR. WILLIAMS: You're not required to
7 speculate, but you can answer his question.

8 THE WITNESS: State the question, again.

9 BY MR. MIHET:

10 Q. Why do you believe that this document emphasizes
11 the word all by putting it in all caps? What does that
12 convey to you?

13 A. To me, it means all cases.

14 Q. Without exception?

15 A. Correct.

16 Q. Okay. And also another word that is emphasized
17 is the word prior. It appears in all caps, right?

18 A. Yes.

19 Q. What does that mean to you when it says, prior to
20 the issuance of a notice of violation?

21 A. Again, all cases.

22 Q. All cases have to be referred prior to when a
23 notice of violation is issued?

24 A. Yes.

25 Q. Okay. And whose decision was it that all

1 possible cases, without exception, would have to be
2 referred to legal for review?

3 MR. WILLIAMS: Object to the form.

4 Lack of foundation.

5 You can answer it, if you can.

6 THE WITNESS: Say, again.

7 BY MR. MIHET:

8 Q. Whose decision was it that all possible cases,
9 without exception, would have to be referred to legal
10 for review?

11 A. Well, I mean, I'm in agreement with it. So...

12 Q. I understand that.

13 A. That would be my answer. I'm in agreement with
14 it.

15 Q. Okay. My question is: Where did this directive
16 originate? In light of the fact that you hadn't seen
17 this prior to last Thursday --

18 A. All right.

19 Q. -- who came up with this directive? Can we agree
20 that it wasn't you?

21 A. It wasn't me. It wasn't me that wrote this on
22 the paper --

23 Q. Okay.

24 A. -- okay? Anything follow-up from that?

25 Q. Yeah. Before this was put on paper, who came up

1 with this directive that all cases would be referred to
2 legal for review? Do you know?

3 A. I don't recall. You'd have to ask
4 Jerrod Simpson.

5 Q. Okay. It wasn't you?

6 A. Did I tell him to write this on the paper?

7 Q. Did you tell -- did you call Jerrod up and say,
8 hey Jerrod, I want to issue a directive that all
9 possible conversion cases must be referenced to legal
10 for review, please help me do that? Or words to that
11 effect.

12 A. I don't recall.

13 Q. Okay.

14 A. I don't recall having a conversation like that.

15 Q. You don't recall ever instructing Jerrod Simpson
16 or anyone else from the legal department that it was
17 your decision that all possible conversion therapy cases
18 must be referred to legal for review?

19 A. I don't recall having that conversation --

20 Q. Okay.

21 A. -- with those -- with those words. I don't
22 recall it.

23 Q. Do you recall ever making that decision yourself?

24 MR. WILLIAMS: "That decision," meaning
25 what?

1 MR. MIHET: That all possible conversion
2 therapy cases must be referred to legal for review prior
3 to the issuance of a notice of violation.

4 MR. WILLIAMS: Do you understand the
5 question, Mr. Ruggiero?

6 THE WITNESS: Yeah, I do.

7 MR. MIHET: Okay.

8 THE WITNESS: I just can't -- I don't recall
9 every conversation that I had. You know, I -- can I
10 talk to you for a second?

11 MR. MIHET: No.

12 MR. WILLIAMS: No.

13 THE WITNESS: Okay. So here's the thing. I
14 directed him to conduct training.

15 MR. MIHET: Okay.

16 THE WITNESS: Okay? Like I prior stated.

17 MR. MIHET: Sure.

18 THE WITNESS: I don't recall actually saying
19 what's on this paper.

20 MR. MIHET: Okay.

21 THE WITNESS: But I don't disagree with it.

22 MR. MIHET: I understand that.

23 BY MR. MIHET:

24 Q. But you don't recall coming up with this
25 directive and asking him to include it in this

1 presentation, correct?

2 A. No, I did not. No.

3 Q. Okay. So, you know, we talked about this before;
4 but, now that we know what the actual directive is, can
5 you tell me any other cases that must be referred to
6 legal for review prior to the issuance of a notice of
7 violation?

8 MR. WILLIAMS: I'm going to object to the
9 form of the question because you continue to use the
10 word directive. And that's your connotation, not
11 necessarily an accurate connotation of the slide that
12 we're looking at.

13 But, with that objection, please answer the
14 question, Mr. Ruggiero.

15 BY MR. MIHET:

16 Q. Let me -- okay, given that objection, I don't
17 normally do this; but do you see the word must that
18 appears in this slide?

19 A. Right. Yes, I do.

20 Q. It says, all possible conversion cases must be
21 referred to legal for review. Yes?

22 A. I see it, yes.

23 Q. And this was a slide that Mr. Simpson displayed
24 for your code enforcers to see at this mandatory
25 training, correct?

1 A. Are you asking that question as I was intendant
2 -- attending?

3 Q. No. As the head of the department --

4 A. Yeah.

5 Q. -- who -- who testified that this took place and
6 that this is the PowerPoint presentation that was given,
7 do you have any reason to doubt that this slide was
8 shown to your code enforcers at this mandatory training?

9 A. No, I don't doubt it.

10 Q. Okay. And so did your code enforcers -- were
11 they given any discretion to not refer some cases if
12 they felt that they weren't appropriate for referral?

13 A. On conversion therapy?

14 Q. Yeah.

15 A. We haven't had a case, so I really can't answer
16 that.

17 Q. In terms of the instruction, the training that
18 they received, were they told that they could decide
19 which cases had to be referred; or were they told that
20 all of them had to be referred?

21 A. No. It says all.

22 Q. Okay. So was that a -- what would you
23 characterize this as? An instruction? A training? A
24 directive? I don't want to put words in your mouth.
25 But what was -- how would you characterize --

1 A. This slide right here?

2 Q. Yeah.

3 A. This is how we're going to operate on conversion
4 therapy cases.

5 Q. Okay. Is it an instruction, or is it a
6 directive? I don't want to put words in your mouth.
7 What would you characterize this as?

8 A. The way we do business --

9 Q. Okay.

10 A. -- on conversion cases.

11 Q. Is it fair to call it policy? This is going to
12 be our policy?

13 A. Yes.

14 Q. Okay. So what other cases besides conversion
15 therapy cases must be referred to legal for review prior
16 to the issuance of a notice of violation pursuant to
17 City of Tampa's policy?

18 A. We have inspection warrants. And we get with
19 them on -- when we're going to do a criminal affidavit
20 on a -- you know, on a -- if somebody has risen to
21 the -- where it would go to criminal court, those would
22 be reviewed by the legal department.

23 Q. Okay. My question is: Prior to the issuance of
24 a notice of violation, what other cases must be referred
25 to legal for review?

1 A. Oh, none.

2 Q. None?

3 A. (The witness nods head).

4 Q. The only cases that must be referred to legal for
5 review prior to the issuance of a notice of violation
6 are conversion therapy cases?

7 A. Yes.

8 Q. Why is that?

9 A. Well, I think -- I think you're going to have to
10 get with the attorney on that. And I think you'll get a
11 better -- you know, a legal answer out of that.

12 Q. I'm not looking for a legal answer. I'm looking
13 for the answer of the head of the enforcement
14 department, which is you, Mr. Ruggiero, right?

15 A. Uh-huh, yes.

16 Q. And you are trusted with enforcing all of the
17 code provisions of the City of Tampa, correct?

18 A. Not all of the codes.

19 Q. Okay. Well, code enforcement that deals with --

20 A. Housing and zoning and things like that.

21 Q. Okay.

22 A. But we don't enforce every code in the City.

23 Q. And, out of the ones that you're entrusted to
24 enforce, one and only one has to be referred to the
25 legal department for review prior to the issuance of a

1 notice of violation.

2 And my question to you is: Why is that?

3 A. Well, I think because, if we ever do get a case
4 -- and we have never had a case -- I think there's
5 issues there that -- that, as building code inspectors,
6 we may not be fully capable of working through without
7 assistance.

8 Q. Okay. And what kind of issues are you --

9 A. Well, I mean, just one off the top of my head
10 would be doctor-patient privilege.

11 Q. Okay.

12 A. The other thing is -- is, you know, there may be
13 child abuse involved. I don't know. There's all kinds
14 of possibilities. And I think the way this is set up is
15 the best way to operate.

16 Q. Okay. Your code enforcers are trained to deal
17 with tangible things they observe, like, the tallness of
18 the grass or the existence of trash on a particular
19 property, right?

20 A. Yes.

21 Q. They're not trained to deal with things that are
22 in the arena of mental health, correct?

23 A. Correct.

24 Q. They're not trained to know whether a particular
25 mode of therapy is conversion therapy or something else?

1 A. I would -- I would agree.

2 Q. Okay. They're not trained to know whether or not
3 a child struggling with gender identity confusion has
4 already reached a point where they embraced the identity
5 of an opposite sex or whether they're still exploring
6 it, correct?

7 A. Correct.

8 Q. Somebody with a high school diploma would not be
9 able to make those determinations?

10 A. I don't know about that. But...

11 MR. WILLIAMS: Yeah. I object to that.
12 That's an offensive question, as far as I'm concerned.

13 THE WITNESS: Yeah. I mean, they're
14 hardworking people. I'm going to defend them. These
15 code inspectors are hardworking --

16 MR. MIHET: Sure.

17 THE WITNESS: -- dedicated people --

18 MR. MIHET: Sure.

19 THE WITNESS: -- that do a good job.

20 BY MR. MIHET:

21 Q. Yeah. And it's no slight on them to say that
22 there are some things that are going to be outside of
23 their area of expertise just like they would be out of
24 mine or out of yours, right?

25 A. I agree.

1 Q. So we don't mean to insult their intelligence.

2 What I'm asking you is: Is someone with a high
3 school diploma able to determine whether a patient is at
4 a point where they've already embraced a gender identify
5 that's different from theirs or whether they're just
6 exploring their own gender identity?

7 MR. WILLIAMS: I object to the form of the
8 question as being overbroad and improper hypothetical
9 and incomplete hypothetical, if it's a hypothetical at
10 all.

11 You may answer the question, if you can.

12 THE WITNESS: I don't think I can. I don't
13 have an answer for that.

14 BY MR. MIHET:

15 Q. Okay. Does your Code Enforcement division
16 enforce any other ordinances with respect to mental
17 health counselors?

18 A. No.

19 Q. Okay. The only ordinance that you enforce with
20 respect to mental health counseling is the conversion
21 therapy ordinance?

22 A. Yes.

23 Q. Does your department enforce any ordinances that
24 attempt to regulate other modes of therapy besides
25 conversion therapy?

1 A. No.

2 Q. Conversion therapy is the only mode of therapy
3 that your department enforces and regulates?

4 A. Yes.

5 Q. Is it fair to say then that your code enforcers
6 have no experience or expertise in enforcing other
7 regulations against mental health counselors and mental
8 health professionals?

9 A. Yes.

10 Q. That's fair?

11 A. Yes.

12 Q. That's accurate? Yes?

13 A. Yes.

14 Q. Okay. Other than this August 1, 2017, training,
15 have there been any other enforcement guidelines or
16 memos or training materials provided to you and your
17 department with respect to enforcement of the ordinance?

18 A. No.

19 Q. Do you know how long was the training? How long
20 did it last when it took place?

21 A. No. I think you'd have to ask Jerrod Simpson on
22 that.

23 Q. Okay. Did you ever discuss with Mr. Simpson or
24 others any concerns that you might have about how the
25 ordinance -- how the ordinance might be enforced and

1 whether it could be enforced?

2 A. That's why we had this training.

3 Q. Okay.

4 A. You know? Other than that, I wasn't involved in
5 any conversations as far as the development of this or
6 the enforcement of it.

7 Q. Have you ever expressed the view that it was not
8 appropriate to have Code Enforcement officers enforce
9 the conversion therapy ordinance?

10 A. Have I?

11 Q. Yeah.

12 A. No.

13 Q. Have you ever heard anyone within the City of
14 Tampa express that view?

15 A. Not that I know of.

16 Q. Has anyone expressed that view to you?

17 A. No.

18 Q. Any of your code enforcers come up to you to say,
19 Mr. Ruggiero, I don't know how we could possibly enforce
20 this?

21 A. No. I haven't heard anything like that.

22 Q. None of the supervisors or senior inspectors?

23 A. No, I don't recall any conversations like that.

24 Q. Okay. You're not aware of them taking place
25 within your department?

1 A. No.

2 Q. So we've obviously seen now the PowerPoint
3 presentation and the sign-in -- sign-in sheet. What
4 other documents with regard to the conversion therapy
5 ordinance have you seen since the ordinance was enacted?

6 A. This is it.

7 Q. Okay.

8 A. Yes.

9 Q. Can't think of any other -- other documents?

10 A. Not -- no, I can't recall anything else.

11 Q. Okay.

12 MR. WILLIAMS: I want to make it clear on
13 the record that I have, I think, been very flexible in
14 enabling you to explore this frankly to avoid
15 unnecessary disagreement. Hopefully, this has
16 accomplished that. We'll see. But, by allowing you to
17 explore this, Counsel, I am not waiving the Court's
18 parameters at all. I'm trying to avoid, as I said,
19 unnecessary disagreements.

20 MR. MIHET: How is that different from what
21 you've already said two or three times on the record?

22 MR. WILLIAMS: It's different in the sense
23 that I'm making a statement as to what some lawyers
24 might argue is an implied waiver of something. And I'm
25 being very cautious. Don't read too much into it. It

1 says what it says.

2 MR. MIHET: Okay. I understand your
3 position, and I think you understand mine. And we'll
4 probably just take the time to explore that with the
5 Court.

6 Can we take another three-minute break?

7 MR. WILLIAMS: Yeah. I'm going to go to
8 this order before we do. I am sensitive -- and this is
9 on the record too. The general scope of Plaintiffs'
10 Rule 30(b)(6) deposition that starts on page six, it's
11 paragraph seven, and concludes on the second page -- or
12 the seventh page of United States Magistrate Judge
13 Sansone's order. And that was the purpose of my most
14 recent comment because these things are not specifically
15 delineated in any order. I think Judge Sansone is
16 counting on counsel to use their common sense and
17 experience, and that's the reason for my comment.

18 MR. MIHET: Is it your understanding we're
19 here for a 30(b)(6) deposition today, Mr. Williams?

20 MR. WILLIAMS: No. No. I'm just giving you
21 the only indication I have of what the Court thinks
22 about discovery and this case. And we've gone beyond
23 the dates of her prior order. And so that's what I'm
24 saying. You can take it for what it's worth and use it
25 for what you think it's worth.

1 All right. Let's take a break.

2 (Recess)

3 (Plaintiffs' Exhibit No. 4 marked for identification)

4 BY MR. MIHET:

5 Q. Mr. Ruggiero, I've handed you a document that we
6 have marked as Plaintiffs' Exhibit 4. I'd like for you
7 to take a look at this document and tell me if you can
8 confirm that this is City of Tampa's conversion therapy
9 ordinance that we've been talking about today?

10 A. I want to say yes.

11 Q. Okay. You say you want to say yes?

12 A. I said I would say yes.

13 Q. It is?

14 A. Yes.

15 Q. Okay. Turning over to page six of this document,
16 you'll see in the provision at the very bottom, which is
17 Section 7 -- do you see that?

18 A. Yes.

19 Q. In subparagraph (a) it says: "The director shall
20 have all powers, duties and responsibilities to
21 administer and enforce the following City Code chapters
22 or sections." Did I read that correctly?

23 A. Yes.

24 Q. So who is the director of the department of Code
25 Enforcement?

1 A. That's me.

2 Q. That's you.

3 And it's your understanding then that this
4 ordinance places with you all powers, duties and
5 responsibilities to administer and enforce it, correct?

6 A. Yes.

7 Q. Now, is it necessary for you to know what the
8 ordinance prohibits in order for you to be able to carry
9 out your duties and responsibilities in enforcing it?

10 A. Yes.

11 Q. Take a look at the -- first of all, on the same
12 page, page six, when you're looking in Section 5, that's
13 the section that makes it unlawful for any provider to
14 practice conversion therapy efforts within the City of
15 Tampa. Do you see that?

16 A. You're talking about Section 14-312?

17 Q. Right, within Section 5 of the ordinance, yes.

18 A. Yeah, I see it.

19 Q. So then, when you look at the definition of
20 conversion therapy, of what is prohibited, which appears
21 at the very bottom of page five, if you'd take a look at
22 that.

23 A. Okay.

24 Q. Why don't you just take a minute to read that for
25 yourself so it's fresh in your mind, and then I'll have

1 some questions about it.

2 MR. WILLIAMS: The definition?

3 MR. MIHET: Yes.

4 THE WITNESS: Okay.

5 BY MR. MIHET:

6 Q. Okay. I'll actually read the first sentence for
7 the record. It says: "Conversion therapy or reparative
8 therapy means, interchangeably, any counseling, practice
9 or treatment performed with the goal of changing an
10 individual's sexual orientation or gender identity,
11 including, but not limited to, efforts to change
12 behaviors, gender identity, or gender expression, or to
13 eliminate or reduce sexual or romantic attractions or
14 feelings towards individuals of the same gender or sex.
15 Did I read that correctly?

16 A. Yes.

17 Q. Okay. Does -- I don't see in the -- in the
18 ordinance a definition for sexual orientation or gender
19 identity. What do you understand those terms to mean as
20 the person entrusted with enforcing the ordinance?

21 A. What was the question, again?

22 Q. Sure. I don't see a definition in the ordinance
23 for sexual orientation or for gender identity. My
24 question is: What do you understand those terms to
25 mean?

1 A. Sexual -- what? Sexual orientation?

2 Q. Sexual orientation for gender identity.

3 A. You're asking what my opinion is of it?

4 Q. As the person who is chiefly responsible for
5 enforcing this document, I'm asking you what your
6 knowledge is. What do you understand those two terms to
7 mean? Let's take them in turn. First, sexual
8 orientation.

9 MR. WILLIAMS: In the context of the
10 sentence as a whole, I take it?

11 MR. MIHET: As that term is being used in
12 this document.

13 MR. WILLIAMS: Yeah.

14 THE WITNESS: Sexual orientation?

15 MR. MIHET: Yes.

16 THE WITNESS: To me, it's a decision by an
17 individual that -- who they want to identify with, a
18 male or a female. Who they want to be their partner.

19 BY MR. MIHET:

20 Q. And what about gender identity? What does that
21 term mean?

22 A. Well, a particular individual that wants to
23 identify themselves -- maybe they're a female. They
24 want to identify themselves as a male or vice versa.
25 That's the best I can do.

1 Q. How are the two terms different, if they are?

2 Sexual orientation, how is it different from gender
3 identity?

4 A. I don't think I'm qualified to answer that.

5 Q. Okay. Why not?

6 A. Because it's not something that I deal with every
7 day. I'm not involved with that determination of, you
8 know, what you're getting at. I'm not involved in that.

9 Q. You are involved with enforcing this ordinance?

10 A. Correct.

11 Q. And you have to know what it provides and what it
12 prohibits and what it allows in order for you to enforce
13 it, correct?

14 A. Yeah.

15 Q. And so, seeing as how the ordinance prohibits any
16 counseling, practice or treatment performed with the
17 goal of changing an individual's sexual orientation or
18 gender identity, don't you think it's important for you
19 to know whether or not there's a difference between
20 sexual orientation or gender identity?

21 A. Okay. Yes.

22 Q. Okay. So what is the difference between those
23 two terms?

24 A. Well, the difference, in my opinion, is sexual
25 orientation is what I just said, who you prefer to be

1 with.

2 Q. Okay.

3 A. And gender identification is, like I just said,
4 what do you want to be; a male be a female, a female be
5 a male.

6 Q. Okay.

7 A. That's my understanding of it.

8 Q. As the head of the enforcement division charged
9 with enforcing this ordinance?

10 A. Yes.

11 Q. Okay. So the ordinance says that, you know,
12 conversion therapy means any counseling, practice or
13 treatment performed with the goal of changing an
14 individual's sexual orientation or gender identity.

15 My question to you is: Whose goal is the
16 ordinance referring to there?

17 A. I think you have to ask that question to City
18 counsel.

19 Q. Okay. Well, I'm asking it right now to the
20 person trusted with enforcing the ordinance.

21 A. Uh-huh.

22 Q. In order for you to determine whether -- or for
23 your department to determine whether or not a violation
24 has occurred, you have to determine whether or not there
25 was a goal of changing an individual's sexual

1 orientation or gender identity, do you not?

2 A. Correct.

3 Q. And so my question to you is: As you go about
4 enforcing this, whose goal are you looking to see
5 whether it was a goal of changing someone's sexual
6 orientation or gender identity?

7 MR. WILLIAMS: And, as to that specific
8 question, I object to the form because it asked the
9 question to answer the meaning of a word out of context.

10 BY MR. MIHET:

11 Q. Go ahead. Whose goal must you -- must you look
12 at to determine whether or not a violation of the
13 ordinance has occurred?

14 A. I don't understand. The goal of the possible
15 victim.

16 Q. Okay.

17 A. That's where I would think it would lie.

18 Q. Okay.

19 A. You look at it from the victim's -- are they
20 being victimized in this.

21 Q. So let's say, for example, you have an adolescent
22 female, born as a female. Are you with me?

23 A. Yes.

24 Q. Let's say a seventeen-year-old person that was
25 born biologically as a female but, for some time, she

1 decided that she was going to be a male and identified
2 as a male. Are you still with me?

3 A. Yep.

4 Q. And now she decides that she wants to try to
5 change back to being a female, to live in accordance
6 with her biological body. That is her goal.

7 A. Okay.

8 Q. Okay? Does the ordinance come into play to
9 prohibit her from receiving therapy to assist her with
10 her goal of changing her gender identity back to match
11 her biological body?

12 MR. WILLIAMS: Object to the form to the
13 extent that it purports to be a hypothetical. If so,
14 it's an incomplete hypothetical. And also to the extent
15 it asks this witness to respond to a conclusion of law.

16 But you may give it your best shot,
17 Mr. Ruggiero.

18 THE WITNESS: Well, that's why we're going
19 to get the legal department involved because these are
20 not easy cases in my opinion.

21 MR. MIHET: Okay.

22 THE WITNESS: And my answer would be we'll
23 get the legal department involved.

24 MR. MIHET: Okay.

25 THE WITNESS: That's all I can add to that.

1 BY MR. MIHET:

2 Q. So you say these are not easy. Do you not feel
3 qualified to make a determination as to whether or not
4 the example I just gave you would be something that
5 would be conversion therapy prohibited by the ordinance?

6 MR. WILLIAMS: Same objection.

7 Please proceed.

8 THE WITNESS: Yeah, I don't -- I don't think
9 I -- what was you trying to get at, again?

10 BY MR. MIHET:

11 Q. Do you feel qualified or able to -- to tell me
12 whether or not the example I gave you with the
13 adolescent girl, whether that constitutes conversion
14 therapy that is banned by the ordinance?

15 A. My -- my answer to that is that I'm going to
16 present those facts to our legal adviser.

17 Q. Okay.

18 A. And then we're going to proceed from there.

19 Q. But you, yourself, are you qualified to make that
20 determination?

21 A. What kind of qualifications are you looking for?

22 Q. Are you able? Do you feel able to make that
23 determination yourself?

24 MR. WILLIAMS: Again, objection.

25 Overly broad under the circumstances of this

1 case and an improper hypothetical. I'm just making that
2 for the record.

3 You can give it your best shot,
4 Mr. Ruggiero.

5 THE WITNESS: In your example, female wants
6 to be a male, goes to counseling and then wants to
7 convert back to the female, correct?

8 MR. MIHET: No. Let's refresh the example.

9 THE WITNESS: Yeah.

10 BY MR. MIHET:

11 Q. Adolescent seventeen-year-old was born
12 biologically as a female.

13 A. Okay.

14 Q. For some time, she identified as a male and lived
15 with a male gender identity. That was in the past. Now
16 she decides she wants to change her gender identity back
17 to female to match her biological gender, and she
18 decides she needs help with that change. She can't do
19 it on her own. It's too difficult. There's too many
20 mental issues involved. And so she goes to a counselor
21 within the City of Tampa and says, Mr. or Mrs.
22 Counselor, I need your help. I need your counseling. I
23 need your therapy to help me with this change that I
24 want to make back from a male gender identity to a
25 female gender identity. The counselor says, if that's

1 your goal, if that's your desire, I'm willing to help
2 walk you and talk you through that. Let's go do some
3 counseling.

4 A. Okay.

5 Q. And they go do counseling. And, as a result of
6 that counseling, now the female has changed; and she
7 identifies as a female, no longer as a male. Is that
8 example clear?

9 A. Yes.

10 Q. Is that example a violation of the ordinance's
11 prohibition on Sexual Orientation or Gender Identity
12 Change Efforts?

13 MR. WILLIAMS: Repeat the same objection as
14 to form.

15 Overly broad and improper and incomplete
16 hypothetical, and calls for speculation.

17 THE WITNESS: How do we get involved?

18 BY MR. MIHET:

19 Q. Someone calls you, say a neighbor of this person;
20 and the neighbor says, man, over coffee yesterday, this
21 person told me that this happened. You know? I asked
22 her why she doesn't identify as a boy anymore; and she
23 said, well, I went and I got some counseling because I
24 wanted to change. And now, because of what Dr. So and
25 So helped me, now I identify as a girl.

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1 So now this neighbor is aware of this ordinance,
2 and she calls you up. Says, Mr. Ruggiero, I heard -- I
3 heard something that I think you should know about. And
4 she files a complaint with you.

5 MR. WILLIAMS: Same objection.

6 THE WITNESS: I mean, my answer is going to
7 be the same as I said. We're going to put it through
8 the legal department. I mean, that's the best I can do
9 for you.

10 BY MR. MIHET:

11 Q. Okay. You're not able to tell me whether that's
12 a violation of the ordinance or not?

13 A. We're going to put it through the legal
14 department. Just as --

15 Q. Okay.

16 A. -- you know, like the training was set up.
17 That's the way we're going to operate.

18 Q. But, as you sit here today, you're not able to
19 tell me whether that example is a violation of the
20 ordinance or not?

21 A. My answer is is I'm going to put it in front of
22 the legal department.

23 Q. That's not the question. You're answering a
24 question that I'm not asking, and I can appreciate that.

25 My question is: Are you able to tell me as you

1 sit here today whether or not the example we've
2 discussed is a violation of the ordinance?

3 MR. WILLIAMS: Repeat the same objections.

4 BY MR. MIHET:

5 Q. You either are able or you're not able. My
6 question is which -- which of those two?

7 A. In the example that you gave --

8 Q. Yes.

9 A. -- with a complainant that's getting to us --

10 Q. Yes.

11 A. -- I think that we could initially talk to that
12 complainant and then refer to the legal department to
13 see how we would proceed further.

14 Q. Okay. If there are no other facts other than
15 what I've just told you, has a violation taken place or
16 not?

17 MR. WILLIAMS: Same objection.

18 THE WITNESS: My answer is that there is a
19 violation in that it needs to be referred to the legal
20 department to see how we proceed further.

21 BY MR. MIHET:

22 Q. Okay. So your conclusion would be that the
23 example that we talked about is a form of conversion
24 therapy that is prohibited by the ordinance?

25 A. That would -- yes.

1 Q. Okay. And so suppose you talk to legal; and
2 legal says, we need to conduct an investigation. What
3 do you do next?

4 A. Well, we would interview the person that you said
5 called us.

6 Q. Okay. And, when you say, "we," one of your code
7 enforcers?

8 A. Not me. It would be a Code Enforcement officer,
9 yeah.

10 Q. One of your code enforcers with a high school
11 diploma would go out there --

12 A. Well, I mean, yeah, with a high school diploma --

13 Q. Would go out there --

14 A. -- hardworking code enforcement officer --

15 Q. Correct.

16 A. -- yes.

17 Q. Would go out there and interview the neighbor as
18 to her complaint?

19 A. Correct.

20 Q. What else would that code enforcer do?

21 A. Well, they would have to bring that information
22 back to the legal department.

23 Q. Okay.

24 A. And then we'll see where we go next.

25 Q. Would that code enforcer then also talk to the

1 alleged victim about what happened?

2 A. We would see, after that initial interview,
3 what -- what the legal department would recommend --

4 Q. Okay.

5 A. -- and then go from there.

6 Q. Code Enforcement would not be able to make a
7 decision about what to do next without talking to legal
8 first?

9 A. Correct.

10 Q. Why not?

11 A. Because that's the way we set it up.

12 Q. Okay. Why?

13 A. Because the legal department is going to handle
14 this in court, and they need -- they need the facts and
15 circumstances and direct the investigation just like a
16 prosecutor would do under any other normal circumstance.

17 Q. Under a normal circumstance, a prosecutor would
18 tell the cops when or where to do a drug bust, for
19 example?

20 A. No, not that. Not that. But, I mean, there's --
21 you know, I worked narcotics years ago --

22 Q. Okay.

23 A. -- and there's certain things that you might get
24 with them on to see how they -- how they want to handle
25 something.

1 Q. Okay. But you wouldn't get with them to see
2 whether you should arrest someone for possession of
3 narcotics, would you?

4 A. In certain cases, we did.

5 Q. You did?

6 A. Yes.

7 Q. They would direct you whom to arrest?

8 A. They didn't say, go get that guy. We would give
9 them facts and circumstances and see if they were
10 comfortable with a case --

11 Q. Okay.

12 A. -- that type of thing.

13 Q. Okay. And so would you interview the -- the
14 doctor, the alleged violator? Would you interview any
15 other witnesses? How would this investigation play out?

16 MR. WILLIAMS: Same objection.

17 We're getting into hypotheticals upon
18 hypotheticals, and they're improper. And I'm going to
19 make that objection, and I'm going to object every time.
20 So I'll just say same objection, and that's what I'm
21 referring to is the series of objections that I've made
22 for the last ten minutes.

23 Please answer the question if you feel
24 capable of doing so.

25 THE WITNESS: Would we interview the doctor?

1 MR. MIHET: Yeah.

2 THE WITNESS: Well, that would be -- depend
3 on what direction we receive from the legal department.

4 BY MR. MIHET:

5 Q. You couldn't decide whether or not to interview
6 the doctor unless you talked to legal first?

7 A. Correct.

8 Q. Just like you couldn't decide whether or not to
9 interview the victim unless you talked to legal first?

10 A. Correct.

11 Q. Okay. Suppose a -- a notice of violation or a
12 citation is issued in the circumstance we've been
13 talking about, what -- what would happen then in the
14 enforcement process?

15 MR. WILLIAMS: Same objection.

16 THE WITNESS: I don't understand.

17 BY MR. MIHET:

18 Q. Well, you end up issuing a notice of violation,
19 yes?

20 A. All right.

21 Q. And what happens next in the -- in the
22 enforcement process?

23 A. I don't -- I can't answer that because I don't
24 know -- it's a hypothetical question that I don't know
25 the outcome of.

1 Q. Okay.

2 A. You know? I can't answer that question.

3 Q. As the -- as the head of the department that's
4 charged with enforcing the ordinance, you don't --
5 you're not able to tell me what happens after a notice
6 of violation is issued in the enforcement process?

7 A. Well, this is irrevocable, so it would go right
8 to a ticket.

9 Q. Okay.

10 A. So...

11 Q. All right. So a ticket is issued?

12 A. Correct.

13 Q. The doctor has been ticketed for engaging in
14 conversion therapy with this adolescent
15 seventeen-year-old female we've been talking about.
16 What happens next in the enforcement process?

17 A. They either pay the ticket or they challenge it.

18 Q. Okay. And, if they challenge it, what happens
19 next?

20 A. It goes to a court system.

21 Q. Does it go to a court or a special magistrate?

22 A. No, that should go to the court.

23 Q. It does?

24 A. (The witness nods head).

25 Q. Okay. Why do you believe it goes to the court?

1 A. Because it's -- it's a -- a ticket with a fine on
2 it, and that's where they appeal those tickets at.

3 Q. To the court?

4 A. Yes.

5 Q. There would not be a special magistrate involved?

6 A. Not in this particular case.

7 Q. If you determine that a violation has occurred,
8 is there any other possibility besides issuing a ticket?
9 When I say, "any other possibility," is there any other
10 possibility of bringing the matter forward and
11 continuing the enforcement process besides issuing a
12 ticket?

13 A. Give me an example.

14 Q. A letter written to the doctor saying, this is
15 what was reported, don't do it again kind of a thing.
16 Or --

17 A. Like a warning letter?

18 Q. Yeah, a warning letter. I mean, you know, you're
19 the enforcement official --

20 A. No, I don't --

21 Q. -- so I'm asking you.

22 A. -- know of anything like that.

23 Q. Okay. The only way to engage the enforcement
24 process and to move the matter forward is through the
25 issuance of a ticket?

1 A. Correct.

2 Q. Let's talk about another example. Instead of the
3 seventeen-year-old adolescent girl, we've got a
4 prepuberty child, say a ten-year-old, born as a boy but
5 has expressed a female gender identity.

6 MR. WILLIAMS: At the age of ten?

7 MR. MIHET: Yes. Okay?

8 BY MR. MIHET:

9 Q. Would the ordinance prohibit a therapist in the
10 City of Tampa from encouraging that child to embrace his
11 given male -- biological male identity --

12 MR. WILLIAMS: Same objection.

13 BY MR. MIHET:

14 Q. -- and to align with his gender role?

15 A. Yes.

16 Q. It would?

17 A. Yes.

18 Q. Even if the child voluntarily assents to that
19 kind of therapy and even requests help to be more like a
20 boy, that would still be a violation under the
21 ordinance?

22 MR. WILLIAMS: Same objection.

23 THE WITNESS: I feel as though I have to be
24 an appellate court judge to answer that question.

25 MR. MIHET: Okay.

1 THE WITNESS: My answer would be yes.

2 BY MR. MIHET:

3 Q. Okay. Would the ordinance prohibit a therapist
4 from verbally endorsing and supporting behaviors and
5 attitudes that align with that child's sex at birth?
6 For example, saying, look, you know, boys like to play
7 with trucks and football and whatnot. Would you feel
8 comfortable spending more of your time engaged in those
9 typically male activities? Would that be a violation of
10 the ordinance for a counsellor to say to someone like
11 that?

12 A. I --

13 MR. WILLIAMS: Same objection.

14 THE WITNESS: Oh, sorry.

15 MR. WILLIAMS: Just making my objection.

16 THE WITNESS: Are you asking me if they --
17 what toys they play with, would that --

18 MR. MIHET: Yeah, as one component.

19 BY MR. MIHET:

20 Q. Gender confused child comes to a therapist
21 biologically born as a boy but now having some female
22 tendencies, would it be a violation of the ordinance for
23 the therapist to encourage this biological boy to be
24 more comfortable and to act in ways that are
25 traditionally associated with boys and male behavior?

1 MR. WILLIAMS: Same objection.

2 I'll augment it by saying the question as
3 posed is vague and imprecise as to form.

4 THE WITNESS: I -- you know, I would have to
5 say if -- if there's any therapy involved in trying to
6 change the child into something else --

7 MR. MIHET: Uh-huh.

8 THE WITNESS: -- I would have to say that,
9 yes.

10 BY MR. MIHET:

11 Q. That would be a violation?

12 A. Yes.

13 Q. Even if the child voluntarily assents to it and
14 requests it?

15 A. Now you're asking -- I don't know -- you know --
16 I don't know who's complaining, who's -- there's a lot
17 of factors I don't know. But if they -- you know --

18 Q. The neighbor is complaining.

19 A. Okay. It's something that -- it's -- it could
20 be -- it's a violation.

21 Q. Okay.

22 A. Yeah.

23 Q. Okay. Now, say you have an adolescent
24 sixteen-year-old boy born biologically as a boy and he
25 is going through an uncertain time now in his life; and

1 he's just not sure whether or not he is a boy or whether
2 or not he wants to identify as a girl. He's kind of
3 exploring the options and the possibilities. Are you
4 with me?

5 A. Yes. He's a boy --

6 Q. He's a boy exploring some ideas and some thoughts
7 but hasn't yet made a decision, hey, I'm a girl now.
8 Okay? Are you with me?

9 A. Yes.

10 Q. He goes to a therapist in -- a licensed therapist
11 in the City of Tampa to seek help with the things that
12 he's struggling with. And, after receiving that help,
13 he decides he doesn't want to change. He's going to
14 stay as a boy and identify as a boy. Has the therapist
15 committed a violation of the ordinance in that example?

16 MR. WILLIAMS: Same objection as to the last
17 objection, the one that I augmented.

18 THE WITNESS: He decided that he wanted to
19 go back? The counselor didn't sway him one way or the
20 other?

21 BY MR. MIHET:

22 Q. Yeah, because -- he hasn't yet changed --

23 A. Right.

24 Q. -- to be a girl, but he was questioning or
25 thinking about it. He goes and has some counseling; and

1 he decides, nah, I think I'm going to remain as a boy.

2 A. Well --

3 MR. WILLIAMS: Same objection.

4 THE WITNESS: Oh, sorry.

5 MR. WILLIAMS: Go ahead. I'm just making a
6 record.

7 THE WITNESS: I'm just looking at this
8 section here that talks about counseling therapy --
9 conversion therapy does not include counseling that
10 provides support and assistance to a person undergoing
11 gender transition or counseling that provides acceptance
12 and support. I think that example applies in there, so
13 I don't think it would be a violation.

14 BY MR. MIHET:

15 Q. That would not be a violation. Okay.

16 So, if the boy doesn't yet reach the stage where
17 he's changed to be a girl, there is no violation. But,
18 if the boy has already reached the stage where he
19 identifies as a girl and now seeks help to change back
20 to a boy, then that would be a violation?

21 MR. WILLIAMS: Same objection.

22 You're asking, by the way, his -- his
23 answer, not his answer guided by legal counsel; is that
24 right?

25 MR. MIHET: I'm asking for your answer as

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1 the head of the Code Enforcement division which is the
2 principal and sole authority charged with enforcing the
3 conversion therapy ordinance.

4 THE WITNESS: I'm just going to say my
5 answer is I'm always going to get with the legal
6 department. No matter what you say or how you twist it,
7 they're going to be involved without --

8 MR. MIHET: Okay.

9 THE WITNESS: You know, say the question,
10 again.

11 BY MR. MIHET:

12 Q. So I believe your testimony was that, if this boy
13 that we've been talking about hasn't yet reached a
14 decision to identify as a girl and receives counseling
15 and decides to remain a boy, there is no violation of
16 the ordinance, right? Is that what you told me earlier?

17 A. Yeah. I'm just going to say it's like -- in my
18 opinion, it's exploratory --

19 Q. Okay.

20 A. -- and nothing -- yeah.

21 Q. Okay. I understood that. We're clear.

22 But, if the same boy actually reaches the point
23 where he identifies as a girl --

24 A. Okay.

25 Q. -- and then seeks and receives voluntary

1 counseling to assist him to change back to be a boy, I
2 believe, in that scenario, you testified earlier that
3 that would be a violation of the ordinance?

4 A. Yes.

5 Q. Right?

6 A. Yes.

7 Q. So, in those two examples then, the difference is
8 whether or not the boy has actually reached the point
9 where he identifies as a girl or whether he's still
10 exploring, right?

11 A. Yes.

12 Q. Okay. Is that a determination that you would be
13 able to make based on your expertise and your training
14 and your qualifications?

15 A. No.

16 MR. WILLIAMS: Objection. Overly vague.

17 THE WITNESS: Sorry.

18 MR. WILLIAMS: It's overly vague.

19 BY MR. MIHET:

20 Q. Is that a determination that any of your Code
21 Enforcement officers would be able to make based on
22 their training and experience and expertise?

23 MR. WILLIAMS: Same objection.

24 Calls for speculation, as well.

25 THE WITNESS: No.

1 BY MR. MIHET:

2 Q. Okay. If you look at the ordinance, again, the
3 definition of conversion therapy --

4 A. Which page are you on?

5 Q. Still page five on the bottom.

6 A. Okay.

7 Q. It's still first sentence. It says: "Conversion
8 therapy or reparative therapy means, interchangeably,
9 any counseling, practice or treatment performed with the
10 goal of changing an individual's sexual orientation or
11 gender identity including, but not limited to, efforts
12 to change behaviors, gender identity, or gender
13 expression." Do you see that?

14 A. Yes.

15 Q. So my question is: The reference to efforts to
16 change behaviors, what -- what do you understand that to
17 be a prohibition of? Behaviors.

18 A. Behaviors as far as changing their identity? Is
19 that what you're getting at?

20 Q. I'm asking you.

21 A. That's my -- when I look at this, it's -- to me,
22 it's any effort that changes the behavior from a boy
23 trying to become a female.

24 Q. Okay. What about behaviors in terms of sexual
25 conduct? You know, say a seventeen-year-old boy comes

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1 to a counselor within the City of Tampa, a licensed
2 therapist, and says, Doctor, I have been having sexual
3 intercourse with other boys. I don't feel good about
4 that, and I would like to stop that behavior. Can you
5 please walk me through and help me to change that
6 behavior. Would that --

7 MR. WILLIAMS: Objection.

8 MR. MIHET: Let me ask my question, first.

9 MR. WILLIAMS: Sure. Sure. I'm sorry.
10 Just let me know when you're through.

11 BY MR. MIHET:

12 Q. Would that be counseling that would be prohibited
13 by the ordinance?

14 MR. WILLIAMS: Object to the form as being
15 overly broad, too vague and constituting an improper,
16 incomplete hypothetical.

17 MR. MIHET: Okay.

18 MR. WILLIAMS: And, Mr. Ruggiero, I'm making
19 these objections for the record what this lady is typing
20 down so I can preserve my objections as to form, which
21 I'm required to do under the rules of evidence. But
22 that should not deter you from giving an answer, if you
23 can do so. If it calls for an answer that I believe is
24 not mandated because it's privileged or something like
25 that, I will so inform you; and we can go from there.

1 Okay?

2 THE WITNESS: All right.

3 BY MR. MIHET:

4 Q. In other words, unless he specifically tells you
5 not to answer a question, then let the lawyers and the
6 judge worry about the objections that he makes. Okay?

7 THE WITNESS: Yes.

8 MR. WILLIAMS: That's another way to put it.
9 I agree. Except, I don't instruct people not to answer
10 questions. It's not appropriate.

11 THE WITNESS: All right. So is it a
12 violation?

13 MR. MIHET: Yes.

14 THE WITNESS: The therapy to convert him
15 from going -- you know, not having sex with other boys?

16 MR. MIHET: Yeah. So...

17 THE WITNESS: Yes.

18 BY MR. MIHET:

19 Q. It is?

20 A. Yes.

21 Q. So just because it's been a while since we had
22 the example, you have the boy that comes in, tells a
23 doctor that he's been having sex with other boys, that
24 he doesn't feel good about it and wants to stop that
25 behavior. If the doctor engages in counseling to help

1 him to no longer have sex with boys, to become
2 abstinent, that's the kind of change therapy that the
3 ordinance prohibits?

4 A. Yes.

5 MR. MIHET: Okay. I think we're getting
6 close to being done. Let me take a quick break with my
7 counsel here, and we'll see about wrapping this up.

8 (Recess)

9 MR. MIHET: Back on the record. All right.
10 Mr. Ruggiero, those are all the questions that I have
11 for you today. You've been very helpful. Thank you.

12 THE WITNESS: All right. Thank you.

13 MR. WILLIAMS: I have no questions.

14 (Proceedings concluded at 12:59 o'clock p.m.)
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Sal Ruggiero

10/30/2018

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CERTIFICATE OF OATH

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STATE OF FLORIDA)
COUNTY OF PALM BEACH)

I, Rachele L. Cibula, the undersigned authority,
certify that SAL RUGGIERO personally appeared before me
and was duly sworn.

Witness my hand and official seal this 2nd day of
November, 2018.


RACHELE L. CIBULA
Notary Public, State of Florida
My Commission #FF 936928
Expires: December 14, 2019



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Sal Ruggiero

10/30/2018

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1 C E R T I F I C A T E

2 THE STATE OF FLORIDA)

3 COUNTY OF PALM BEACH)

4

5 I, Rachele Lynn Cibula, Notary Public, State of
6 Florida at Large,

7 DO HEREBY CERTIFY that I was authorized to and did
8 stenographically report the foregoing deposition; and
9 that the transcript is a true and correct transcription
10 of the testimony given by the witness.

11 I FURTHER CERTIFY that I am not a relative, employee,
12 attorney or counsel connected with the action, nor am I
13 financially interested in the action.

14 Dated this 2nd day of November, 2018.

15

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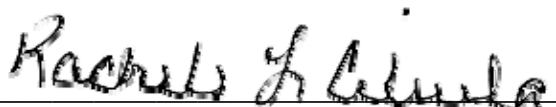
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RACHELE LYNN CIBULA, NOTARY PUBLIC

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No. 19-14387

VAZZO, *etc., et al.* v. CITY OF TAMPA, FLORIDA

133-2

Vazzo v. City of Tampa
Guido Maniscalco

10/31/2018

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IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF FLORIDA
Tampa Division
Civil Action No. 8:17-cv-02896-CEH-AAS

ROBERT L. VAZZO, LMFT, individually
and on behalf of his patients,
DAVID H. PICKUP, 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,

Plaintiffs,

vs.

CITY OF TAMPA, FLORIDA, and
SAL RUGGIERO, in his official capacity as
Manager of the City of Tampa
Neighborhood Enhancement Division,
Defendants.

* * * * *

DEPOSITION OF COUNCILMAN GUIDO MANISCALCO
TAKEN AT THE INSTANCE OF THE PLAINTIFFS

* * * * *

DATE: October 31, 2018
PLACE: 201 North Franklin Street
Suite 3200
Tampa, Florida 33603
TIME: 9:02 - 1:46 o'clock p.m.

Florida Court Reporting
561-689-0999

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Guido Maniscalco

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8	(Tampa Bay Times Article)	
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10	(E-mail from Erica Dotson to Tampa City Council dated 2/20/2017)	
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13	Plaintiffs' Exhibit No. 9 marked for identification	53
14	(E-mail from Tea Sefer to Tampa City Council dated 3/2/2017)	
15	Plaintiffs' Exhibit No. 10 marked for identification	56
16	(E-mail from Carrie Henriquez to Nadine@eqfl.org dated 2/16/2017)	
17	Plaintiffs' Exhibit No. 11 marked for identification	62
18	(E-mail from Annie Greenspan to Carrie Henriquez dated 2/10/2017)	
19	Plaintiffs' Exhibit No. 12 marked for identification	64
20	(E-mail string beginning from Carrie Henriquez to Nadine Smith and Dan Benoit dated 2/16/2017)	
21		
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Guido Maniscalco

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1	EXHIBITS CONTINUED	
2	Plaintiffs' Exhibit No. 13 marked for	67
3	identification	
4	(E-mail string beginning from Carrie	
5	Henriquez to hannah@eqfl.org, Stratton	
6	Pollitzer and Nadine Smith dated	
7	2/16/2017)	
8	Plaintiffs' Exhibit No. 14 marked for	69
9	identification	
10	(E-mail string beginning from Carrie	
11	Henriquez to Hannah Willard and Kaitlin	
12	Connolly dated 3/2/2017)	
13	Plaintiffs' Exhibit No. 15 marked for	75
14	identification	
15	(E-mail string beginning from Hannah	
16	Willard to Carrie Henriquez dated	
17	4/7/2017)	
18	Plaintiffs' Exhibit No. 16 marked for	77
19	identification	
20	(E-mail string beginning from Carrie	
21	Henriquez to Mark Puskarich dated	
22	12/11/2017)	
23	Plaintiffs' Exhibit No. 17 marked for	95
24	identification	
25	(Report of the American Psychological	
	Association Task Force on Appropriate	
	Therapeutic Responses to Sexual	
	Orientation)	

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1 The deposition of COUNCILMAN GUIDO MANISCALCO,
2 witness, was taken before me, Rachele Cibula, Notary
3 Public, State of Florida at large, at 201 North Franklin
4 Street, Suite 3200, in the City of Tampa, County of
5 Hillsborough, State of Florida, pursuant to notice in
6 said cause for the purpose of taking said deposition at
7 the instance of the Plaintiffs in the above-styled
8 action pending in the above-styled court.

9 THE COURT REPORTER: Raise your right hand,
10 Please, sir.

11 THEREUPON,

12 COUNCILMAN GUIDO MANISCALCO,
13 being by me first duly sworn to testify the whole truth
14 as is hereinafter certified, testifies as follows:

15 THE WITNESS: I do.

16 DIRECT EXAMINATION

17 BY MR. GANNAM:

18 Q. Good morning. I'm Roger Gannam, and we just met
19 a moment ago. I'm a Plaintiffs' attorney in this
20 lawsuit against the City of Tampa and Sal Ruggiero
21 regarding Tampa's conversion therapy ban.

22 I want to go over a few ground rules with you
23 before we get started. And let me ask you, first, have
24 you ever given a deposition before?

25 A. No.

Florida Court Reporting
561-689-0999

1 Q. Okay. As you know, we're making a written
2 transcript of today's proceedings. So it's very
3 important that, when we speak to each other, that we
4 each give the other a chance to finish before starting
5 with an answer or a question. Is that okay with you?

6 A. Yes.

7 Q. It's also important that all of your answers be
8 out loud. You've already demonstrated you know how to
9 do that. But, in normal conversation, we might tend to
10 nod our head or give nonverbal responses. It's very
11 important that everything be out loud today. Are you
12 okay with that?

13 A. I understand.

14 Q. And, throughout the deposition, if I remind you
15 of that, it's just for the purposes of the record. We
16 all tend to not, you know, want to speak to each other
17 in a way that's conducive to a written record. But I
18 may remind you, and your attorney may remind you at some
19 point today. Are you okay with that?

20 A. Yes.

21 Q. If I ask you a question that you don't
22 understand, please let me know; and I will address
23 whatever the problem might be.

24 A. I will.

25 Q. Okay?

1 A. I will.

2 Q. If I ask you a question and you answer it, I will
3 assume that you understood me. Is that okay with you?

4 A. Yes.

5 Q. If your lawyer makes an objection, which he
6 probably will at some point to one or more of my
7 questions, the procedure is for him to make his
8 objection for the record; and then you go ahead and
9 answer the question --

10 A. Okay.

11 Q. -- unless he tells you specifically not to
12 answer. Are you okay with that?

13 A. I understand.

14 Q. We are going to be here for most of the day
15 between the two witnesses. But this is not a marathon.
16 If you need to take a break, just let me know. And all
17 I would ask is, if I have asked a question, that you
18 answer it before we take any breaks.

19 A. I will.

20 Q. Okay. Do you have any questions for me before we
21 go further?

22 A. No.

23 Q. All right. I'm going to go over a few terms that
24 will come up today throughout this deposition just to
25 make sure we both understand what I'm talking about.

1 When I say the City, I mean the City of Tampa. Are you
2 okay with that?

3 A. Yes.

4 Q. And, when I say the ordinance, I'll be speaking
5 of the Tampa conversion therapy ordinance, also known as
6 2017-47, which is the subject of this lawsuit. Do you
7 understand that?

8 A. Yes.

9 Q. The initials or abbreviation LGBT, do you
10 understand what that means?

11 A. Yes.

12 Q. The initials or acronym SOCE, S-O-C-E, do you
13 understand what that means?

14 A. Yes.

15 Q. Okay. And, just for the record, I'm talking
16 about sexual orientation change efforts.

17 I may also refer to gender identity change
18 efforts as being something different or separate from
19 sexual orientation change efforts. Does that make
20 sense?

21 A. Yes.

22 Q. And, when I refer to conversion therapy, that
23 will refer to generally what is identified in the
24 ordinance as conversion therapy. But that may include
25 sexual orientation change efforts or gender identity

1 change efforts or both. Is that okay?

2 A. Yes.

3 Q. And, if I use one of those terms and, in the
4 context of my question, it doesn't make sense or you
5 don't understand what I mean, please just say so; and
6 we'll work on that.

7 A. I will.

8 Q. All right. Let's start with your name for the
9 record, please.

10 A. Guido Maniscalco.

11 Q. And, Mr. Maniscalco, in what capacity are you
12 appearing here today? I mean, what is your position
13 with the City of Tampa?

14 A. City Council Member representing District 6.

15 Q. And are you currently taking any medication that
16 could affect your ability to recall facts or testify
17 truthfully today?

18 A. No.

19 Q. All right. Are you -- do you have any injury or
20 condition that would prevent you from being able to
21 recall facts or testify truthfully today?

22 A. No.

23 Q. And you are appearing today pursuant to a Notice
24 of Deposition. I'm handing you a copy. I've marked it
25 as Exhibit 5.

1 (Plaintiffs' Exhibit No. 5 marked for identification)

2 BY MR. GANNAM:

3 Q. This is Plaintiffs' Exhibit 5. It is Plaintiffs'
4 Notice of Taking Depositions of Defendants. It includes
5 the topics for the deposition of the City of Tampa for
6 which you are appearing today. It is my understanding
7 from conversation with your attorney that, starting on
8 page three where the topics are numbered, you are
9 appearing to testify regarding topics 1 through 5, 7 and
10 8; and that's it. Is that also your understanding?

11 A. Yes.

12 MR. WILLIAMS: It could flow into 9 because
13 it has the word enactment.

14 MR. GANNAM: Okay. Understood. There may
15 be some overlap between --

16 MR. WILLIAMS: That's what I --

17 MR. GANNAM: -- Mr. Maniscalco and
18 Mr. Simpson. Okay.

19 MR. WILLIAMS: That's what I was alluding
20 to.

21 MR. GANNAM: Were there any other comments
22 you wanted to make regarding that, Rob?

23 MR. WILLIAMS: No.

24 MR. GANNAM: Okay.

25 MR. WILLIAMS: Just trying to help out.

1 BY MR. GANNAM:

2 Q. Do you understand, Mr. Maniscalco, that, as the
3 City's representative at this deposition, you're
4 testifying, not only as to what you know, but what the
5 City knows on any particular subject? Is that your
6 understanding?

7 A. Yes.

8 Q. And, when I say, "you," or ask the question do
9 you know, do you understand that I'm referring to what
10 the City knows and not necessarily just you
11 individually?

12 A. I do.

13 Q. Okay. Did you review any documents to prepare
14 for your testimony today?

15 A. Just what I have in front of me, the questions.

16 Q. The deposition notice?

17 A. Yes, this is it.

18 Q. You didn't look at any other documents to
19 prepare?

20 A. No, just the questions.

21 Q. Did you speak to anyone to prepare for your
22 testimony today?

23 A. Just the attorney.

24 Q. You mean, Mr. Williams?

25 A. Yes.

1 Q. Anyone on the City Attorney's staff?

2 A. No.

3 Q. And how many times did you meet with Mr. Williams
4 to prepare for today?

5 A. One time.

6 Q. When was that?

7 A. Two days ago.

8 Q. And about how long did you meet for?

9 A. About two hours.

10 Q. All right. So, apart from Mr. Williams, did you
11 meet with anyone else to prepare for your testimony
12 today?

13 A. No, just him.

14 Q. I want to talk about your background. Can you
15 give me just a summary of your education following high
16 school.

17 A. A bachelor's degree from the University of South
18 Florida.

19 Q. What year did you receive that degree?

20 A. 2007.

21 Q. What was the degree in?

22 A. English.

23 Q. Any other college degrees?

24 A. No, that's it.

25 Q. Any professional certifications or licensures or

1 anything like that?

2 A. No.

3 Q. Can you kind of now just give me a summary of
4 your professional career following college.

5 A. I always worked in retail, retail sales.

6 Q. What -- what companies have you worked for?

7 A. Dillard's, Montblanc and just for myself in the
8 watch industry, vintage watches.

9 Q. Is your position as a City Council member a
10 full-time job?

11 A. Yes, it is. This is what I do for a living.

12 Q. So do you maintain any other employment or
13 business interests outside of your City Council
14 membership?

15 A. No, just this.

16 Q. What did you do immediately before joining the
17 City Council?

18 A. Vintage watches, what I stated before, retail
19 sales just for myself.

20 Q. Was that your own business?

21 A. Yeah. It was just a website.

22 Q. Does that website still exist?

23 A. No. After I got elected, I just did this
24 full-time.

25 Q. How long were you in that vintage watch venture?

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1 A. I would say about three years, three and a half
2 years.

3 Q. And when did you -- when were you elected to the
4 City Council?

5 A. 2015.

6 Q. Okay. Were you -- prior to the passage of the
7 ordinance at issue, were you involved in any advocacy
8 for LGBT organizations or causes?

9 A. No.

10 Q. What about, since the ordinance was passed, have
11 you been involved in advocacy for any LGBT organizations
12 or causes?

13 A. No.

14 Q. And I take it then, since you weren't involved in
15 any LGBT-related organizations or causes, you also have
16 not been involved in any advocacy specifically relating
17 to conversion therapy before or after the ordinance?

18 A. No.

19 MR. WILLIAMS: His statement is correct what
20 you --

21 THE WITNESS: Oh, yeah. You're right, yeah.

22 MR. GANNAM: Yeah. Thanks for the
23 clarification.

24 THE WITNESS: Right. Right.

25 BY MR. GANNAM:

1 Q. Do you have any training or experience in
2 counseling or any other mental health related field?

3 A. No.

4 Q. When does your current term of office end?

5 A. I believe it's May 1st or April 30th. The new
6 people get sworn in May 1st of this coming year, 2019.

7 Q. 2019?

8 A. Uh-huh.

9 Q. When will that election occur?

10 A. The election is March 5th.

11 Q. Of 2019?

12 A. Of 2019.

13 Q. And are you eligible for re-election?

14 A. Yes, I am.

15 Q. And are you running for re-election?

16 A. Yes, one more term.

17 Q. And then are you term limited after two?

18 A. Yes.

19 Q. All right. On the City Council, do you hold any
20 positions on -- on committees or task forces or anything
21 within your council responsibilities?

22 A. Yes. There's several Boards that I serve on.

23 Q. Okay. What are those?

24 A. The Hillsborough River Board; the Tampa Theater
25 Board; the MPO, which is Metropolitan Planning

1 Organization.

2 Q. Okay.

3 A. And MM -- no, that's it. That's it.

4 Q. What is your position on the Hillsborough River
5 Board?

6 A. Chairman.

7 Q. What about the Tampa Theatre Board?

8 A. Just a Board member.

9 And I also forgot to mention I'm on the Tampa Bay
10 Estuary Policy Board. That's the other one. And that's
11 just a Board member.

12 Q. And what is your position on the MPO?

13 A. Just a Board member.

14 And also, just not to leave it out, City Council
15 is also the CRA Board. It's the same members. It's the
16 Community Redevelopment Agency. And I'm current
17 chairman of that. But it's -- we just, you know, close
18 one set of books and open another. And those are all
19 the Boards.

20 Q. Do you hold any officer positions or titles on
21 the council at large?

22 A. No. I'm just a regular Board member.

23 Q. Okay. And all these -- the Hillsborough River
24 Board, Tampa Theatre Board, MPO, Tampa Estuary Planning
25 Board and the Community Redevelopment Agency, are those

1 all appointed positions?

2 A. Yes, they are.

3 Q. And who appoints those?

4 A. The Chairman of the City Council can appoint some
5 Board positions. I am the mayor's appointee to the
6 Tampa Bay Estuary Policy Board.

7 Q. Do you have any other -- do you hold any other
8 mayoral appointments?

9 A. No. That's the only one.

10 Q. And the mayor is Mr. Buckhorn?

11 A. Yes, sir.

12 Q. Okay. It's my understanding that you were the
13 originator or sponsor of the ordinance at issue in this
14 lawsuit; is that correct?

15 A. Yes.

16 Q. Tell me, when did -- or can you just kind of tell
17 me how that came about. Where did it start?

18 A. A friend of mine brought the idea up to me and
19 said why not -- why doesn't -- why don't you look into
20 this, you know, from a City Council perspective. And,
21 soon after, I think within a few weeks, I made a -- made
22 the motion to get that rolling.

23 Q. Who was that friend?

24 A. His name is Bryan, B-r-y-a-n. Last name is
25 Farris, F-a-r-r-i-s.

1 Q. And how do you know Mr. Farris?

2 A. Through political circles.

3 Q. And does he have -- does he hold a political
4 position?

5 A. No. No, he's just a private citizen.

6 Q. How long have you known him?

7 A. I've known him since 2012.

8 Q. Is Mr. Farris a Tampa resident?

9 A. Yes.

10 Q. And did he tell you what his interest was in the
11 subject of conversion therapy?

12 A. No, he did not.

13 Q. In other words, did he tell you why he thought it
14 was a good idea?

15 A. He's a -- he's a gay man --

16 Q. Right.

17 A. -- and he just said, why don't you look into
18 this; and that was it. Pretty basic.

19 Q. Do you know whether Mr. Farris is involved in
20 LGBT advocacy organizations?

21 A. No.

22 Q. You don't know or he's not?

23 A. Not that I know of, no.

24 Q. Okay. Did Mr. Farris tell you that he personally
25 had experienced anything that would fit the definition

1 of conversion therapy under the ordinance?

2 A. No, he did not.

3 Q. So do you know whether he had experienced
4 anything like that?

5 A. No, I do not.

6 Q. All right. When did he bring this idea to you;
7 do you recall?

8 A. From when I made the motion, a few weeks prior, I
9 would think. You know, within thirty days prior.

10 Q. So we're thinking sometime around January 2017,
11 December 2016, in that timeframe?

12 A. Whenever I made the motion, you know, let's say
13 within thirty days before that.

14 Q. Okay. And that first motion was the motion to
15 have the -- the City of Tampa legal department draft an
16 ordinance?

17 A. It was to bring back a staff report just to get
18 information, you know, how other places that have
19 proposed this ban. You know, just for them to have a
20 template and then just bring back a general staff report
21 of -- before council.

22 Q. That staff report would have been prepared by the
23 legal department?

24 A. Yes.

25 Q. Is that, in fact, what they did?

1 A. Yes.

2 Q. Did Mr. Farris tell you that he knew others who
3 had experienced what is defined as conversion therapy in
4 the ordinance?

5 A. No.

6 Q. At the time he brought the idea to you, did you
7 know what conversion therapy was?

8 A. Yes, I did.

9 Q. And did you know of people who had -- who had
10 received or experienced conversion therapy?

11 A. Through -- through some of my mother's friends
12 growing up. She had a lot of friends that were gay, and
13 I knew several of them. They're all dead. And just
14 growing up, you know, hearing stories from her or from
15 them.

16 Q. So you heard stories directly from some of those
17 people who had experienced it?

18 A. Yes, as teen-agers.

19 Q. And how old were you when you heard these
20 stories?

21 A. I may have been thirteen, fourteen.

22 Q. Do you know, from those stories, whether any of
23 those persons experienced whatever they experienced in
24 Tampa?

25 A. They were all from Tampa. Yeah, they're all

1 local people.

2 Q. And do you recall specifically what -- what
3 practices or -- or therapies these people received or
4 experienced that they told you about?

5 A. They -- nothing specific other than they were
6 sent to, you know, some kind of counselor. I had
7 heard -- you know, this is going back, you know, forty,
8 fifty years -- electroshock therapy, you know, basic
9 one-on-one counseling but nothing -- nothing further
10 than that.

11 Q. Did any of them indicate that they were sent
12 against their will or were receiving this without their
13 consent?

14 A. One ended up committing suicide as a teen-ager.
15 The other one essentially drank himself to death, just
16 like a downward alcoholic spiral.

17 Q. But did any of them tell you whether -- what they
18 -- whatever therapy they received was done against their
19 will?

20 A. No. The one that committed suicide I never met.
21 I only heard stories.

22 Q. And the one who suffered from alcoholism, did
23 that person tell you about whether -- was it a he or a
24 she?

25 A. It was a man. And all he told me was, you know,

1 my father always said he would never have a gay son. He
2 would not accept a gay son. And, you know, I never went
3 into -- you know, as a young man, I never asked, well,
4 so what did your father -- you know, where did they send
5 you to? He always had a difficult relationship with
6 him.

7 Q. Apart from -- from these things you heard from
8 these men or from your mother about them when you were a
9 teen-ager, had you had any other reason to think about
10 or consider conversion therapy prior to Mr. Farris
11 bringing the idea to you?

12 A. Other than what -- what --

13 Q. Sorry. You can go ahead.

14 A. Other than what I would, you know, read on the
15 internet, you know, things that would come up. I mean,
16 it's brought up. I know one candidate for governor
17 earlier this year brought up -- Gwen Graham brought up a
18 -- you know, to have a statewide ban in the State of
19 Florida. Of course, she -- she lost in the primary.
20 But, you know, it's an issue that I see. I follow the
21 news, and it comes up.

22 Q. I just want to go back to the -- the man who you
23 knew when you were younger who you told us about his
24 alcoholism and his father's rejection.

25 A. Uh-huh.

1 Q. Did he indicate to you any specifics about what
2 kind of conversion therapy or similar therapy he
3 received?

4 A. No. Out of respect, I just never -- never went
5 further in the questioning other than, you know, we --
6 we love you for who you are; and that's it.

7 Q. Do you know whether he had, in fact, received any
8 kind of therapy that would be considered conversion
9 therapy?

10 A. I never asked him. I know he -- other than, you
11 know, struggled with his relationship with -- and his
12 father was very strict. But I never went into further
13 detail with him.

14 Q. Had you proposed any kind of conversion therapy
15 related legislation to the City Council before
16 Mr. Farris brought the idea to you?

17 A. No. This is the only time.

18 Q. Has anyone else, to your knowledge --

19 A. No.

20 Q. -- any other council members?

21 A. No, none at all. I'm the first and only one.

22 Q. You said you generally had -- or I don't want to
23 put words in your mouth. Correct me if I'm wrong. You
24 had some general knowledge of conversion therapy issues
25 from what you heard or read in the news; is that

1 correct?

2 A. Other than what I would hear from, you know,
3 growing up. My mother had so many friends that were
4 gay, you know, from high school on up. Yeah, just --
5 you know, whatever comes up in the news. Like, I -- you
6 know, I follow the news fairly closely. So...

7 Q. At the time Mr. Farris presented the idea to you,
8 were you personally aware of any particular instances of
9 conversion therapy happening in Tampa?

10 A. I was not.

11 Q. And were you aware at that time of any specific
12 complaints about the effects of conversion therapy from
13 anyone outside of Tampa?

14 A. I was not.

15 Q. What was your specific motion or charge to the
16 legal department? Were there particular questions you
17 wanted answered? What was your expectation from the
18 staff report that they were preparing?

19 A. If I remember correctly, it was -- I made the
20 motion for the legal department to come back with a
21 staff report to see about proposing a conversion therapy
22 ban in the City of Tampa and looking at other
23 municipalities, you know, in order to use it as a
24 template and get information.

25 Q. And is that, in fact, what they did?

1 A. Yes, sir.

2 Q. What was the next step in that process? After
3 the staff report came back, what happens next in the
4 enactment?

5 A. You make a motion to bring it back as a draft
6 ordinance for a first reading. And that's where you
7 have discussion and a possible vote to move forward. So
8 the other Council members can -- will chime in. And
9 they could chime in when the staff report comes back.
10 But it's another opportunity to have that public forum.

11 Q. Just, generally speaking, if it comes back for a
12 first reading --

13 A. Uh-huh.

14 Q. -- is there a vote taken at that time --

15 A. First --

16 Q. -- on the first reading?

17 A. You have to vote twice. So you vote to move
18 forward at first reading, and then you vote a second
19 time at second reading to certify it and then send it to
20 the mayor.

21 Q. And so I just want to make sure I understand the
22 process. In this case, your first motion was to --

23 A. Get information.

24 Q. -- get information or a staff report, as you
25 described it, right?

1 A. Yes.

2 Q. The second step was a motion to actually prepare
3 a draft ordinance?

4 A. Yeah, where we could vote on to move it
5 forward --

6 Q. Okay.

7 A. -- for preliminary approval.

8 Q. And then the third step was what you call the
9 first reading where I take it there is some debate and
10 discussion about it and a vote at that time?

11 A. Yes.

12 Q. And then the final step would be the second
13 reading where, again, you have discussion, debate and a
14 vote?

15 A. And then you send it to the mayor.

16 Q. And then it gets sent to the mayor. Okay.

17 And that process that I just described with your
18 help, is that generally how any ordinance gets passed in
19 the law?

20 A. Yeah, that's of anything.

21 Q. Let me show you an exhibit I will mark as Exhibit
22 6.

23 (Plaintiffs' Exhibit No. 6 marked for identification)

24 BY MR. GANNAM:

25 Q. This is a printout of an article from the Tampa

1 Bay Times produced in discovery with Bates number COT
2 PRODUCTION 003826.

3 A. Uh-huh.

4 Q. Are you familiar with that article?

5 A. I am, yes.

6 Q. The headline reads, Tampa City Council discusses
7 ban on conversion therapy for minors. It's dated
8 January 26, 2017. The second paragraph reads, The City
9 Council voted to schedule a February 16 discussion of
10 the idea at the request of Council Member
11 Guido Maniscalco.

12 A. Yes.

13 Q. Is that an accurate statement?

14 A. Yes. That would be that motion to bring it
15 forward.

16 Q. Would that have been the motion to have the staff
17 report prepared or the motion to go forward with the
18 draft?

19 A. That is the -- the staff report, I believe.

20 Q. Okay. The next paragraph is a quote attributed
21 to you. To me, it's a form of torture, Maniscalco said.
22 He wants to base a Tampa ban on one already approved in
23 Miami Beach.

24 First of all, is that quote accurate?

25 A. Yes, it is.

1 Q. When you said it's a form of torture, what were
2 you talking about?

3 A. I think it's a -- it's a harmful practice to
4 minors -- because this conversion therapy is a ban for
5 minors so, of course, under eighteen. Because of, you
6 know, the one gentleman that committed suicide as a
7 teen-ager, other stories that you read and hear. You
8 know, beyond -- there's bullying in school. And then
9 you have this kind of mental abuse that could lead
10 people down different paths; alcoholism, drug addiction,
11 even as far as suicide.

12 You know, because, I mean, there's -- there's
13 the -- you know, the mental torture, I mean, you know.
14 If someone is too afraid to face their parents, you
15 know, they could commit suicide. They could numb the
16 pain with -- you know, with alcohol and drugs, as is
17 very common. So I think that just all fits into, you
18 know, what that quote means.

19 Q. What specific, you know, practices, what specific
20 things done to -- or that may have been done to minors
21 did you have in mind when you said torture?

22 A. Well, I mean, electroshock therapy which is seen
23 as -- you know, you don't hear about it as you would
24 have fifty years ago. But, even one-on-one counseling,
25 you know, you can have mental and verbal abuse.

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1 Because, you know, someone is who they are; and they're
2 essentially being forced to, you know, think another
3 way. And...

4 Q. Let me back up to electroshock therapy. I've
5 heard the term electroshock therapy. I can't say that I
6 have any idea what that really involves. I mean, do you
7 know any specifics about that kind of therapy and what's
8 involved with it?

9 A. No, I do not.

10 Q. And, based on my earlier questions, did you have
11 any information or knowledge that electroshock therapy
12 was being performed on minors in Tampa at the time that
13 you proposed this ordinance?

14 A. No. This is an older practice. It's evolved
15 over the years.

16 Q. Do you know whether it's done at all anymore in
17 the context of sexual orientation or gender identity?

18 A. I do not, not in 2018 or 2017.

19 Q. And the second example you gave me was one-on-one
20 counseling that involved some kind of verbal abuse. Did
21 I say that correctly?

22 A. Uh-huh.

23 Q. What would be the content of -- at least in your
24 mind when you use the term torture, what kind of
25 counseling? What kind of things would be said that

1 would constitute torture, in your mind?

2 A. Well, I mean, take for example a husband and
3 wife. You know, he never hits her; but he tells her,
4 you're fat, you're fat, you're fat, you're disgusting,
5 you're ugly. I -- you know, that's common. You know?
6 There was never physical abuse. There was verbal.

7 But then you're -- you know, you have a counselor
8 that says, you know, you're going to burn in hell. You
9 know, God doesn't forgive this. You know, society
10 doesn't accept this. It's not normal, you know, two men
11 together. It's Adam and Eve, not Adam and Steve. I
12 mean, that's -- it's -- it is mental torture. It's
13 the -- it's just like being bullied in high school, you
14 know, being called this or that. And, you know, it's a
15 form of abuse; and I think it's very harmful. And it's
16 something that will, you know, psychologically stay with
17 the person throughout their lives.

18 Q. At the time that you proposed the ordinance, did
19 you have any knowledge of any of those examples that you
20 just gave me occurring in the City of Tampa?

21 A. Other than reading and hearing stories, nothing
22 specific.

23 Q. Had you read stories of those particular things
24 going on in Tampa?

25 A. No, just in general.

1 Q. Okay. And had you heard from anyone a story of
2 any of those particular examples you gave going on in
3 Tampa?

4 A. Kids that I went to high school with and whatnot,
5 they wouldn't give me specifics of, you know, where they
6 went. But it would be, you know, my father sent me
7 away. My parents put me into counseling. Nothing
8 specific as to, you know, who or -- whomever that
9 counselor or licensed professional was. But, you know,
10 their parents were not accepting of, you know, who they
11 were or said they were. And that's that.

12 Q. Apart from electroshock therapy and one-on-one
13 counseling that is -- that is verbally or mentally
14 abusive, as you've explained, were there any other
15 practices or types of therapy that you had in mind when
16 you used the word torture to describe conversion
17 therapy?

18 A. No.

19 Q. And did you have any other practices or therapies
20 in mind when you actually proposed to move forward with
21 this ordinance?

22 A. No.

23 Q. So, you know, have you now told me all of the
24 kinds of practices or therapies that you had in mind
25 when you used that word torture in this newspaper quote?

1 A. Yes, I have.

2 Q. And have you also now told me all of the
3 practices or therapies you had in mind when you
4 originally proposed the Conversion Therapy Ban
5 Ordinance?

6 A. Yes, I have.

7 Q. You mentioned kids that you knew in high school.
8 I want to take them one by one. You used the example of
9 my parents put me in counseling. Did you know someone
10 in high school who said their parents put them in some
11 kind of counseling related to sexual orientation or
12 gender identity?

13 A. Yes.

14 Q. Did you know this in high school, or did you find
15 this out after?

16 A. In college. In high school, you didn't come out
17 that you were gay. You know, people felt like they had
18 more freedom post high school, you know, a bigger -- you
19 know, a bigger population such as college where you can
20 blend in with the crowd.

21 Q. What year did you graduate high school?

22 A. 2002.

23 Q. What high school was that?

24 A. Tampa Catholic High School.

25 Q. And so how many of your high school classmates

1 told you that their parents put them in counseling
2 regarding sexual orientation or gender identity?

3 A. If I recall, two.

4 Q. Let's take them one by one. What did the -- the
5 first one -- maybe just make it easier. Are these boys?
6 Girls?

7 A. Both men.

8 Q. Both men. Okay.

9 The first one who told you about this, did he
10 tell you that his parents put him in counseling against
11 his will?

12 A. His father put him in counseling against his --
13 against his will. He would not see -- he would not
14 accept that his son was gay.

15 Q. And it was clear that this friend of yours did
16 not want to go to this counseling?

17 A. Yes.

18 Q. And did the friend tell you what happened in the
19 counseling sessions?

20 A. Other than it was -- it was a very bad experience
21 for him. That's it. That's all he told me.

22 Q. And do you know whether this was with a licensed
23 counselor or unlicensed?

24 A. I do not. I never asked those specifics.

25 Q. And do you also know whether this person was part

1 of a religious organization or not?

2 A. I do not know.

3 MR. WILLIAMS: You mean, a member of a
4 church?

5 MR. GANNAM: Well, start with the broad --
6 the broadest. And if -- you know, if he had said yes, I
7 might have narrowed it down.

8 MR. WILLIAMS: Okay. Well, I don't want to
9 interrupt. But I don't know what a part of a religious
10 organization -- that could be a lot of things. That's a
11 little vague. And --

12 MR. GANNAM: I'll clarify.

13 BY MR. GANNAM:

14 Q. Did you know whether the counseling was received
15 through a person who was an employee or affiliated with
16 a church?

17 A. I do not know.

18 Q. The second man who you said you knew who
19 experienced some kind of conversion therapy, what did
20 that person experience?

21 A. Same thing, being sent off to -- they would call
22 it -- he would call it treatment. But he never gave
23 specifics. I never -- I tried to be respectful of their
24 privacy.

25 Q. The first one -- let me go back -- did he receive

1 his -- his counseling in Tampa?

2 A. I don't know.

3 Q. Okay. Do you know whether he went to any kind of
4 residential facility where he was away for a period of
5 time?

6 A. I don't know.

7 Q. What about the second? Do you know where he
8 received his treatment?

9 A. No, I don't know. I didn't ask.

10 Q. Do you know the details of what that treatment
11 entailed?

12 A. No.

13 Q. And did you also understand that to have been
14 against his will?

15 A. Yes on both of them.

16 Q. When did you gain this knowledge? You said it
17 was in college. Is that generally the timeframe?

18 A. Regarding what?

19 Q. These two men and what they experienced.

20 A. Yeah, college. It was after high school.

21 Q. Okay. At the time you proposed the ordinance --
22 and I think we've already covered this, and forgive me
23 if I'm -- if I'm being redundant. But did you -- did
24 you know whether any of those things that those two men
25 described to you were being done by licensed counselors

1 in the City of Tampa?

2 A. No, I don't.

3 Q. Do you understand the difference between aversive
4 and non-aversive therapies to change sexual orientation
5 or gender identity? Do you know those terms?

6 A. Could you provide the definition?

7 Q. Well, I take it -- is the answer, no, you don't
8 know what the difference is?

9 A. No. I don't understand the terms. I don't know
10 the words.

11 Q. You don't know what those terms mean?

12 A. Yeah.

13 Q. Okay. Understood.

14 Prior to today, had you ever heard those terms
15 before?

16 A. Yes.

17 Q. And had you ever undertaken to find out what
18 those terms meant before today?

19 A. No, just in reading. But no.

20 Q. When did you see those terms for the first time?

21 A. I don't remember.

22 Q. Do you remember what you were reading?

23 A. I do not.

24 Q. Was it related -- were you reading something in
25 connection with this lawsuit?

1 A. No. No.

2 Q. Were you reading something in connection with
3 your sponsoring the therapy ban ordinance?

4 A. I don't remember.

5 Q. Okay. Now, when I say aversive therapy, I'm
6 referring to therapy that involves some kind of
7 punishment or reprimand carried out on the client to,
8 you know, discourage certain thoughts or behaviors.
9 Does that make sense?

10 A. No. Yeah, I understand. I understand.

11 Q. Okay. And the APA in the report that's
12 identified in the ordinance, it gives some examples.

13 A. Uh-huh.

14 Q. It talks about them as -- let's see.

15 MR. WILLIAMS: For the record, Roger, you're
16 talking about the American Psychiatric Association?

17 MR. GANNAM: American Psychological
18 Association. And I'm referring to the 2009 report
19 that's cited in the ordinance. And we'll talk about it
20 more.

21 THE WITNESS: Okay.

22 BY MR. GANNAM:

23 Q. Some examples that the APA gives of aversive
24 treatment: Inducing nausea, vomiting or paralysis;
25 providing electric shocks or having the individual snap

1 an elastic band around the wrist when the individual
2 became aroused to same-sex erotic images or thoughts.
3 So, based on those examples of kind of, you know,
4 punitive or reprimanding conduct that's carried out on a
5 client, did you know -- generally understand what I mean
6 by aversive therapy?

7 A. Yeah. I mean, I would have seen it as
8 electroshock or punishment or --

9 Q. Sure.

10 A. -- another term. But I understand.

11 Q. So would it be fair to say that the various kinds
12 of therapy that you had in your mind when you, you know,
13 used that word torture speaking in the newspaper and
14 when you brought this ordinance forward, would it be
15 fair to say that those would be in that category of --

16 A. Yeah.

17 Q. -- aversive therapies?

18 A. Yes.

19 Q. Now, do you also then understand that there are
20 therapies that aren't considered aversive in relation to
21 sexual orientation or gender identity change?

22 A. I would assume that that's, you know, one-on-one,
23 just verbal counseling.

24 Q. Yeah. So, when I say non-aversive therapy, I'm
25 -- yeah, that's what I'm referring to.

1 A. Okay. No, I understand.

2 Q. Speaking to a client to ask the client questions,
3 find out what the client wants, you know, where the
4 client wants to go, things that don't involve any kind
5 of punishment or reprimand or shaming or anything like
6 that.

7 A. Uh-huh.

8 Q. So, when I say non-aversive, you understand I'm
9 talking about that kind of client-directed --

10 A. Yeah --

11 Q. -- talking?

12 A. -- no, I understand. I understand.

13 Q. This distinction between aversive or
14 non-aversive, I take it you didn't have those
15 distinctions in mind when you brought this ordinance
16 forward?

17 A. I saw it as, you know, psychological torture, to
18 use that word again, some kind of punishment. I think
19 the punishment is, you know, minors being put in these
20 kind of therapies to begin with. I mean, that -- you
21 talk about, you know, snapping an elastic band or
22 getting some electroshock therapy. But, you know,
23 people being put in this against their will by their
24 parents because, you know -- you have a parent that
25 could say, you need to stop this, you're going through a

1 phase, stop being gay. It's not -- that's not how it
2 works. You know? And that's the punishment. If not,
3 I'm going to send you somewhere. And there's the
4 punishment in itself.

5 Q. Prior to enacting the ordinance --

6 A. Uh-huh.

7 Q. -- had the City of Tampa received any complaints
8 that any minor had been harmed by conversion therapy?

9 A. Not to my knowledge.

10 Q. And do you know whether -- since the ordinance
11 was enacted, whether that has happened?

12 A. Not to my knowledge.

13 Q. And this would be one of the points that I just
14 want to clarify. When you say, not to your knowledge,
15 we're talking about the City of Tampa since you're here
16 testifying for them --

17 A. Yes.

18 Q. -- today. Does the City of Tampa have any
19 knowledge --

20 A. I don't --

21 Q. -- of any complaints?

22 A. I don't know. Not to my office, I don't know.

23 Q. Is there anyone else in the City of Tampa who may
24 know more than you when it comes to whether complaints
25 about harm received from conversion therapy have come

1 into the City?

2 A. I don't know.

3 Q. At the time that you first brought this ordinance
4 forward and asked for the staff report, did you request
5 anyone to investigate whether there had been any
6 complaints in the City of Tampa of harm from conversion
7 therapy?

8 A. No, I did not. I simply made that request for
9 information to look at a ban. That was it.

10 Q. And would it have been your expectation in making
11 that request for the City Attorney's Office or someone
12 else within the City to conduct that kind of
13 investigation --

14 A. No --

15 Q. -- to find out?

16 A. -- no. I specifically requested a report on a
17 conversion therapy ban, and that was it.

18 Q. Do you know whether -- regardless of your
19 expectations, whether anyone within the City did, in
20 fact, undertake to investigate whether there had been
21 any complaints of harm?

22 A. No, I don't know.

23 Q. Apart from complaints of harm, did you have any
24 knowledge -- did the City have any knowledge at the time
25 that you proposed this ordinance whether anyone was

1 actually receiving anything that could be called
2 conversion therapy in the City of Tampa?

3 A. No, not that I know of.

4 Q. All right. In the -- when was the first time
5 that -- strike that.

6 When the first staff report was prepared at your
7 request --

8 A. Uh-huh.

9 Q. -- did it -- did the information that came back
10 to you include any information about whether there had
11 been harm or whether there had even been any conversion
12 therapy happening in Tampa?

13 A. No. The request was specifically looking at a
14 ban and looking at other municipalities to see how
15 they've done it, you know, to use it as a template. But
16 that was -- that was the nature of the request.

17 Q. Did the City ever receive any evidence in the
18 process of -- from proposing the ordinance to its
19 enactment, during that period of time, did the City
20 receive any evidence of harm occurring as a result of --

21 A. I don't know.

22 Q. -- conversion therapy?

23 A. I don't know.

24 MR. WILLIAMS: Well, let me clarify that
25 because there are public hearings. Are you including

1 the public hearings?

2 MR. GANNAM: I'm just asking did the City
3 receive any evidence.

4 BY MR. GANNAM:

5 Q. Were you part of -- were you present at all of
6 the City Council meetings where this ordinance was
7 discussed and voted?

8 A. Yes, at all of the discussions.

9 Q. And, during the course of any of those meetings,
10 did the City receive any evidence of harm resulting from
11 sexual orientation change efforts or gender identity
12 change efforts?

13 A. I don't know.

14 Q. And, when I say did the City receive evidence,
15 I'm talking about did anyone stand up and say
16 anything --

17 A. Oh --

18 Q. -- for the consideration of the Council?

19 A. -- at the public hearing?

20 Q. Right --

21 A. Yeah --

22 Q. -- or at any point during those meetings.

23 A. -- people did speak because it was a public
24 forum, and people had three minutes to speak. And there
25 were several personal stories of, you know, what they

1 had gone through.

2 Q. And all of those statements would be a part of
3 the official record, correct?

4 A. Yes, and in support of this ban.

5 Q. And so, if there is -- apart from what people
6 said during the public comment period, did any member of
7 the City Council call a witness to testify regarding the
8 conversion therapy ban?

9 A. No.

10 Q. Is that a process that you're familiar with? Do
11 you have the ability as a City Council member to
12 actually bring a particular witness to come up and
13 present information to council members?

14 A. The only thing we can do is have someone come and
15 speak about their organization. Unrelated to this. You
16 know, talk about the cancer hospital. You know? And
17 they'll come and, you know, discuss. But those are just
18 in general. But I've never called a witness. And,
19 since I've been there, I've never seen a witness get
20 called.

21 Q. Okay. Fair enough.

22 So, in connection with the conversion therapy
23 ordinance, no member of the council actually called a
24 witness to --

25 A. No.

1 Q. -- to bring out testimony?

2 A. No, no, no.

3 Q. So, apart from the statements made to the council
4 during the various public comment periods related to
5 this ordinance, was there any other information shared
6 with the council members relating to this ordinance
7 before it was enacted?

8 A. No, other than the information that we requested,
9 you know, how municipalities do it and moving forward
10 with it. That was it.

11 Q. Apart from what happened at the meetings,
12 themselves, did you, as a City Council member, receive
13 any written communications from constituents, advocacy
14 organizations, anyone at all, either -- you know, urging
15 you to pass it or not pass it?

16 A. There may have been letters of support sent. But
17 people -- people came and spoke in support or in
18 opposition. I mean, everything was done in the public
19 forum. Some meetings were busier than others.

20 Q. Did you personally receive any e-mails as a City
21 Council member indicating either support or opposition
22 to the ordinance?

23 A. I don't remember any specifically being sent to
24 me.

25 Q. Is there a way for a member -- or for a member of

1 the public or anyone, for that matter, to send an e-mail
2 that goes to all the Council members at one time?

3 A. Yes. You can send it to Tampa City Council so
4 everybody gets the same copy.

5 Q. Okay. So, if the e-mail is sent to Tampa City
6 Council, everyone gets it?

7 A. Yeah. Please support this or please oppose this,
8 thank you. Signed, so and so.

9 Q. And those messages are logged by someone within
10 the City?

11 A. Yes.

12 Q. Do you know who maintains those logs?

13 A. The clerk's office. I don't know who
14 specifically there, but the clerk handles all the
15 communications.

16 Q. Do you receive copies of those logs or summaries,
17 you know, this many people said yes, this many people --

18 A. No --

19 Q. -- said no?

20 A. -- no, no.

21 Q. Could you obtain it if you wanted to?

22 A. You would do a public records request, and it
23 would be general. And then it would be up to you to
24 sort through them one by one.

25 Q. I understand. I mean, you, as a council member.

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1 Do you have the ability to phone someone and say, hey,
2 can you send me a report of all the messages that came
3 in about --

4 A. I don't know. I've never asked.

5 Q. Okay. So you don't recall any specific e-mails
6 about this ordinance that you yourself read; is that
7 correct?

8 A. I do not.

9 Q. And I take it you don't know what any other
10 individual council member read or didn't read in
11 connection with their individual consideration?

12 A. If they were sent directly to a council member,
13 no.

14 Q. Okay.

15 A. No, we don't have access to their personal
16 e-mails.

17 Q. And I take it you haven't discussed with other
18 council members what e-mails they read or don't read?

19 A. No, no. We are -- due to the Sunshine Laws, we
20 can't discuss anything privately. Everything has to be
21 at the public meeting or public forum at a council
22 meeting.

23 Q. And so that means you can't have a discussion
24 with a fellow council member about this ordinance unless
25 you give a public notice that there's going to be a

1 meeting and then have that meeting out in the public?

2 A. Yeah. And those were only held at the City
3 Council meetings in view of cameras and the public.
4 That's the only time we can discuss it legally.

5 Q. So there were no other -- no other, you know,
6 I'll call them Sunshine meetings outside of the --

7 A. No.

8 Q. -- normal City Council meetings --

9 A. Everything was held in City Hall, publicly
10 noticed, you know, regular City Council meetings.

11 Q. Now, as a council member, I take it you're free
12 to have private conversations with constituents or --

13 A. Yes.

14 Q. -- or advocates or anything like that, correct?

15 A. Yes.

16 Q. Did you have private conversations with
17 constituents regarding this ordinance?

18 A. No. I didn't take any meetings. I don't -- I
19 don't believe I had any requests for meetings.

20 Q. If you had had a meeting, would that be logged on
21 a document somewhere?

22 A. Yes.

23 Q. Where would that be logged?

24 A. Our calendars are public so you can see who met
25 with whom. But, on this issue, I didn't meet with

1 anybody.

2 Q. Okay. Did you have any telephone calls with
3 constituents --

4 A. No.

5 Q. -- regarding this ordinance?

6 Did you have any telephone calls with anyone at
7 all regarding this ordinance?

8 A. No. Everybody came publicly and spoke about it.
9 Once this article came out, you know, the public knew;
10 and that's when people started showing up, you know, for
11 and against.

12 Q. So you didn't take any meetings. You didn't have
13 any telephone conversations. Did you have any other
14 kinds of communications with constituents or anyone at
15 all, for that matter, about this ordinance during that
16 time from when you proposed it to its enactment?

17 A. No. Everybody came publicly before City Council.

18 Q. Would it be fair to say that, if it didn't happen
19 during one of those City Council meetings as part of the
20 official record, it wasn't something that you considered
21 in connection with this ordinance?

22 A. No. Everything was done out in the open. No
23 City Hall meetings, office meetings, phone calls,
24 nothing like that.

25 Q. Okay.

1 (Plaintiffs' Exhibit No. 7 marked for identification)

2 BY MR. GANNAM:

3 Q. I'm showing you a document that's been marked as
4 Plaintiffs' Exhibit 7. For the record, this was
5 produced by the City, Bates number COT PRODUCTION
6 005122.

7 A. Uh-huh. See how it's addressed to Tampa City
8 Council, so it's sent to everybody.

9 Q. So you've identified this as an e-mail that was
10 sent to the Tampa City Council?

11 A. Yes.

12 Q. And that's based on the "to" field reading Tampa
13 City Council, all one word?

14 A. Yes.

15 Q. That's how it would normally look if it was sent
16 to the whole council?

17 A. Yeah. You send this to all seven members.

18 Q. Do you know who the sender, Erica Dotson, is?

19 A. I do not.

20 Q. The date of this is February 20, 2017.

21 A. Uh-huh.

22 Q. That would have been during that period of time
23 that this ordinance was being considered by the council,
24 correct?

25 A. Yes.

1 Q. Now, since this says it was sent to the Tampa
2 City Council, upon seeing it, does it refresh your
3 recollection whether you've ever seen this before?

4 A. It does not.

5 Q. Would you have any reason to believe that you did
6 not receive this based on the fact that it was sent
7 to --

8 A. No. If it was sent to us --

9 (Interruption by the court reporter)

10 THE COURT REPORTER: Would you have any
11 reason to believe that you did not receive this based on
12 the fact that it was sent --

13 BY MR. GANNAM:

14 Q. -- to the Tampa City Council e-mail address?

15 A. No.

16 Q. And, now, would it be fair to say that you --
17 strike that.

18 If it was sent to the Tampa City Council e-mail
19 address and, therefore, you received it, do you believe
20 that you read this when you received it?

21 A. I may have.

22 Q. Okay. But you can't say for sure?

23 A. I don't remember this -- seeing this specific
24 e-mail.

25 Q. Okay. I'm going to draw your attention to the

1 opening sentences. Says, my name is Erica Dotson; and I
2 consider myself a part of the LGBT community. Although
3 I do not know anyone who has been through conversion
4 therapy, I believe that conversion therapy is something
5 that minors should not be forced to go through.

6 Let me stop there. Now, reading that out loud,
7 does it help you remember whether you saw this before?

8 A. It does not.

9 Q. Okay. So do you have any reason to believe that
10 you would have responded or followed up with Ms. Dotson
11 about what she sent to you here?

12 A. No. I don't respond to e-mails ninety-nine
13 percent of the time.

14 Q. Is that just a -- your common practice as a City
15 Council member?

16 A. Yeah. I mean, sometimes we get a thousand
17 e-mails on a rezoning case. And, I go, okay, I got it.
18 You know, people are mad. But I generally don't -- you
19 know, the most I respond is thank you for writing. I
20 appreciate your e-mail. You know, try to be polite.
21 But -- or we'll look into that if they have a
22 neighborhood issue. But I just don't respond. Just how
23 I am.

24 (Plaintiffs' Exhibit No. 8 marked for identification)

25 BY MR. GANNAM:

1 Q. I'm handing you a document that I'll mark as
2 Plaintiffs' Exhibit 8. For the record, this was
3 produced by the City as COT PRODUCTION 003883. This is
4 also an e-mail with the same recipient, Tampa City
5 Council, from it appears to be Leslie Reed --

6 A. Uh-huh.

7 Q. -- dated March 2, 2017.

8 Now, the date, March 2, 2017, is also within the
9 period of time that the ordinance was being considered,
10 correct?

11 A. Yes.

12 Q. And this e-mail, the -- again, just going to the
13 first couple of sentences. I am writing to urge the
14 council to strongly support the ban on conversion
15 therapy for minors. It is a barbaric and damaging
16 practice that often includes forced shock treatment.

17 Let me stop there. Do you recall having seen
18 this e-mail?

19 A. I may have seen it, but I don't remember
20 specifically.

21 Q. Okay. Do you recall whether you followed up or
22 responded to this e-mail?

23 A. No, I didn't respond.

24 Q. Let me just move to the next one.

25 (Plaintiffs' Exhibit No. 9 marked for identification)

1 BY MR. GANNAM:

2 Q. Handing you a document I'm marking as Plaintiffs'
3 Exhibit 9.

4 A. Thank you.

5 Q. This is a document produced with the Bates number
6 COT PRODUCTION 003881. It is also an e-mail to Tampa
7 City Council. It is from Tea or Tea Sefer. And it
8 appears to be on behalf of GLSEN, G-L-S-E-N, Tampa Bay.
9 It's dated March 2, 2017. First, is that date also
10 within the time period that the ordinance was being
11 discussed?

12 A. Yes.

13 Q. And have you ever seen this communication before?

14 A. I don't remember specifically, no.

15 Q. Are you familiar with the organization GLSEN?

16 A. I'm not.

17 Q. Prior to today, had you ever heard of GLSEN
18 before?

19 A. No.

20 Q. I want to look at the third paragraph. It reads,
21 conversion therapy, also known as reparative therapy, is
22 a set of discredited practices that use rejection, shame
23 and psychological abuse aimed at changing one's sexual
24 orientation or gender identity slash expression.

25 Now, having read that, does it refresh your

1 recollection whether you saw this in connection with the
2 ordinance?

3 A. I don't remember.

4 Q. Do you have any reason to believe that you
5 responded or followed up to GLSEN in any way --

6 A. No.

7 Q. -- as a result of this?

8 A. No, no.

9 Q. So we've now just gone through several e-mails.
10 I don't represent that these are all the ones sent to
11 the Tampa City Council, but they are just examples.
12 Having seen those, do you remember at all receiving any
13 e-mails as a City Council member in connection with the
14 ordinance, either for or against it?

15 A. I don't remember, but I'm sure I did.

16 Q. And, just so I'm clear, it's addressed to Tampa
17 City Council, as all of these examples were. Those
18 would have been e-mails that were at least sent to all
19 of the Council members?

20 A. Yes.

21 Q. Whether or not any of them actually read them, we
22 don't know?

23 A. I don't know. I mean, I get so many e-mails. I
24 just -- you know, it's been already almost two years. I
25 don't -- you know, I don't specifically remember.

1 Q. And would there be any way to know whether any
2 individual council member read an e-mail like this
3 without asking the individual council member?

4 A. No. No, it's not -- you don't see, like, you
5 know, e-mail read at that time or opened or -- it
6 doesn't -- it doesn't do that.

7 MR. GANNAM: Okay. We've been going about
8 an hour. Can we just take a break for five minutes.

9 (Recess)

10 BY MR. GANNAM:

11 Q. All right. Mr. Maniscalco, I'm going to move on
12 to some other exhibits here. I'll mark this next one as
13 Exhibit 10.

14 (Plaintiffs' Exhibit No. 10 marked for identification)

15 BY MR. GANNAM:

16 Q. All right. This is an e-mail produced by the
17 City at COT PRODUCTION 004037. The date is February 16,
18 2017. It's from Carrie Henriquez with an e-mail address
19 @tampagov.net. And it's to Nadine@eqfl.org; subject,
20 conversion therapy for minors ban, Tampa City Council.

21 A. Uh-huh.

22 Q. First of all, who is Carrie Henriquez?

23 A. She is my legislative aide.

24 Q. And what does that position entail?

25 A. I don't want to say like a secretary. But she'll

1 set up meetings, you know, handles my calendar. I mean,
2 that's really it. I don't ask her to make coffee or
3 anything like that.

4 Q. Is she an employee of the City of Tampa?

5 A. Yes.

6 Q. And does she act as a legislative aide to any
7 other council member?

8 A. No, just myself.

9 Q. And have you seen this particular communication
10 before?

11 A. I have not.

12 Q. Do you know who Nadine@eqfl.org is?

13 A. Nadine I assume is Nadine Smith at
14 @eqflflorida (sic) is Equality Florida. She's I think
15 the statewide director or -- you know, she handles a big
16 area.

17 Q. Did you have any communications yourself with
18 Equality Florida in connection with the ordinance?

19 A. No.

20 Q. Do you know what -- are you familiar with what
21 Carrie was seeking from Equality Florida with this
22 e-mail?

23 A. I mean, reading this, I have not seen this e-mail
24 before. To get people to the meeting, I guess, or put
25 the word out there. But, at this point, it was -- it

1 was already in the -- in the newspaper.

2 Q. The third paragraph begins, we really need
3 Equality Florida's support in passing this ban. Did I
4 read that correctly?

5 A. Yes.

6 Q. Did you direct Ms. Henriquez to get in touch with
7 Equality Florida to solicit their support?

8 A. I did not.

9 Q. Is it part of her job responsibilities to solicit
10 support for legislation that you propose?

11 A. No. This is, I think, the -- the one piece of
12 legislation that I -- that I have -- I think it's the
13 only thing that I've proposed thus far being elected.

14 Q. Did you know Ms. Henriquez was reaching out to
15 Equality Florida?

16 A. I did not.

17 Q. Did she ever -- before you read this e-mail, did
18 you know that she had ever done that?

19 A. No, I did not.

20 Q. Did you and Ms. Henriquez ever discuss Equality
21 Florida in connection with this ordinance?

22 A. I don't remember --

23 MR. WILLIAMS: You mean, at the time it was
24 being enacted? That period of time?

25 BY MR. GANNAM:

1 Q. Well, I'm asking have you ever discussed it with
2 Ms. Henriquez?

3 MR. WILLIAMS: Well, let's make it clear. I
4 think the Court's order is very clear that we're talking
5 October 1, '16, through December 15, 2017. I will
6 advise you that that's the timeframe that the Court has
7 ascribed to this deposition.

8 BY MR. GANNAM:

9 Q. If you can -- if you can sort of separate your
10 memories on one side of December 17, 2017, and
11 everything before that and everything after that. Did
12 you have any conversations with Ms. Henriquez about
13 Equality Florida prior to mid December 2017?

14 A. Not that I recall, no.

15 Q. Seeing this e-mail, do you approve of
16 Ms. Henriquez reaching out to an organization like
17 Equality Florida to solicit support for your ordinance
18 that you proposed?

19 A. I don't see it out of the ordinary. You know,
20 kind of like -- you know, not rally the troops but, you
21 know, to put the word out there that this is happening.
22 I mean, Equality Florida, with my -- with what I'm
23 familiar with, this is -- this is something that they
24 champion. I mean, it would be any LGBT issues, which
25 this would fall under their purview. So I think it's

1 just, you know, putting the word out there. And, at
2 this point, the newspaper article has already come out.
3 You know? But this -- this is the first time that I'm
4 seeing this e-mail.

5 Q. What other -- besides this e-mail, what other
6 communications did the City of Tampa have with Equality
7 Florida in connection with the passage of this
8 ordinance?

9 A. I think this is it. I don't know of anything
10 else.

11 Q. What about the City and the Southern Poverty Law
12 Center?

13 A. That, I don't know. I've never communicated with
14 them.

15 Q. And do you know whether anyone on behalf of the
16 City has communicated with SPLC?

17 A. No. That name never -- that group's name never
18 comes up.

19 Q. What communications did the City of Tampa have
20 with the NCLR, National Center for Lesbian Rights, in
21 connection with this ordinance?

22 A. Nothing that I'm aware of. I never have.

23 Q. And, as the City's designee to testify regarding
24 item 7 in the deposition notice, which is all
25 communications and coordination between Defendant and

1 Equality Florida and, as modified by the Court order,
2 also SPLC and NCLR regarding the ordinance, is it your
3 testimony that you're not aware of any other
4 communication between the City and any of those
5 organizations in connection with the ordinance?

6 A. That is correct. The only thing is this e-mail
7 here.

8 Q. Are you aware of any communications between the
9 City and a man named Rand Hoch in Palm Beach County
10 regarding this ordinance?

11 A. No, I'm not.

12 Q. Have you personally ever had any conversations
13 with Mr. Hoch about the ordinance?

14 A. No. I don't even know who he is.

15 Q. Okay. So, when you look at this e-mail from
16 Ms. Henriquez with -- you're writing to Equality
17 Florida. She signs it with her Tampa City Council
18 Legislative Aide to Councilman Guido Maniscalco,
19 District 6. Do you consider this to be a communication
20 between the City and Equality Florida?

21 A. It's coming from a legislative aide, you know,
22 somebody that works as an assistant at my office. It
23 wasn't from my direction or the direction of the City.
24 I think this was -- I don't know. I mean, I don't -- I
25 don't see it out of the ordinary. Just we need your

1 support is, you know, pass-the-word kind of thing.

2 Q. Now, Ms. Henriquez, does she have any authority
3 to act beyond whatever duties she has to serve you as
4 your legislative aide?

5 A. I mean, she has freewill to write an e-mail like
6 this. I mean, I just -- it's her trying to be helpful.
7 You know? But that's -- that's really it.

8 Q. Would you agree with me that this is an e-mail
9 that she has written to aid your legislation, your
10 ordinance?

11 A. Since I'm the one that proposed it, yes.

12 Q. Do you know whether Nadine Smith or the Nadine
13 addressed here responded to Ms. Henriquez?

14 A. I don't know.

15 (Plaintiffs' Exhibit No. 11 marked for identification)

16 BY MR. GANNAM:

17 Q. All right. I'm marking a document as Plaintiffs'
18 11. This is an e-mail dated February 10, 2017.

19 A. Uh-huh.

20 Q. It shows from
21 annie.greenspan@thetrevorproject.org to Carrie Henriquez
22 regarding conversion therapy ordinance. Do you
23 recognize this e-mail?

24 A. I do not.

25 Q. Do you know who The Trevor Project is?

1 A. I do not.

2 Q. So, prior to this moment, have you ever seen this
3 e-mail before?

4 A. No, because it's addressed to her; and I don't
5 have access to her e-mail.

6 Q. But this is Carrie's --

7 A. That is her --

8 Q. -- work e-mail, correct?

9 A. Yes, it is.

10 Q. Do you have a policy regarding use of the
11 Tampgov.net e-mail account for personal use?

12 A. No. Everything is -- all work-related stuff goes
13 to -- anything that's with the City goes to the tampgov
14 e-mails.

15 Q. I guess my question is: Does the City of Tampa
16 have a policy or do you have a policy with respect to
17 Ms. Henriquez prohibiting her from using her
18 tampgov.net e-mail account for personal use?

19 A. No, I don't.

20 Q. You don't have a policy?

21 A. No. I mean, we just assume everything
22 work-related goes through there; and that's it. No need
23 to have, you know, other ones.

24 Q. And so am I correct then that -- or strike that.

25 Did Ms. Henriquez have your authority or approval

1 to -- to communicate with The Trevor Project about this
2 ordinance?

3 A. I never told her to go ahead and -- I don't
4 know -- since, you know, before this e-mail, I've never
5 heard of The Trevor Project. But this is an e-mail to
6 her. Okay, we spoke a few weeks ago. I don't know if
7 she had called the office by telephone. I don't know.

8 Q. Would it be fair to say that, again with this
9 e-mail, that Ms. Henriquez was communicating with The
10 Trevor Project on your behalf?

11 A. As representing my office and me being the one
12 that proposed this, you know, I would say yes.

13 (Plaintiffs' Exhibit No. 12 marked for identification)

14 BY MR. GANNAM:

15 Q. All right. I'm showing you Plaintiffs' Exhibit
16 12. This is a string of e-mails produced in this case
17 at COT PRODUCTION 005221.

18 A. Uh-huh.

19 Q. Going to the earliest e-mail which starts about
20 halfway down the page.

21 A. Uh-huh.

22 Q. I think you'll see it's the same e-mail --

23 A. Yes.

24 Q. -- involved in Plaintiffs' Exhibit 10; is that
25 correct?

1 A. Yes, it is.

2 Q. And so appearing directly above that, looks like
3 it is a response from Nadine Smith to Carrie Henriquez
4 and Dan Benoit dated February 16, 2017. Do you see
5 that?

6 A. I see it, yes.

7 Q. And it reads, Hi Carrie. Thanks for reaching
8 out. I've cc'd Dan Benoit to help set up a time to
9 talk, best, Nadine. Did I read that correctly?

10 A. Yes, you did.

11 Q. Does this confirm that it is, in fact,
12 Nadine Smith of Equality Florida whom Carrie was
13 communicating with?

14 A. Yes. That's who signed the e-mail.

15 Q. And do you know who Dan Benoit is?

16 A. I do not.

17 Q. And, when Nadine writes, I've cc'd Dan Benoit to
18 help set up a time to talk, do you know whom she's
19 intending to talk to?

20 A. May have been Carrie. I mean, Carrie wrote the
21 e-mail, and she put her office number and -- well, the
22 office number and her personal cell. So it would be --
23 I would assume it would be with them.

24 Q. And, having read this, does this refresh your
25 recollection as to whether you ever arranged or attended

1 any kind of meeting --

2 A. No.

3 Q. -- with Nadine Smith?

4 A. No, I never did. I never met with Nadine or Dan.

5 Q. Did you ever talk with them on the phone --

6 A. I don't --

7 Q. -- in connection with the ordinance?

8 A. No, no.

9 Q. And do you know what happened after this e-mail
10 as far as whether any kind of meeting occurred without
11 you in connection with the ordinance?

12 A. No. My aide doesn't meet with people like that
13 on my behalf. So they would have never walked into City
14 Hall or met for coffee or anything.

15 Q. She could have talked with them on the phone,
16 right?

17 A. That is possible, but I don't remember of any
18 phone conversation.

19 Q. Now, Ms. Henriquez doesn't keep a log of all of
20 her phone conversations, does she?

21 A. No. Nobody does.

22 Q. And, if she had a conversation with someone from
23 Equality Florida and you weren't in the room with her,
24 would you have any reason to know whether she spoke to
25 them or not?

1 A. No, unless I was witness, which I was not. So,
2 as far as I know, no.

3 (Plaintiffs' Exhibit No. 13 marked for identification)

4 BY MR. GANNAM:

5 Q. Showing you Plaintiffs' Exhibit 13. It's another
6 e-mail string produced by the City at COT PRODUCTION
7 005224. The earliest e-mail in this string begins
8 halfway down the second page. I think you'll see it's
9 the same e-mail that we discussed in Plaintiffs' Exhibit
10 10.

11 A. Yes.

12 Q. And then directly above that is the response from
13 Nadine Smith that we just discussed in Plaintiffs'
14 Exhibit 12.

15 A. Yes.

16 Q. And then we see an additional message in the
17 string, actually starts at the bottom of the first page,
18 from Stratton Pollitzer to Nadine Smith,
19 hannah@eqfl.org, cc to Carrie Henriquez and Dan Benoit.

20 A. Wait, wait. Where do you -- oh, Hanna up top.
21 Okay.

22 Q. I'm sorry. Looking at the very bottom of the
23 first page --

24 A. Okay.

25 Q. -- it's the next message in the string, you know,

1 because these go from back to front in time.

2 A. Okay.

3 Q. It's from Stratton Pollitzer, February 16, 2017,
4 to Nadine Smith, Hannah and cc to Carrie Henriquez and
5 Dan Benoit. Do you see that?

6 A. The only time I see -- oh, I see Hannah. Okay.
7 I'm sorry. I do see it at the bottom of the page.

8 Q. Do you know who Stratton Pollitzer is?

9 A. I do not.

10 Q. And then, in the first sentence of the body of
11 the e-mail, it says, I'm also looping in Hannah Willard,
12 our public policy director. Do you know who that is?

13 A. I do not.

14 Q. Okay. The next message in the string appearing
15 above this one on the first page about two-thirds of the
16 way down, says, please send the cavalry, from
17 Carrie Henriquez. Do you see that?

18 A. I do.

19 Q. Do you know what Ms. Henriquez is talking about?

20 A. When one says send in the cavalry --

21 MR. WILLIAMS: Don't speculate. He asked
22 you if you know.

23 THE WITNESS: You know, I don't...

24 BY MR. GANNAM:

25 Q. What do you understand that to mean as you read

1 it?

2 A. Send people, I would assume.

3 Q. The timing of this e-mail is February 16, 2017.

4 Did you have any -- had you given any particular
5 directive or instructions to Ms. Henriquez to drum up
6 support for the ordinance?

7 A. No.

8 Q. Did you have any notion at that time whether
9 support was needed to get the ordinance passed?

10 A. I think, once the newspaper article came out --
11 because that's how the -- the opposition, people
12 opposing this, got wind of all this. So, you know,
13 through the media, people found out. Then social media.
14 And you know how news travels.

15 Q. So, prior to today, had you ever seen these
16 communications before?

17 A. No.

18 (Plaintiffs' Exhibit No. 14 marked for identification)

19 BY MR. GANNAM:

20 Q. This is Plaintiffs' 14 I just showed you.
21 Produced at COT PRODUCTION 003943. This is another
22 e-mail string.

23 A. Uh-huh. Where do we start?

24 Q. That's a good question. Let me see. It's four
25 pages. I just want to start with the message -- let's

1 just start with the top message, which would be the
2 latest one in the string on the first page, from
3 Carrie Henriquez to Hannah Willard, Kaitlin Connolly,
4 March 2, 2017. Also copied on the e-mail,
5 Mark Puskarich --

6 A. Uh-huh.

7 Q. -- Amber Paoloemilio --

8 A. Uh-huh.

9 Q. -- Brittany Link.

10 First of all, do you recognize who any of those
11 people are?

12 A. Mark Puskarich I have met in the past.

13 Q. You ever speak to him in connection with this
14 ordinance?

15 A. No, not until after the fact. I met him after
16 all this.

17 Q. After the ordinance was passed?

18 A. Yes.

19 Q. And did you -- was the purpose of your meeting or
20 the occasion for the meeting the ordinance?

21 A. Oh, no. It was at a social event.

22 Q. Did you discuss the ordinance at that time?

23 A. No.

24 Q. So the body of this latest e-mail in the string
25 on the first page, it begins, update, the draft

1 ordinance motion passed unanimously a few minutes ago.

2 Moves to first reading two weeks from today.

3 So, just so I'm clear in the process, there was a
4 vote to move the ordinance to the first reading --

5 A. Yes.

6 Q. -- and that passed unanimously, correct?

7 A. Yes.

8 In this e-mail at this point, it's the draft.
9 City Council agreed on the language; and we voted to
10 move it to first reading, which shows there March 16th.

11 Q. Now, the last sentence of that first paragraph
12 reads, if all goes smoothly and we don't lose majority
13 support, this baby passes on the 6th of April,
14 exclamation point.

15 First, have you ever seen this communication
16 before?

17 A. No.

18 Q. Do you know who Ms. Henriquez is referring to
19 when she says, "we," in that phrase we don't lose
20 majority support?

21 A. The City Council, the people that are voting on
22 this.

23 Q. At that point in time, did you have reason to
24 believe that there was majority support on the City
25 Council for final passage of the ordinance?

1 A. Oh, well, when we voted to move forward with the
2 draft ordinance to first reading, it was a unanimous yes
3 vote.

4 Q. The second paragraph says, so now we need even
5 more hands on deck. Would it be possible to pow wow
6 sometime next week in preparation of the March 16th
7 meeting?

8 Did I read that correctly?

9 A. You read that correctly, yes.

10 Q. Do you know what pow wow Ms. Henriquez was
11 referring to?

12 A. I don't know. I didn't attend any pow wow.

13 Q. Do you understand that to mean some kind of
14 meeting?

15 A. Or gathering.

16 Q. Do you know whether Ms. Henriquez did, in fact,
17 meet or pow wow with these folks in this communication?

18 A. No. She didn't tell me anything.

19 Q. But did you tell me that she does not meet with
20 people?

21 A. Yeah. If -- if she's in a meeting -- if I'm in
22 the meeting, if she's -- you know, she shows up to take
23 notes and whatnot. But not, you know, her going solo on
24 her own, no.

25 Q. And so did you have any kind of meeting with the

1 people involved in this communication?

2 A. No, because I've never met Hannah, Amber,
3 Brittany, any of these.

4 Q. Go down to the immediately preceding message in
5 the string, and it starts at the bottom of page one --

6 A. Uh-huh.

7 Q. -- from Hannah Willard to Kaitlin Connolly,
8 copies to Carrie, Mark, Amber and Brittany. Do you see
9 that?

10 A. Yes, I do.

11 Q. And it reads, more resources from SPLC are
12 attached. Then it says, as for survivors slash
13 providers, we are checking and will let you know ASAP if
14 anyone is available to attend the hearing.

15 Do you know what that's referring to?

16 A. Well, SPLC is, what, Southern Poverty Law Center?

17 Q. Okay.

18 A. I've never communicated with them.

19 Q. Do you know what resources from SPLC are referred
20 to in the e-mail?

21 A. I do not.

22 Q. Did you ever review materials provided by SPLC or
23 that were created by SPLC in connection with this
24 ordinance?

25 A. No, only what I specifically asked from the City

1 in the original staff report. When I made the original
2 motion, I stuck with whatever they provided.

3 Q. What about this statement in the second sentence,
4 as for survivors slash providers, we are checking and
5 will let you know ASAP if anyone is available to attend
6 the hearing, do you know what that's referring to?

7 A. I would think it's people to come and speak in
8 their support or share their stories.

9 Q. And still, at this point on March 2nd, did you
10 have any knowledge that Ms. Henriquez was communicating
11 with Equality Florida, looking at materials from SPLC,
12 being involved in organizing people to attend hearings?
13 Did you have any knowledge of any of this?

14 A. No, because it was all through her e-mail and I'm
15 not cc'd; and I don't have access to it, no.

16 Q. And did she ever tell you about it?

17 A. No.

18 Q. Okay. In connection with the passage of the
19 ordinance?

20 A. No, other than the days of the hearings, you
21 know, there's a lot of people here. You know? We look
22 at the crowd size before we start meetings. Yeah. So
23 you see how long public comment is going to go for.

24 MR. WILLIAMS: "We," being the City Council?

25 THE WITNESS: Yeah, City Council members.

1 (Plaintiffs' Exhibit No. 15 marked for identification)

2 BY MR. GANNAM:

3 Q. Handing you what I've marked as Exhibit 15. This
4 is produced at COT PRODUCTION 003941. It's another
5 e-mail string.

6 A. Where do we start?

7 Q. Let's look at the way this message at the top of
8 the page.

9 A. Uh-huh.

10 Q. It's from Hannah Willard to Carrie Henriquez. It
11 reads, hey Carrie, congratulations on an amazing victory
12 yesterday.

13 Let me stop there. The date is April 7, 2017.
14 Do you know what amazing victory is being referred to
15 here?

16 A. That would be -- City Council meetings are always
17 held on Thursdays. So Thursday, April 6th, is the day
18 before this e-mail. And that was when it moved to -- it
19 was approved unanimously in the second vote and goes to
20 the mayor for his signature, to sign the ordinance.

21 Q. So this was the final act of the City Council
22 that passed the ordinance --

23 A. Yes.

24 Q. -- that had just occurred the day before?

25 A. Yes.

1 Q. The next sentence says, a unanimous vote, wow.
2 Your leadership on this has been just incredible, and
3 I'm so grateful we got to be a part of it.

4 Do you know what leadership of Carrie Henriquez
5 is being referred to by Ms. Willard?

6 A. I mean, the leadership is on my part because I
7 proposed it. I think the credit should go to me for
8 bringing it up. I think it was just a compliment.

9 Q. Did you have any knowledge of this communication
10 before today?

11 A. No. I don't have access to her e-mails, and I
12 can't -- I can't see these.

13 Q. So do you believe that Ms. Willard is -- when she
14 said, "your leadership," is referring generally to your
15 office?

16 A. Yeah, I think so, as a generalization.

17 Q. Where she says, I'm so grateful we got to be a
18 part of it, what is the City's position on what part
19 Equality Florida played in the passage of the ordinance?

20 A. I think it was for people coming out to speak
21 during public comment.

22 Q. Anything else?

23 A. No, that's really it. It was just those public
24 meetings and unanimous approval all the way through. I
25 think the vote always stayed the same.

1 Q. Did anyone from Equality Florida ever lobby you
2 directly to take any particular action in connection
3 with this ordinance?

4 A. No. They spoke with me at the public hearing
5 during public comment, meaning, they spoke to us as a
6 City Council body.

7 Q. And do you know whether anyone on behalf of
8 Equality Florida directly communicated with any other
9 council member outside of a public meeting in connection
10 with the ordinance?

11 A. I do not believe so. I think they all showed up
12 publicly to speak during the public meetings.

13 Q. And so, when Ms. Willard says, I'm so grateful we
14 got to be a part of it, is there any other activities by
15 Equality Florida that were part of getting the ordinance
16 passed besides speaking at the public meetings and
17 whatever e-mail communications they had with
18 Ms. Henriquez that we've been looking at?

19 A. No, this would be it. It would be like
20 organizing a protest in a park. That would be the --
21 you know, we being a part of it. You know, people
22 coming together.

23 (Plaintiffs' Exhibit No. 16 marked for identification)

24 BY MR. GANNAM:

25 Q. I'm handing you Exhibit 16. This is an e-mail --

1 MR. WILLIAMS: 16, Roger?

2 MR. GANNAM: Yeah, 16.

3 BY MR. GANNAM:

4 Q. An e-mail produced at COT PRODUCTION 007528.

5 It's a string of e-mails.

6 A. Uh-huh.

7 Q. The last page is a picture of you.

8 A. That's me.

9 Q. The -- the earliest written portion of this is
10 actually on the second page --

11 A. Okay.

12 Q. -- at the bottom about a little more --
13 three-quarters of the way down where it reads, on
14 Thursday, December 7, 2017, at eleven-thirty-two a.m.
15 Do you see that?

16 A. Yes, I do.

17 Q. It says Mark Puskarich -- am I saying that
18 correctly?

19 A. Yes, Puskarich.

20 Q. Mark Puskarich wrote, Hi Carrie, I hope you're
21 doing well. I have some great news. Equality Florida
22 would like to recognize Guido with our Voice for
23 Equality Award at our Tampa Gala on February 24th at
24 Tpepin's Hospitality Centre.

25 Did I read that correctly?

1 A. Yes, you did.

2 Q. What is this referring to?

3 A. Equality Florida has an annual gala. And they --
4 they recognize certain individuals, not always
5 political, just members of the community in general that
6 have been advocates for pro LGBTQ policies or supportive
7 in the community and whatnot.

8 Q. Now, the next -- third sentence in that paragraph
9 says, because of Guido's work in helping to pass the ban
10 on conversion therapy on minors in Tampa this year,
11 which was just incredible, and his support of Equality
12 Florida, we find him most deserving of this recognition.

13 Do you know what "his support of Equality
14 Florida" is in view by Mr. Puskarich here?

15 A. When he says, "his support of Equality Florida,"
16 he's referring to me; and, "me," being the individual
17 that originally proposed this. So they're giving, you
18 know, me credit for it and, of course, the award.

19 Q. At this point in time, had you ever given any
20 kind of financial contribution to Equality Florida?

21 A. No.

22 Q. Had you ever done any other work or advocacy on
23 their behalf?

24 A. No.

25 Q. The next -- or the following communication

1 directly above that one, it says, from Mark Puskarich,
2 Friday, December 8, 2017, to Carrie Henriquez, says, Hi
3 Carrie, just an update on this. The title of the award
4 is Ally for Equality Award, and it recognizes a
5 non-LGBTQ person that moves us closer to full equality.
6 Sorry about that.

7 Did I read that correctly?

8 A. Yes.

9 Q. Now, between this first e-mail on December 7th
10 and the follow-up on December 8th, had Carrie told you
11 about what Equality Florida wanted to do as far as
12 recognizing you?

13 A. After the original December 7th e-mail, yes. And
14 I didn't know what the award was, so I googled Voice for
15 Equality Award. And I think it's a different award
16 because it's, like, mayors and bigger-named people get
17 it. So, at first, I thought, wow, this is -- that's
18 exciting. And then he -- where it says Mark above, he
19 clarified that it's the Ally for Equality Award.

20 Q. Okay. So, based on this correction, did you
21 believe that they had picked the more appropriate award
22 for you?

23 A. Yeah, because I'm not a -- I'm not gay; and I
24 think they go with, you know, an ally like the -- the
25 mayor of St. Petersburg I think got one of these. And

1 he's considered an ally. So, when you say, LGBTQA, A is
2 the ally.

3 Q. All right. And moving up to the next
4 communication above this one, it says, on Friday,
5 December 8, 2017, at nine-fifty-seven a.m.,
6 Carrie Henriquez wrote. Do you see that?

7 A. Yes, where she says, thanks so much?

8 Q. Right.

9 A. Okay.

10 Q. Thank you so much. Councilman Maniscalco is
11 absolutely thrilled at this prestigious honor.

12 Was that an accurate statement?

13 A. Yes, I was thrilled.

14 Q. Okay. So, at this point, you knew about the
15 award; and you had agreed to accept it?

16 A. Yes.

17 Q. Did you ultimately receive this award as they --

18 A. Yes, I did at their gala. I don't remember the
19 date. May have been February of this year. It was
20 early this year. I don't remember the exact date.

21 Q. Was that the social event or social occasion
22 where you spoke to Mr. Puskarich?

23 A. Yes. It was that -- it was their gala where he
24 congratulated me and said thank you. I mean, there was
25 a lot of people there. But that's where I saw him.

1 Q. Now, when you -- at any point in time from your
2 proposal -- strike that.

3 Prior to your proposal of the ordinance, had you
4 had any discussions with Equality Florida about, you
5 know, helping them to either achieve the ordinance or
6 had they --

7 A. No.

8 Q. -- indicated to you any offer or promise of an
9 award --

10 A. No --

11 Q. -- if you got the ordinance passed?

12 A. -- I never had communication like that, no.

13 Q. So this was completely unexpected?

14 A. That is correct.

15 MR. WILLIAMS: "This," being the award?

16 MR. GANNAM: The award.

17 BY MR. GANNAM:

18 Q. Now, based on our review of those communications
19 with your legislative aide, Ms. Henriquez, and your
20 testimony that you had no knowledge of these
21 communications as they were happening, would it be fair
22 to say that -- that Equality Florida did not have any --
23 any formal or official input into the passage of this
24 ordinance?

25 A. Other than organizing people to come and speak --

1 mind you, the newspaper article had come out; and I know
2 it was shared on social media. I mean, that's as far as
3 they went is, you know, getting people to come and share
4 their stories during the public hearing.

5 Q. Would it be also fair to say that the City of
6 Tampa had no formal agreement or arrangement with
7 Equality Florida for Equality Florida to provide support
8 for the ordinance?

9 A. No. I mean, it's on a volunteer basis. People
10 take time out of their day from work and come and speak
11 for their three minutes, and that was it.

12 Q. Just to clarify it. The way I asked the question
13 probably wasn't the best. Am I correct that the City of
14 Tampa and Equality Florida had no agreement to -- for
15 Equality Florida to provide support or help to get this
16 ordinance passed?

17 A. That is correct.

18 Q. And is it also correct that the City of Tampa and
19 Equality Florida have no agreement between them
20 regarding a -- let me strike that.

21 I think I'm satisfied with my last question.

22 I want to go back to --

23 MR. WILLIAMS: Roger, before you go any
24 further, are you guys planning on breaking for lunch
25 or --

1 MR. MIHET: Yes.

2 MR. GANNAM: Yeah, we'll take lunch.

3 (Off-the-record discussion)

4 BY MR. GANNAM:

5 Q. I just wanted to finish this train of thought.

6 Will you look back at Exhibit 10.

7 A. There we go.

8 Q. This is the e-mail COT PRODUCTION 004037. We
9 talked about this e-mail. It appears to be the first
10 communication from Ms. Henriquez to Equality Florida.
11 Do you recall talking about it?

12 A. We discussed it a little bit ago today, yes.

13 Q. Now, the second paragraph, last sentence, says,
14 two of the men who spoke claim that conversation therapy
15 helped them transition from gay to straight. Did I read
16 that correctly?

17 A. Yes, you did.

18 Q. Do you know what -- when or what event those two
19 men spoke at?

20 A. This was at a public hearing. I remember one
21 gentleman -- I don't remember his name. But he said
22 that he was, you know, gay for so many years; and now
23 he's happily married.

24 Q. To a woman?

25 A. To a woman, yes.

1 Q. So is it an accurate statement that there were at
2 least two men who claimed that conversion therapy helped
3 them during the public comment portion of the
4 consideration of the ordinance?

5 A. I remember one. There may have been two. But I
6 specifically remember what that gentleman said, what I
7 had just said prior.

8 Q. So you don't know -- you remember one. But you
9 don't disagree with Carrie that there could have been
10 two?

11 A. I wouldn't disagree with the statement, no. And
12 it's -- the meetings were all public record, and you can
13 pull up the transcript to see.

14 Q. Sure. Okay.

15 So would it be fair to say that, among the
16 evidence or facts considered by the City Council in
17 connection with the passage of this ordinance, it would
18 include at least the man you remember speaking favorably
19 of conversion therapy and stating that it helped him?
20 Would that be a fair statement?

21 A. Yes, sir.

22 Q. And if, in fact, there were others who said
23 something similar, that would be on the public record?

24 A. Yes. Yes.

25 Q. All right. Let's take a break now.

1 (Recess)

2 BY MR. GANNAM:

3 Q. All right. I'm handing you what's marked as
4 Plaintiffs' Exhibit 4. Here's a clean copy. Do you
5 recognize this as the ordinance --

6 A. Yes.

7 Q. -- at issue? This is the copy filed by the City
8 and a request for the Court to take judicial notice at
9 document 24-1. And also, for the record, this is just
10 pages one through eight of that filing consisting of the
11 ordinance itself and the clerk's certificate on the
12 front certifying that it is, in fact, the ordinance.

13 Do you recognize the ordinance?

14 A. Yes, I do.

15 Q. I want to ask you a couple of questions about it.
16 Let's start on page four of the ordinance --

17 A. Okay.

18 Q. -- using the page numbers at the bottom.

19 A. Uh-huh.

20 Q. And somewhere around line -- let's see -- around
21 line thirty-six.

22 A. Okay.

23 Q. Actually, let me -- yeah, line thirty-six.

24 It's a whereas clause or the recital I'll call
25 it. And, it says, whereas, the City Council hereby

1 finds the overwhelming research. Do you see that?

2 A. Yes.

3 Q. Okay. I'll read the whole thing.

4 "Whereas, the City Council hereby finds the
5 overwhelming research demonstrating that sexual
6 orientation and gender identity change efforts can pose
7 critical health risks to lesbian, gay, bisexual,
8 transgender or questioning persons, and that being
9 lesbian, gay, bisexual, transgender or questioning is
10 not a mental disease, mental disorder, mental illness,
11 deficiency, or shortcoming."

12 Did I read that correctly?

13 A. Yes, you did.

14 Q. The -- the overwhelming research identified in
15 this recital, what does that refer to?

16 A. If you look through the ordinance and the other
17 paragraphs, you'll see quite a few references in
18 specific areas, you know, following a report or a
19 statement or by different -- I mean, there's -- there's
20 several pages of -- that are referenced here from the
21 beginning.

22 Q. So, in the whereas or recital -- whereas clauses
23 or recitals that precede that particular recital are
24 listed several studies, papers, et cetera?

25 A. Yes.

1 Q. And that's what is identified -- or is meant by
2 overwhelming research?

3 A. Yes, sir.

4 Q. Now, is it correct that the -- it's the City's
5 position that it considered all of that research in
6 connection with enacting this ordinance?

7 A. Yes, it did.

8 Q. Did you personally receive copies of all of the
9 various studies and papers that are referenced in the
10 ordinance?

11 A. When we receive the -- the initial information
12 when we first made -- when I first made the motion for
13 it, we had discussion there. And then the ordinance
14 itself, once it was -- once we moved forward with this
15 draft ordinance, it had all this. And, I mean, I can't
16 speak for the other council members. But, you know, we
17 tried to go into each one and, you know, come to our own
18 conclusions.

19 Q. And, when you say, "each one," you're referring
20 to each study --

21 A. Each whereas clause here, yeah, that is
22 referenced.

23 Q. And did each member of the council receive all of
24 the -- or copies of all of the various studies and
25 papers that are referenced here?

1 A. We all receive the same equal material. And you
2 can see, on the bottom of each page, you have web
3 addresses; so you can actually go into further detail
4 and read each one. I don't know if the other council
5 members read all of them. I did my research going one
6 by one in understanding the ordinance.

7 Q. And so you, personally, did you get into each of
8 the studies and papers and actually read them?

9 A. I don't know if I did all of them. I don't
10 remember specifically. I did go through, I know,
11 several -- several of them.

12 Q. Maybe I'll just -- or let me just ask you. Is it
13 correct that, as an official matter, each member of the
14 City Council received or had access to each of the
15 studies and papers that are identified in this
16 ordinance?

17 A. Yes. We all received the same information as
18 seen here in the ordinance, specifically with the web
19 addresses so we can continue to do our own homework.
20 And we all get the same stuff.

21 Q. And do you know whether any of the other council
22 members read one or more or all of the --

23 A. No.

24 Q. -- various papers?

25 A. No. You would have to ask them personally. But,

1 no, I don't know.

2 Q. And there's no -- there wouldn't be a log or a
3 record of which thing each person read?

4 A. No.

5 Q. Okay. So you personally -- let me just go to
6 page one of the ordinance.

7 A. Okay.

8 Q. The first actual paper or study referenced is in
9 the second recital. It begins, whereas, the American
10 Academy of Pediatrics in 1993. Is that correct?

11 A. Yes, sir.

12 Q. And then, going forward to page four, the top of
13 page four, the recital at the beginning of that page
14 reads, The Agency for Healthcare Research and Quality
15 issued a clinician's guideline for practitioners. Do
16 you see that?

17 A. Yes, I do.

18 Q. Now, is that the end of the range of recitals
19 mentioning studies and papers that were relied on for
20 the ordinance?

21 A. That's the -- yeah, at the bottom of this page is
22 where you see the final web address.

23 Q. At footnote fourteen?

24 A. It's -- yeah, footnote fourteen, line forty-nine.

25 Q. Okay. Now, looking at those -- that range of

1 various studies and papers from page one through four,
2 do you -- do you recall specifically looking at any of
3 them?

4 A. I mean, it's a lot of information. I don't
5 remember any, you know, specific link or specific
6 wording in the articles. My conclusion was that there
7 was an agreement through all the sources that this is
8 harmful or that there is no evidence saying that
9 homosexuality can be prevented or anything else along
10 those lines. I mean, they're all in agreement. If you
11 go through it -- I mean, when I did my research based on
12 what -- what is shown here, it's -- you know, they're
13 all on the same -- on the same page.

14 Q. So would it be accurate to say that all these
15 studies and papers, when you put them together, that's a
16 couple hundred pages of stuff --

17 A. Yeah.

18 Q. -- in total?

19 A. Yeah.

20 Q. Okay. And you already told me that you looked at
21 at least some of it?

22 A. Yes.

23 Q. You don't know what other council members --

24 A. No, I don't.

25 Q. -- have read? Okay.

1 And so the -- going back to the recital on page
2 four referring to overwhelming research, that's
3 referring to these various studies and papers identified
4 in the ordinance and nothing else; is that correct?

5 A. That is correct.

6 Q. I want to be careful of the Court's order as far
7 as timing goes. But, since the passage of the
8 ordinance, are you aware of any new research or
9 subsequently identified research or study that disagrees
10 with any of the studies and papers that are identified
11 in this ordinance?

12 A. No, I do not.

13 Q. If there had been some new study brought to your
14 attention that disagreed with the studies and papers
15 that are cited in the ordinance, as the -- the sponsor
16 of the ordinance, would you feel some responsibility to
17 bring that to the public's attention or reconsider
18 anything that was enacted in the ordinance?

19 A. I had not considered it. The most recent, you
20 know, piece of public information that I saw was in this
21 governor's race in the primary. I know candidate for
22 governor, Gwen Graham, said that she would want to
23 propose a statewide ban. And I believe, in the last
24 house session in Tallahassee earlier this year, at least
25 one representative sponsored a bill to do a statewide

1 ban. I don't know where that went. I didn't follow --
2 you know, I didn't look into that. But, I mean, that's
3 the newest -- you know, anything -- newest news source
4 or news story that I saw about this.

5 Q. In the course of the -- from that period of time
6 when you proposed the ordinance to when it was enacted,
7 did anyone present to the council members an
8 explanation, a summary or other kind of, you know,
9 exposition of all the information in these various
10 studies and papers? Or was it just up to each council
11 member to read whatever they felt like --

12 A. Yeah, just like in anything, a rezoning case or
13 an ordinance reading or anything -- you know, something
14 like this, enacting something new, it's up to us to do
15 our own research. I take my time and taking it on a
16 case-by-case basis. And then we wait for the public
17 hearing; and, you know, we go from there allowing, you
18 know, public input. But I can't speak for the other
19 council members. There's some that, you know, are never
20 at City Hall. I'm always there. You know, I treat this
21 as a full-time job, and -- and that's really it.

22 Q. You've already answered for yourself, but are you
23 aware of any of your fellow council members who have any
24 background or training in mental health counseling?

25 A. I do not believe so, no.

1 Q. Do you know whether anyone on staff with the City
2 involved in the initial staff report when this ordinance
3 was initiated has that kind of training in mental health
4 counseling or mental health experience?

5 A. I don't think so, no.

6 Q. Do you know whether any person with that kind of
7 training or background gave input on behalf of the City
8 into the drafting or enacting of this ordinance?

9 A. No.

10 MR. GANNAM: You know what? Now is probably
11 the best time to break.

12 (Recess)

13 (Mr. Simpson is absent)

14 MR. GANNAM: We're back on.

15 BY MR. GANNAM:

16 Q. Before the lunch break, we were talking about the
17 research that's cited in the ordinance. I want to talk
18 about some of that specifically. We'll go to page one
19 of the ordinance. The -- from my count, the longest of
20 the recital paragraphs is the one at the bottom that
21 refers to the American Psychological Association's Task
22 Force on Appropriate Therapeutic Responses to Sexual
23 Orientation. Do you see that?

24 A. Yes, I do.

25 Q. And this refers to a 2009 report by the APA Task

1 Force that I'll just refer to as the APA report. Will
2 you know what I'm talking about if I say --

3 A. Yes.

4 Q. -- that?

5 A. Yes.

6 Q. Now, this report seems to be -- out of all the
7 materials that are cited in here, probably the longest
8 and most robust of the various papers. Would you agree
9 with that?

10 A. I would -- I mean, not just because it's the
11 longest paragraph; but I think it's the most in depth.

12 Q. Okay. Yeah. And so let's talk about some of the
13 things in that report that bear on our ordinance here.
14 I'm going to give you a copy of it. It's a paper copy.
15 I'm going to mark it as Exhibit 17.

16 (Plaintiffs' Exhibit No. 17 marked for identification)

17 BY MR. GANNAM:

18 Q. I hunted for a stapler that could handle this
19 whole thing, and I didn't find it. So we'll have to
20 make due the best we can with a clipped copy. So I just
21 handed you the APA report that's cited in this whereas
22 clause. Do you recognize this report? Have you seen it
23 before?

24 A. Yes. I have seen it in electronic format and
25 PDF.

1 Q. Okay. And did you have an opportunity to look at
2 all or some of that report in connection with the
3 ordinance?

4 A. Some of it. I know I did not -- I did not read
5 through all of this.

6 Q. Okay. Earlier today we talked about the
7 difference between aversive and non-aversive therapies.
8 Do you recall that?

9 A. Yes, I do.

10 Q. Just to generally summarize, the aversive
11 therapies were -- they involve some element of
12 punishment or reprimand --

13 A. Uh-huh.

14 Q. -- some kind of conduct like snapping a rubber
15 band or inducing vomiting, things like that. Do you
16 recall that?

17 A. Yes, I do.

18 Q. I want to talk about another distinction between
19 treatments, the difference between coercive and
20 involuntary treatments on the one hand versus voluntary
21 treatment. Before I go further, do those terms mean
22 anything to you; or is that something you've had an
23 opportunity to look at?

24 A. I understand the meaning of the words.

25 Q. Of coercive and involuntary --

1 A. Yes.

2 Q. -- generally speaking? Okay. Very good.

3 I'm going to ask you to look at page seventy-one
4 of that report down in footnote fifty-nine. It would be
5 at the bottom of the page when you get there.

6 A. Which --

7 Q. The small footnote print. Yeah, you're in the --

8 A. We define?

9 Q. -- right spot. Yeah.

10 So fifty-nine says, we define coercive
11 treatments. Do you see that?

12 A. Yes, I do.

13 Q. Says, "We define coercive treatments as practices
14 that compel or manipulate a child or adolescent to
15 submit to treatment through the use of threats,
16 intimidation, trickery, or some other form of pressure
17 or force."

18 Is that generally consistent with what your
19 understanding of a coercive treatment --

20 A. Yes.

21 Q. -- would be?

22 A. Yes, it is.

23 Q. Okay. Also look at note sixty just over on the
24 page, says, "We define involuntary treatment is that
25 which is performed without the individual's consent or

1 assent and which may be contrary to his or her expressed
2 wishes."

3 Does that definition generally comport with what
4 you would think of as involuntary treatment?

5 A. I would agree with that, yes.

6 Q. And it goes on to say, "Unlike coercive
7 treatment, no threats or intimidation are involved."

8 So coercive involves some kind of threat or
9 intimidation. Involuntary simply means it's against the
10 child's will. Is that fair?

11 A. Yes.

12 Q. So, given that we have these sort of different
13 kinds of treatments that are covered -- we have aversive
14 versus non-aversive, coercive and involuntary treatments
15 versus voluntary -- I want to talk about what the City
16 considered in connection with passing this ordinance
17 based on those categories.

18 And so let me ask this. Did it -- did the City
19 consider or discuss passing a ban against only aversive
20 therapies while leaving non-aversive therapies allowed?

21 A. No. We just went with what -- we requested the
22 information how other municipalities had banned it and
23 moved forward with a -- I think it's a comprehensive ban
24 on conversion therapy, in general.

25 Q. Okay. So is the reason the City didn't consider

1 banning something less than everything based on just
2 what other cities had done?

3 A. I would agree with what the City brought to us
4 because, I mean, in my understanding of conversion
5 therapy and me being against it, me proposing it is --
6 you know, for example, you brought up involuntary
7 treatment without threats or intimidation. I mean,
8 there are children out there, even adults, you know, all
9 they have to do is see their father's face; and, you
10 know, they completely change. You know? Nothing has to
11 be said. And, you know, you wouldn't call it a threat.
12 But there's an understanding and a respect which is a
13 fear where you don't have to say anything; and just that
14 person's presence or the fact of, you know, what will my
15 father and my mother think is enough to intimidate a
16 person. So, when you say involuntary treatment without
17 threats or intimidation, you don't have to have threats
18 or intimidation to send a message across.

19 Q. But did the City consider that a -- a voluntary
20 treatment where the -- the child or adolescent wants to
21 be there and desires the treatment would be less harmful
22 than an involuntary or coercive treatment?

23 A. The City did not consider it. You know, I look
24 at it as it's -- it's a harmful practice regardless.
25 You know? I mean, if -- for example, the legal drinking

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1 age is twenty-one but I feel that, at seventeen, I can
2 handle the alcohol doesn't mean anything. I mean, it
3 could be harmful or the law says that it's twenty-one;
4 so I don't do it anyway.

5 Q. So is it the City's position that there's no
6 difference in harm between a -- on the one hand, a
7 voluntary treatment to change sexual orientation or
8 gender identity, on the one hand, and an involuntary
9 treatment to change those things on the other hand?

10 A. Treatment is equally harmful. It's not about if
11 it's forced or it's -- somebody chooses to do it. It's
12 -- it's -- in the end, the conclusion is the same. It's
13 still equally harmful.

14 Q. So I'll ask the same question then just to make
15 sure we've covered all the possibilities. Am I correct
16 that the City did not consider banning only aversive
17 treatments versus non-aversive treatments?

18 A. No. We were specific in asking for a conversion
19 therapy ban. We looked at other cities; and it was
20 comprehensive where it covered the therapy in general,
21 not one or the other. It was just a comprehensive ban
22 that covered everything.

23 Q. So I am correct that the City did not consider
24 banning only aversive treatments versus non-aversive
25 treatments?

1 A. We specifically asked for a comprehensive ban.

2 Q. From the very beginning?

3 A. From the beginning, it was a ban on conversion
4 therapy, in general.

5 Q. And so -- and I'm sorry if I am beating a horse.
6 I just want to make sure the record is clear. The City
7 did not consider at any point banning only aversive
8 treatments?

9 A. We didn't -- we didn't ask that. We specifically
10 asked for a ban on everything.

11 Q. And I understand you've said that.

12 A. Yeah.

13 Q. But, given that this ordinance was considered,
14 debated to some extent, commented on over a period of
15 weeks between four different meetings, at any point did
16 the City consider only banning aversive treatments?

17 A. No.

18 Q. At any point, did the City consider banning only
19 coercive treatment while leaving voluntary treatment
20 allowed?

21 A. No.

22 Q. At any point, did the City consider banning only
23 involuntary treatments as opposed to voluntary
24 treatments?

25 A. No. It was a general ban covering everything.

1 Q. From the beginning when you first proposed
2 looking into the ordinance to the time of enactment, it
3 was always a comprehensive ban of everything that was
4 considered?

5 A. Yes. And that would reflect in the unanimous
6 votes all the way through. So I think there was a
7 general understanding by all council members that we
8 want a complete ban. We never debated anything else
9 because we specifically wanted the complete ban.

10 Q. Now, the -- can you look at page two of that
11 report.

12 A. Okay.

13 Q. This is in the Executive Summary section. The
14 footnote that is designated by the two asterisks at the
15 lower right, do you see that?

16 A. I see it.

17 Q. It says in this report, we use the term sexual
18 orientation change efforts, S-O-C-E, or SOCE, to
19 describe methods, for example, behavioral techniques,
20 psychoanalytic techniques, medical approaches, religious
21 and spiritual approaches that aim to change a person's
22 same-sex sexual orientation to other sex regardless of
23 whether mental health professionals or lay individuals,
24 including religious professionals, religious leaders,
25 social groups and other lay networks such as self-help

1 groups are involved.

2 Did I read that accurately?

3 A. Yes, you did.

4 Q. Is it your understanding then, from this
5 footnote, that this entire APA report doesn't
6 differentiate between SOCE performed by licensed
7 professionals on the one hand and SOCE performed by
8 people who aren't licensed and may just be part of a
9 religious organization?

10 A. In our ordinance and in the ban, it does exempt
11 churches and clergy and whatnot. So I don't think they
12 -- I mean, they're exempt from this.

13 Q. And so you're probably thinking of my question.
14 You said a moment ago that, in the City's view, the
15 treatment itself is what is harmful. Whether it's
16 voluntary or involuntary, it's the treatment itself that
17 causes harm, correct?

18 A. Yes.

19 Q. And so did the City consider banning all sexual
20 orientation change efforts regardless of whether it was
21 performed by a licensed professional or performed by an
22 unlicensed religious person given that the treatment
23 itself is harmful?

24 A. We separated -- we exempted churches and other
25 religious organizations. However, it's written in the

1 ordinance assuming, you know, freedom of speech, First
2 Amendment, freedom of Religion. So we left it at that.

3 Q. So is it the City's position that, if a practice
4 is harmful to children, that the City could not ban it
5 if that harmful practice was carried out by a member of
6 a church or a leader of a church?

7 A. Well, I mean, you could look at it as Roe versus
8 Wade. The federal government says that abortion is
9 legal. The Catholic church is on the opposite end of
10 that and says that, you know, in their view, abortion is
11 murder; or they are opposed to it. So they have the
12 freedom to express that. But, through licensed
13 professionals, which is doctors who would perform that
14 abortion, a person can legally have it. Whatever the
15 church's opinion is is beyond our purview.

16 Q. I'm going to guess -- and you can correct me if
17 I'm wrong -- that you're at least generally aware of
18 recent news reports of very large prosecutions of
19 Catholic clergy in the Northeast related to childhood
20 sexual abuse carried --

21 A. Uh-huh.

22 Q. -- out over a number of years? Are you generally
23 aware of stories like that?

24 A. Yeah, recently in the news.

25 Q. When you look at a story like that, I think most

1 people would agree that, if sexual abuse is carried out
2 against a child, if it's carried out by a clergy or a
3 church leader, they should still be prosecuted just like
4 if it was carried out by anyone else. Would you agree
5 with that statement?

6 A. Those are criminal offenses, and that's something
7 completely different. This would be -- per the
8 conversion therapy is, you know, a church or whatever
9 religious organization can say it's counseling on their
10 part. But, as a City Council, you know, with the
11 ordinance that we pass within the City of Tampa limits,
12 within, you know, our jurisdiction, you know, we passed
13 this ban exempting, you know, those churches. So that's
14 a completely different jurisdiction.

15 Q. But the City has taken the position by enacting
16 this ordinance that, if an unlicensed member of the
17 clergy performs conversion therapy on a minor, that that
18 is okay with the City? But, if a licensed professional
19 does the exact same thing, that's not okay with the
20 City?

21 A. We see it as harmful either way. You know, we
22 can, you know, create the laws by ordinance and have the
23 mayor sign them and implement them. So whatever
24 jurisdiction we have with the City of Tampa is what we
25 do. What the church does is beyond our control. Should

1 it lead to, as you're talking about recent news stories,
2 that's a separate criminal thing that the City doesn't
3 get involved in beyond, you know, a police officer
4 making an arrest or whatever gets involved at that
5 point.

6 Q. Given that the City looks at the practice itself
7 of conversion therapy as harmful regardless of who's
8 doing it, could the City have included church leaders or
9 clergy or any adult, for that matter, within its ban on
10 conversion therapy?

11 A. We based it on how other municipalities did it.
12 Others have exempted it, so we went with what was the
13 best practice moving forward.

14 Q. I want to now ask you to look at page nine of the
15 report. Now, in the left column -- I'm going to say
16 it's the -- the second complete paragraph that begins
17 with we also concluded. Do you see that?

18 A. Yes.

19 Q. Skipping down to the last sentence of that
20 paragraph. I'll read it. "Due to our charge, we
21 limited our review to sexual orientation and did not
22 address gender identity, because the final report of
23 another task force, the APA Task Force on Gender
24 Identity and Gender Variance, was forthcoming." See APA
25 2009.

1 Did I read that correctly?

2 A. Yes, you did.

3 Q. So can't we conclude from that statement is that
4 this whole 2009 APA report deals only with sexual
5 orientation change efforts and not at all with gender
6 identity change efforts?

7 A. Yes. As it's stated here, there's two different
8 reports.

9 Q. Now, did the City include in its recitals and in
10 its ordinance this separately identified APA Task Force
11 on Gender Identity and Gender Variance report?

12 A. I'm not sure.

13 Q. Okay. Can I ask you for -- to move forward to
14 page forty-two of the report.

15 A. Okay.

16 Q. This is the case where the paper is faster than
17 the computer, so let me just catch up with you.

18 The bottom of -- bottom left of forty-two,
19 there's a heading, Recent Studies. Do you see that?

20 A. Yes.

21 Q. Now, the first sentence reads, "Although the
22 recent studies do not provide valid causal evidence of
23 the efficacy of SOCE or of its harm, some recent studies
24 document that there are people who perceive that they
25 have been harmed through SOCE" -- and then there are

1 several citations -- "just as other recent studies
2 document that there are people who perceive that they
3 have benefited from it."

4 Did I read that correctly?

5 A. Yes, you did.

6 Q. Let me ask you to also look under the heading
7 Summary on the right column. It begins, "we conclude
8 that there is a dearth of scientifically sound research
9 on the safety of SOCE."

10 Did I read that correctly?

11 A. Yes, you did.

12 Q. And then moving down about a little more than
13 halfway down that paragraph, it begins, "thus, we
14 cannot." Do you see that?

15 A. Yes.

16 Q. It reads, "Thus, we cannot conclude how likely it
17 is that harm will occur from SOCE."

18 Based on this information or these statements, do
19 you agree that the APA has taken the position that the
20 studies don't provide any causal evidence of either the
21 efficacy of SOCE or of its harm?

22 A. I would disagree with that because, under recent
23 studies, what we read, there are people who perceive
24 that they have been harmed through SOCE. And, since
25 it's taken on a case-by-case, person-by-person basis, I

1 mean, I think it would be wrong to conclude that -- when
2 they say here, thus, we cannot conclude how likely it is
3 that harm will occur, you have cases where people are
4 saying that they were harmed through SOCE.

5 Q. So is the City in disagreement with these
6 statements of the APA, for example, that there's no --
7 the studies don't provide a causal connection? They
8 don't provide causal evidence of the harm of SOCE? Does
9 the City disagree with that?

10 A. I would disagree with that especially after we
11 had our public meetings and so many people spoke about
12 their own personal stories. You know, that was
13 reflected on the record of how it affected them, you
14 know, one by one. Every person is different. So you
15 can't just make a generalization that, well, maybe yes,
16 maybe no.

17 Q. And the statement further by the APA that, we
18 cannot conclude how likely it is that harm will occur
19 from SOCE, does the City disagree with that statement?

20 A. Once again, I would disagree with that because, I
21 mean, it's -- it's case by case. You know,
22 psychologists or a psychiatrist or a doctor, for that
23 matter, has no guarantee that they can cure somebody of
24 anything. I mean, you can go into remission for cancer
25 and say you're cured; and it comes back with a

1 vengeance. You can put somebody on antidepressants and
2 say after six months that they're fine, and then they
3 commit suicide as -- you know, as I've witnessed in my
4 life. So...

5 Q. But I think my question was: Does the City
6 disagree with the statement that the likelihood of harm
7 from SOCE cannot be determined?

8 A. I would -- well, I would agree with that because,
9 once again, it's case by case. You don't know -- you
10 could have a hundred people, and it could be
11 fifty-fifty. It could be eighty-twenty. You don't
12 know.

13 Q. Let me ask you this. Does the City have a
14 position about how likely it is that loneliness, for
15 example, will result from SOCE counseling or conversion
16 therapy?

17 A. Once again, you know, it would have no position
18 because everybody is different. Everybody's going to
19 react differently.

20 Q. So would it be true that the City of Tampa cannot
21 say whether the likelihood of a negative outcome for a
22 minor who receives SOCE is fifty percent or one percent
23 or zero percent?

24 A. I can't come to a number because humans have
25 freewill; and people -- you know, you don't know how

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1 someone's going to react or behave or change or what
2 incidences in their lives will trigger whatever. So...

3 Q. The answer is, no, the City can't tell what the
4 likelihood is?

5 A. Nobody can.

6 Q. And would the answer be the same for the
7 likelihood that feelings of rejection or depression will
8 result from SOCE counseling?

9 A. I believe it's possible, especially after hearing
10 the comments made from the public when we had the public
11 hearings.

12 Q. So you believe it's possible. But my question is
13 a little different.

14 My question is: Can the City say how likely it
15 is that feelings of rejection or depression will result
16 from SOCE counseling on a minor?

17 A. The only time is to talk to people that have been
18 through it and see from there. But you can never get a
19 definitive number.

20 Q. Okay. And the same question then: Can the City
21 say how likely it is that a minor will experience
22 suicidal thoughts as a result of receiving SOCE
23 counseling?

24 A. We can only use, you know, evidence of what's
25 happened in the past of people that have committed

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1 suicide or have contemplated suicide. Once again, the
2 people that spoke before council, you know, the -- some
3 of the e-mails that you showed me earlier saying how
4 it's barbaric how -- you know, how hurtful it is, how
5 harmful it is. I mean, that's coming from the general
6 public. You know, people have different opinions.

7 Q. And I do want to ask you just to specifically
8 answer the question I asked, which is: Does the City
9 know how likely it is that suicidal thoughts will occur
10 as a result of SOCE?

11 A. No, nobody knows.

12 Q. I want to ask you to look at page forty-three,
13 please. At the end of that -- there's two paragraphs
14 there. At the end of the first one, the last sentence
15 begins, "we found." Do you see that?

16 A. Yes.

17 Q. Says, "We found that nonaversive and recent
18 approaches to SOCE have not been rigorously evaluated.
19 Given the limited amount of methodologically sound
20 research, we cannot draw a conclusion regarding whether
21 recent forms of SOCE are or are not effective."

22 Did I read that correctly?

23 A. You read it correctly. But, continuing into the
24 next sentence, we found that there was some evidence --
25 there was some evidence to indicate that individuals

1 experienced harm from SOCE. So...

2 Q. Understood. I want to ask you about the sentence
3 that I read. It says that they found that non-aversive
4 and recent approaches to SOCE have not been rigorously
5 evaluated. Did I read that part correctly?

6 A. Yes, you did.

7 Q. And then they go on to say, "We cannot draw a
8 conclusion regarding whether recent forms of SOCE are or
9 are not effective."

10 Did I read that correctly?

11 A. You did.

12 Q. So, based on that statement, did the City take
13 that into account when you told me that only a
14 comprehensive ban on all kinds of SOCE was ever
15 considered?

16 A. What year was this -- this published? Was it
17 1997?

18 Q. 2009.

19 A. 2009.

20 So we have almost a decade that has passed --
21 well, at the time that this was proposed, eight years
22 where there's even more information. I mean, this is
23 just one report. You look at the ordinance, there's
24 quite a few reference points. So, if you would look at
25 ten years ago, the word transgender wasn't used; or,

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1 gender identity, the term wasn't as common as it is
2 today. And, since then, the world has changed. And I
3 would say, just because one report says this, we have so
4 much supporting documentation in the ordinance itself
5 that's newer that would say otherwise. So this is just,
6 you know, one sentence, one opinion. But we have to
7 look forward -- I mean, look further than that because
8 almost a decade has passed.

9 Q. Can you point me to any of the other studies or
10 papers that are identified in the ordinance that
11 disagree or updates the conclusions of this 2009 APA
12 report?

13 A. No. I would have to go through them one by one.

14 Q. When you testified a moment or two ago that no
15 one can give a definitive answer on how likely it is
16 that harm will occur as a result of SOCE, you're talking
17 about as we sit here today, correct?

18 A. Exactly.

19 Q. I want to look back now at the ordinance itself,
20 which is Exhibit 4.

21 A. Which part of the ordinance did you want?

22 Q. That's a good question. Let me get there.

23 (Recess)

24 (Mr. Simpson enters the deposition room)

25 BY MR. GANNAM:

1 Q. I asked you to look at the ordinance. Will you
2 turn to page four, around line twenty-nine to thirty, a
3 recital that reads, "Whereas, City of Tampa has a
4 compelling interest in protecting the physical and
5 psychological wellbeing of minors."

6 Do you see that?

7 A. Yes, I do.

8 Q. What is the -- the compelling interest of the
9 City of Tampa in passing an ordinance like this?

10 A. I think it goes under general public safety. Of
11 course, you know, we talk about investing in our
12 communities, in our neighborhoods, you know, the safety
13 of our people, quality of life. I think it's a
14 quality-of-life issue. You know, we've always been --
15 beyond the conversion therapy ban, we have a domestic
16 partner registry that the previous City Council
17 approved. We've been recognized as very inclusive, LGBT
18 friendly, you know, a welcoming city. I mean, so many
19 things that I've been told over the years. People want
20 to come here and start a family here or live comfortably
21 here where they know that, you know, the government and
22 the elected officials have their back and always -- you
23 know, they look to -- to protect one another.

24 Q. Does the City -- is it the City's position that
25 it has the same compelling interest in banning, for

1 example, aversive conversion therapy versus non-aversive
2 conversion therapies?

3 A. I think, with the conversion therapy ban, it's
4 just, in general, covering all aspects of it, both.

5 Q. I understand that's what it does.

6 My question is: Is it the City's position that
7 its interest in banning one kind, for example, aversive
8 therapy, is the same as its interest in banning
9 non-aversive therapy?

10 A. Yes, I would agree with that.

11 Q. And, looking further in that same recital
12 paragraph, we continue on, it -- the first compelling
13 interest is in protecting physical and psychological
14 wellbeing. It then goes on to say, and in protecting
15 its minors against exposure to serious harms caused by
16 sexual orientation and gender identity change efforts.

17 Did I read that correctly?

18 A. Yes, you did.

19 Q. My question is about this statement, "serious
20 harms caused by sexual orientation and gender identity
21 change efforts." Given that we just looked at the APA
22 report, which is one of the more robust reports or more
23 thorough reports recited in the ordinance, and seeing
24 how it says that they, the APA Task Force, concluded
25 they can't draw a causal link between harm and sexual

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1 orientation change efforts, is the City relying on some
2 other source of information for this statement that --
3 about serious harms caused by sexual orientation and
4 gender identity change efforts?

5 A. What you're referencing is one opinion. And
6 there's multiple -- you know, throughout the ordinance,
7 there's -- per paragraph, you have multiple agencies or
8 licensed professionals or, you know, different
9 organizations, World Psychiatric Association, American
10 College of Physicians. I think the general conclusion
11 is that it is harmful overall. I mean, one statement or
12 one opinion from a study that was done ten years ago
13 should also be looked at as, if they were to do it today
14 in 2018 and updated it, would they come to the same
15 conclusion considering how the conversation has changed
16 in this country and in this world? And, as I mentioned
17 earlier, now with gender identification and other topics
18 that had not been thoroughly discussed before.

19 Q. Is it your understanding that the 2009 APA report
20 was itself a study of lots of other studies?

21 A. Well, it was different -- different conclusions
22 from different licensed individuals that -- that
23 contributed to the report, therefore, coming to their
24 conclusion of -- because it depends what you look at.
25 They will say it is harmful, and then the sentence

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1 before they say that they have not come to a conclusion
2 either/or. But I think there's enough evidence in
3 there, in what we looked at on, what was it, page
4 forty-three, four-two where we were at previously, that
5 agrees with the general -- you know, it's the general
6 consensus of it that it is harmful and that they have
7 individual cases that were referenced within that
8 paragraph.

9 Q. So does this statement regarding serious harms
10 caused by SOCE and gender identity change efforts rely
11 on the APA report or one of the other sources that are
12 recited in the ordinance?

13 A. I think it's general consensus from -- from
14 everything as a whole.

15 Q. Including that APA report?

16 A. Yes.

17 Q. You've mentioned a couple of times that the APA
18 report is from way back in 2009. In connection with the
19 consideration or enactment of the ordinance, did the
20 City ask anyone else or ask someone else to complete a
21 study to update any of the studies cited in the
22 ordinance?

23 A. No, because we had so much evidence in the
24 ordinance and so many reference points that were newer
25 than that. I mean, there was just a tremendous amount

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1 of information that I would say, you know, came into
2 agreement with -- with the fact that it is harmful. You
3 see here, in 2014, American School Counselors
4 Association; a 2015 report; 2016, American Medical
5 Association; another 2016 report; 2012; 2012. It goes
6 on and on that it's very convincing and clear that it is
7 harmful, and people would agree with it. Maybe we go
8 back to the beginning, and it's done in order. '93,
9 '98, 2009, you know, beyond the report that you're
10 discussing which is early on in the ordinance. That's
11 one opinion. But, I mean, you have several pages where
12 it's more recent, you know, as people have done more
13 thorough research.

14 Q. Do any of the other studies or papers cited in
15 the ordinance besides the 2009 APA report state that
16 there is a causal connection that can be found between
17 sexual orientation or gender identity change efforts and
18 harm?

19 A. I would say yes.

20 Q. Can you identify which of those --

21 A. No. I would have to go through them one by one.

22 Q. As you sit here today, you can't point me to one
23 of them that says that?

24 A. No. But they are referenced there by website, by
25 PDF, by electronic document where it can be found. And

1 they -- I mean, by reading just the whereas clauses
2 throughout the ordinance, they come to the same
3 conclusion that it is harmful, that it is harmful.
4 There's compelling interest here with the City of Tampa
5 in protecting physical and psychological wellbeing of
6 minors. And we'd say that because of all these previous
7 studies before. I mean, I think it's -- it's more than
8 clear.

9 Q. Is it your understanding that the -- strike that.
10 Who is it that you understand actually drafted
11 the actual language of this ordinance that the City
12 Council voted on?

13 A. We requested from the legal department so someone
14 in the legal department or persons in the legal
15 department.

16 Q. Okay. Is it your understanding that the legal
17 department drafted this ordinance from scratch, or did
18 they rely on language from other ordinances that had
19 been enacted?

20 A. We asked them to come back with the information,
21 the staff report, and looking at other municipalities.
22 So, in order to make their job easier where they can
23 have a template and somewhere to start from, they looked
24 at other places that have already banned this, see how
25 they did it. And, in that, they brought back this

1 ordinance with the specifics here which came before us
2 with the public hearing.

3 Q. Do you know how much of the content of Tampa's
4 ordinance is original to Tampa and how much of it is
5 taken or borrowed from other ordinances that have --

6 A. No, I do not. And it's not a question that we
7 would ask.

8 Q. Okay. Focusing back on this paragraph on page
9 four about the compelling interests, are there any
10 compelling interests claimed by the City of Tampa in
11 enacting this ordinance that are not listed in this
12 recital?

13 A. Specifically in this paragraph?

14 Q. Right.

15 A. I think it covers everything. It covers what we
16 asked them to cover.

17 Q. And by, "we," you mean, the City Council?

18 A. We as the City Council, yes, by way of the
19 motion.

20 Q. So would it be fair to say that all of the
21 compelling interests that the City of Tampa has in
22 enacting this ordinance are covered in this paragraph?

23 A. Yes.

24 Q. In the course of the development of this
25 ordinance and its ultimate enactment, did -- did the

1 council members -- did any of the City Council members
2 meet individually with members of the legal department
3 to discuss the content of the ordinance?

4 A. Do you mean after or during the discussions while
5 we were voting on moving it forward?

6 Q. During that whole period of time from your first
7 request for the staff report through the enactment. So,
8 during that period of time, were there meetings by
9 individual council members and members of the legal
10 staff?

11 A. I had a meeting with one member of the legal
12 department.

13 Q. And who was that meeting with?

14 A. His name is Ernie Mueller.

15 Q. And what is Ernie Mueller's position?

16 A. He's one of the attorneys in the -- for the City
17 of Tampa.

18 Q. What was his role in drafting the ordinance?

19 A. I believe he did some of the research.

20 MR. WILLIAMS: Councilman Maniscalco, I
21 would caution you to not allow the questioning to invade
22 the attorney-client privilege.

23 THE WITNESS: Okay.

24 MR. WILLIAMS: So far so good. Describing
25 what Mr. Mueller perhaps did is not within the ambit of

1 that privilege. But communications between you and
2 Mr. Mueller would be.

3 THE WITNESS: Yes.

4 BY MR. GANNAM:

5 Q. What was the subject matter -- you said one
6 meeting, correct?

7 A. Yes, sir.

8 Q. What was the subject matter of your one meeting
9 with Mr. Mueller?

10 A. It was different municipalities and how their --
11 that had banned this and how they had it worded.

12 Q. Who requested the meeting?

13 A. I believe the -- the legal department, whoever
14 the secretary was, called and set it up saying, you
15 know, we want to follow up with you.

16 Q. Did Mr. Mueller have similar meetings to discuss
17 the same subject matter with the other council members?

18 A. I don't know. It may have been just with me -- I
19 don't know -- because I brought it up. But that would
20 be a matter of public record because the calendars are
21 available. But, as far as I know, I'm the only one that
22 met with him; but I don't know.

23 Q. Is there a -- to your knowledge, a general
24 practice of the legal department of meeting with -- with
25 all council members individually if it meets with one so

1 that all council members have the same information?

2 A. Generally, yes, if it comes to a rezoning or --
3 you know, a major change or an item coming before
4 council for a vote. We would get briefings as
5 individual council members. We can't talk to each
6 other, but legal or whomever can just give us an update.

7 Q. And so the particular meeting that you had with
8 Mr. Mueller, did it in any way involve discussion of
9 possible court challenges to the ordinance?

10 A. No.

11 Q. And I just want to get clarification from your
12 attorney.

13 MR. GANNAM: I'm going to ask him what they
14 talked about. And, if you make the objection, I guess
15 we'll deal with it. But do you know what the content of
16 the meeting was, and that's why you're sort of
17 preliminarily bringing up the privilege? Or...

18 MR. WILLIAMS: Well, Roger, I don't know
19 that I am obligated to answer that question.
20 Communications between a lawyer and a client, in this
21 case the Assistant City Attorney for the City of Tampa,
22 is within the ambit of that type of communication. So
23 whatever I know or don't know is irrelevant.

24 I'm going to object to any question that
25 would intrude on that attorney-client relationship. And

1 I'll do it question by question. And the way I'm going
2 to do it is to advise Councilman Maniscalco that the
3 question, in my opinion, intrudes on the attorney-client
4 relationship; and, therefore, his answer would abrogate
5 the attorney-client privilege. And he is not obligated
6 to answer the question, in my opinion. And he can
7 follow my advice or not follow my advice. But I think
8 he will.

9 MR. GANNAM: So, in light of what your
10 attorney has just said, I want to just -- just take it
11 piece by piece.

12 BY MR. GANNAM:

13 Q. You said, generally, the subject matter of your
14 meeting was what other municipalities had enacted; is
15 that correct?

16 A. Yeah, just a basic overview. This is what we
17 researched.

18 Q. And during what part of the process did this
19 meeting occur? When I say, "the process," from your
20 initial request to the enactment.

21 MR. WILLIAMS: The timeline, if you will.

22 THE WITNESS: I don't really remember. I
23 would guess that it was when I made the initial motion
24 to come back with a staff report. It may have been
25 before that staff report or after. I don't remember.

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1 But it was before the final votes and before it went
2 to -- before the first reading took place. I know that.

3 BY MR. GANNAM:

4 Q. Would it have also been before an actual draft of
5 the ordinance was prepared?

6 A. It may have been.

7 Q. Did you at any -- did you discuss the contents of
8 what should be in the ordinance that goes to the
9 council?

10 A. No. He -- the attorney said this is what --

11 MR. WILLIAMS: Whoa, whoa, whoa. No. I
12 don't want --

13 THE WITNESS: Okay.

14 MR. WILLIAMS: I'm advising you that
15 anything that you said during that meeting to
16 Mr. Mueller and vice versa is privileged. And I'm
17 advising then that you are not required to disclose that
18 communication because it is privileged.

19 THE WITNESS: Then I have nothing to
20 disclose.

21 BY MR. GANNAM:

22 Q. I guess --

23 MR. GANNAM: Could you read back my question
24 before the objection.

25 (Requested portion read back by the court reporter)

1 MR. GANNAM: I'm going to rephrase the
2 question.

3 MR. WILLIAMS: And, Roger, before you do
4 that, just to speed the process up. Since I've
5 announced on the record the basis and the way that I do
6 this, I'm just simply going to object, invades the
7 attorney-client privilege. And can we agree that that
8 statement on my part encompasses the short instructive
9 speech that I made a little earlier, and that way I
10 don't have to go through that speech every time? It
11 will save us probably minutes, if not more than minutes.

12 MR. GANNAM: Okay.

13 MR. WILLIAMS: Is that okay?

14 MR. GANNAM: That's fine with me.

15 BY MR. GANNAM:

16 Q. So, without telling me specifically what was
17 said, I want to ask you: Did the subject matter of your
18 conversation include what content should be in the draft
19 ordinance when it's prepared?

20 A. No.

21 Q. Okay. Did that conversation -- did the subject
22 matter of that conversation include to what extent the
23 City should or should not rely on the various studies
24 and papers that are recited --

25 A. No.

1 Q. -- in the --

2 A. No.

3 Q. -- ordinance?

4 MR. GANNAM: Okay. All right. I'm ready to
5 move on from that. I think we're done with
6 Mr. Maniscalco. I just want to consult with my
7 colleague for just a moment.

8 MR. WILLIAMS: Sure.

9 (Recess)

10 MR. GANNAM: All right. We have no further
11 questions for you, Mr. Maniscalco. And we're ready to
12 move on to the next designee.

13 (Proceedings concluded at 1:46 o'clock p.m.)

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Vazzo v. City of Tampa
Guido Maniscalco

10/31/2018

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CERTIFICATE OF OATH

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STATE OF FLORIDA)
COUNTY OF PALM BEACH)

I, Rachele L. Cibula, the undersigned authority,
certify that GUIDO MANISCALCO personally appeared before
me and was duly sworn.

Witness my hand and official seal this 4th day of
November, 2018.


RACHELE L. CIBULA
Notary Public, State of Florida
My Commission #FF 936928
Expires: December 14, 2019



Florida Court Reporting
561-689-0999

Vazzo v. City of Tampa
Guido Maniscalco

10/31/2018

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1 C E R T I F I C A T E

2 THE STATE OF FLORIDA)

3 COUNTY OF PALM BEACH)

4

5 I, Rachele Lynn Cibula, Notary Public, State of
6 Florida at Large,

7 DO HEREBY CERTIFY that I was authorized to and did
8 stenographically report the foregoing deposition; and
9 that the transcript is a true and correct transcription
10 of the testimony given by the witness.

11 I FURTHER CERTIFY that I am not a relative, employee,
12 attorney or counsel connected with the action, nor am I
13 financially interested in the action.

14 Dated this 4th day of November, 2018.

15

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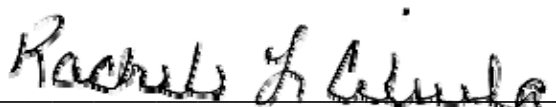
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RACHELE LYNN CIBULA, NOTARY PUBLIC

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Florida Court Reporting
561-689-0999

No. 19-14387

**IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

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,

Plaintiffs–Appellees,

v.

CITY OF TAMPA, FLORIDA,

Defendant–Appellant

On Appeal from the United States District Court
for the Middle District of Florida
in Case No. 8:17-cv-02896-T-02AAS before the Honorable William F. Jung

**PLAINTIFFS-APPELLEES' SUPPLEMENTAL APPENDIX
VOLUME II**

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VAZZO, etc., et al. v. CITY OF TAMPA, FLORIDA

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IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF FLORIDA
Tampa Division
Civil Action No. 8:17-cv-02896-CEH-AAS

ROBERT L. VAZZO, LMFT, individually
and on behalf of his patients,
DAVID H. PICKUP, 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,

Plaintiffs,

vs.

CITY OF TAMPA, FLORIDA, and
SAL RUGGIERO, in his official capacity as
Manager of the City of Tampa
Neighborhood Enhancement Division,

Defendants.

* * * * *

DEPOSITION OF JERROD SIMPSON, ESQUIRE
TAKEN AT THE INSTANCE OF THE PLAINTIFFS

* * * * *

DATE: October 31, 2018
PLACE: 201 North Franklin Street
Suite 3200
Tampa, Florida 33603
TIME: 1:47 - 5:29 o'clock p.m.

FLORIDA COURT REPORTING
561-689-0999

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1

EXHIBITS CONTINUED

2

Plaintiffs' Exhibit No. 25 marked for 125
identification

3

(E-mail from Jerrod Simpson to Erin Bradley
and Ernest Mueller dated 3/9/2017)

4

Plaintiffs' Exhibit No. 26 marked for 128
identification

5

(Considerations for Conversion Therapy
Ordinance)

6

7

Plaintiffs' Exhibit No. 27 marked for 128
identification

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(Memo from Ernest Mueller to the City
Council)

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1 The deposition of JERROD SIMPSON, ESQUIRE, witness,
2 was taken before me, Rachele Cibula, Notary Public,
3 State of Florida at large, at 201 North Franklin Street,
4 Suite 3200, in the City of Tampa, County of
5 Hillsborough, State of Florida, pursuant to notice in
6 said cause for the purpose of taking said deposition at
7 the instance of the Plaintiffs in the above-styled
8 action pending in the above-styled court.

9 THE COURT REPORTER: Raise your right hand,
10 Please, sir.

11 THEREUPON,

12 JERROD SIMPSON, ESQUIRE,
13 being by me first duly sworn to testify the whole truth
14 as is hereinafter certified, testifies as follows:

15 THE WITNESS: I do.

16 DIRECT EXAMINATION

17 BY MR. GANNAM:

18 Q. All right. Mr. Simpson, good afternoon. I am
19 the attorney for -- or one of the attorneys for the
20 Plaintiffs in this lawsuit. My name is Roger Gannam.
21 And we're going to be continuing with the deposition of
22 Defendant, City of Tampa.

23 Before we get into the questions, I want to go
24 over some of the same ground rules I went over with the
25 prior witness. I know you've been here most of the day,

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1 so forgive me if some of this is cumulative.

2 First of all, let me ask, have you ever given a
3 deposition before?

4 A. No.

5 Q. Okay. Have you ever taken a deposition before?

6 A. No.

7 Q. We are making a transcript, so it's important
8 that we only speak one at a time. Are you okay with
9 that?

10 A. Yes.

11 Q. It's also important that all of your answers be
12 out loud as opposed to nonverbal responses. Is that
13 okay?

14 A. Yes.

15 Q. If you don't understand a question, please tell
16 me; and I will address whatever problem might be. Are
17 you okay with that?

18 A. Yes.

19 Q. And, if I do ask a question that you answer, I
20 will assume that you understood me. Is that okay with
21 you?

22 A. Yes.

23 Q. Your lawyer may object. And, as a general rule,
24 you should go ahead and answer my question anyway unless
25 your lawyer tells you not to answer. Are you okay with

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1 that?

2 A. Yes.

3 Q. We can take breaks, so let me know if you need
4 one. I would only ask that, if I've asked a question,
5 that you answer before we start a break. Is that okay?

6 A. Yes.

7 Q. Any questions for me before we continue?

8 A. No.

9 Q. All right. Go over a couple of definitions.
10 Again, these are somewhat redundant since we did it this
11 morning. But, when I say the City or City, I'm
12 referring to the City of Tampa unless I say otherwise.
13 Do you understand that?

14 A. Yes.

15 Q. And, when I say the ordinance, I'm referring to
16 Tampa Ordinance 2017-47, also known as the Conversion
17 Therapy Ban or Conversion Therapy Ordinance. Do you
18 understand that?

19 A. Yes.

20 Q. The letters LGBT stand for lesbian, gay,
21 bisexual, transgender. Do you understand that?

22 A. Yes.

23 Q. The initials S-O-C-E or SOCE stand for sexual
24 orientation change efforts. Do you understand that?

25 A. Yes.

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1 Q. And the initials GICE, if I use them, would stand
2 for gender identity change efforts. Do you understand
3 that?

4 A. Yes.

5 Q. If I talk about conversion therapy, I may be
6 referring generally to SOCE or GICE or any practice
7 that's otherwise covered by the ordinance. Do you
8 understand that?

9 A. Yes.

10 Q. All right. Can you just state your name and
11 business address for the record, please.

12 A. It's Jerrod Simpson. And it's 315 East Kennedy
13 Boulevard in Tampa, Florida. 33602 I believe is the
14 zip.

15 Q. And, Mr. Simpson, are you currently taking any
16 medication that would affect your ability to testify
17 truthfully or recall facts today?

18 A. No.

19 Q. And do you have any injury or condition that
20 would affect your ability to recall facts or testify
21 truthfully?

22 A. No.

23 Q. All right. It's my understanding you are
24 appearing here today as the designee for the City of
25 Tampa pursuant to a Notice of Deposition which you'll

Page 9

1 find in front of you as Exhibit 5. They should be in
2 order. And on page three of that notice begins the list
3 of topics. And I just want to confirm. It's our
4 understanding that you are designated to testify
5 regarding topics 6, 9, 11 and 12. Is that also your
6 understanding?

7 A. Yes.

8 Q. And 12 is modified by the court order to exclude
9 sub-part D. Is that also your understanding?

10 A. Yes.

11 Q. Okay. Do you also understand that your
12 appearance on behalf of the City means that, when I ask
13 you a question, you'll be testifying, not to your
14 personal knowledge, but also, more generally speaking,
15 what the City knows in response to my questions?

16 A. I'm sorry. Is that -- what was your question
17 there?

18 Q. Do you understand that that's the case?

19 A. Yes.

20 Q. And let me begin the questions then with -- just
21 for the record, I'll clarify. When I say do you know,
22 I'm asking you does the City know. Does that make
23 sense?

24 A. Yes.

25 Q. Now, you were here for most of the questioning of

Page 10

1 Mr. Maniscalco; is that correct?

2 A. Yes.

3 Q. Did you hear anything Mr. Maniscalco said that --
4 as you sit here now, that you disagree with or would
5 want to correct?

6 A. Can I repeat the question as if what I think
7 you're asking?

8 Q. Sure.

9 A. Did he say things that I disagree with? Is that
10 what you --

11 Q. In terms of -- I should clarify.

12 Did Mr. Maniscalco testify to anything factually
13 that you think needs correction or that you disagree
14 with as a factual matter?

15 MR. WILLIAMS: I'm glad you repeated the
16 question because I assumed that you -- your question, as
17 posed, is asking Mr. Simpson about anything that
18 Mr. Maniscalco said that would come within the ambit of
19 the designated matters for which Mr. Simpson is
20 appearing that you delineated on the record.

21 To that extent, if it's beyond that, I
22 object because that would not be fair to Mr. Simpson.
23 Beyond that, if you can answer the question,
24 Mr. Simpson, my objection is on the record.

25 THE WITNESS: There may be answers that I

Page 11

1 give that might be different than answers that he gave.

2 But I don't have anything specific that I would -- that

3 I would want to correct.

4 BY MR. GANNAM:

5 Q. Okay. Just sort -- just a practice to give the

6 City a chance to correct the City, you know, so that we

7 have a good record at the end of the day.

8 MR. WILLIAMS: Well, there is the errata

9 sheet --

10 MR. GANNAM: Sure.

11 MR. WILLIAMS: -- that the City is entitled

12 to sign after the transcript is typed up and delivered.

13 BY MR. GANNAM:

14 Q. I'm going to show you a new exhibit that we'll

15 mark as Plaintiffs' 18.

16 (Plaintiffs' Exhibit No. 18 marked for identification)

17 BY MR. GANNAM:

18 Q. And this is a copy of the City's written

19 responses and objections to the Plaintiffs' written

20 discovery requests. Do you recognize this document?

21 A. Yes.

22 Q. I want to point you to the last -- second to last

23 page.

24 MR. WILLIAMS: Page forty-six?

25 MR. GANNAM: Page forty-six.

Page 12

1 BY MR. GANNAM:

2 Q. At the top, it says, Verification to Answers to
3 Interrogatories. Is that your signature that appears
4 there?

5 A. Yes.

6 Q. And so I am -- is it correct to say that you are
7 the official who verified these answers on behalf of the
8 City of Tampa?

9 A. Yes.

10 Q. Okay. And just, as we sit here today, are you
11 currently aware of any factual statement in these
12 answers to discovery that are inaccurate or need to be
13 changed or updated?

14 A. No.

15 Q. Okay. Did you review any documents to prepare
16 for your testimony today?

17 A. Yes.

18 Q. What did you review?

19 A. I reviewed my file that -- from the time that I
20 was working on the ordinance during the time of passage.
21 I reviewed the -- the research that is cited in the
22 whereas clauses. I reviewed some of the litigation
23 documents in this case and the parallel case that's
24 happening in the Southern District.

25 Q. Is that the Otto case?

Page 13

1 A. Yes.

2 Q. Okay.

3 A. And I think that's it for documents.

4 MR. WILLIAMS: Before counsel asks the next
5 question, I want to point out to you, Mr. Simpson, that
6 there's a court order that governs the discovery of
7 documents in this case. And that order names twenty
8 custodians, and you are not one of those custodians. So
9 to the extent that there are documents that you reviewed
10 that would not come within the ambit of that order that
11 are not yet public, you are not to disclose those. I
12 don't think there are any, but I'll leave it up to you.
13 Do you understand the point of my -- my point?

14 THE WITNESS: I think so. Yeah.

15 BY MR. GANNAM:

16 Q. To follow up what your counsel just stated, are
17 you aware, generally speaking, of the Court's discovery
18 orders designating twenty particular document custodians
19 and thirty particular search terms relating to discovery
20 in this case?

21 MR. WILLIAMS: In a timeframe?

22 MR. GANNAM: And a timeframe, correct.

23 THE WITNESS: Yes.

24 BY MR. GANNAM:

25 Q. And is it your understanding that you are not one

Page 14

1 of the twenty custodians?

2 A. Yes.

3 Q. Can you tell me -- you said you reviewed your
4 file from working on the ordinance. Can you tell me the
5 types of documents that are in that file?

6 A. There's some case law. There are copies of the
7 studies. There are correspondence, e-mails. I believe
8 that's it.

9 Q. And, to your knowledge, have any of the contents
10 of your file -- or what you refer to as your file --
11 been produced as documents that were within the custody
12 of any of the twenty identified custodians?

13 A. I haven't personally reviewed all of the
14 documents that were produced in this case. So I don't
15 think I can -- I'm not sure how to answer your question.

16 Q. I was going to ask you what your involvement was
17 in the -- the production of documents in this case. Do
18 I understand correctly that you have -- you personally
19 have reviewed all of the documents that were produced in
20 this case?

21 A. No. What I just said is that I have not
22 personally reviewed all the documents that were
23 produced. And so that's why I couldn't say what is in
24 my file, whether or not that was produced or not, I
25 can't say because I did not review what was produced.

Page 15

1 Q. So, as you sit here, you don't know the answer to
2 whether documents one or any of them have been produced
3 in this case by someone else or by one of those other
4 custodians?

5 A. I know that documents were produced. I know that
6 they were produced in accordance with the terms of the
7 order, which limits custodians, limits search terms and
8 limits timeframe. Whether or not there are documents in
9 my file that -- that do not fall into those categories I
10 can't say with certainty.

11 Q. Did any of the documents that you reviewed from
12 your file in preparation for your testimony today
13 refresh your recollection regarding matters that you
14 will be testifying to today?

15 A. Well, I don't -- I don't think I can answer that
16 either because I'm not sure exactly what you're going to
17 ask me. I mean, are you -- with regard to specific
18 topics? If you could clarify.

19 Q. Fair enough. I guess all I can ask you at this
20 point is in -- in your preparation for the particular
21 topics, did you -- do you believe that reviewing any of
22 the documents from your file refreshed your recollection
23 as to any of the particular topics that you're appearing
24 for today?

25 A. I'm sorry. I really -- I'm having trouble

Page 16

1 understanding the question. I mean, when -- I reviewed
2 the file to refresh my recollection what happened during
3 the time that we were working on the ordinance. And so
4 I don't really know how to answer beyond that.

5 Q. We'll deal with them specifically I guess as it
6 comes up.

7 So, apart from the review of your file, review of
8 some research, review of some litigation documents both
9 from this case and from the Otto case pending in the
10 Southern District, were there any other documents that
11 you reviewed in preparation for your testimony today?

12 A. No.

13 Q. Did you speak to anyone to prepare for your
14 testimony today?

15 A. Yes. I -- I'm just -- that you're going to ask
16 me who it was --

17 Q. Right.

18 A. -- that I spoke with? My attorneys, obviously,
19 here; and I spoke with Ernie Mueller and Sal Ruggiero.

20 Q. And the attorneys here, you mean Rob Williams?

21 A. Yes. And David Harvey.

22 Q. And David Harvey. Okay.

23 And Mr. Mueller and Mr. Ruggiero.

24 When did you -- how many times did you meet with
25 Mr. Williams?

Page 17

1 A. I don't recall.

2 Q. Was it more than once?

3 A. Yes.

4 Q. Do you recall approximately how many times?

5 A. Anywhere from three to five times maybe.

6 Q. About how much time total did you spend in those
7 meetings?

8 A. Anywhere from fifteen minutes to an hour.

9 Q. I guess what I'm looking for is sort of a total
10 of about how much time you think you spent with
11 Mr. Williams in total?

12 A. Just taking those two estimates, rough estimates,
13 I'd have -- you know, say five -- five times.
14 Conservatively saying an hour each, maybe five hours.

15 Q. Okay. That's all I'm asking for is just to --
16 you know, as best you can.

17 Now, were those meetings with Mr. Williams alone;
18 or were there others present there?

19 A. There were others present. They were different.
20 I mean, obviously, there were several meetings.

21 Q. Okay. So at any of the meetings was Mr. Harvey
22 also there, for example?

23 A. Yes.

24 Q. Did you have any meetings with Mr. Harvey alone?

25 A. Yes.

Page 18

1 Q. About how many times?

2 A. Maybe three.

3 Q. Okay.

4 A. Four.

5 Q. For about how long total?

6 A. I'm estimating the same, thirty minutes to an
7 hour.

8 Q. At each meeting, you would estimate? Or total?

9 A. For each, yeah.

10 Q. So thirty minutes to an hour times three is
11 anywhere between ninety minutes to three hours,
12 approximately?

13 A. Sure.

14 Q. Okay. And did you ever -- I guess, the same
15 question for -- for Mr. Mueller. Did you have -- how
16 many meetings did you have with him?

17 A. I think I had two meetings probably. Less
18 meetings with Ernie than the others, and those were
19 shorter.

20 Q. And, with Mr. Mueller, did you meet with him
21 alone?

22 A. Yes.

23 Q. And, again, approximately how much time total?

24 A. Fifteen minutes.

25 Q. Okay. And with Mr. Ruggiero -- is it Ruggero or

Page 19

1 Ruggiero?

2 A. Well, it's spelled Ruggiero. But I think I've
3 even heard him say Ruggiero.

4 Q. Okay.

5 A. So I -- you'll have to ask him what he prefers.

6 MR. WILLIAMS: Just for the record, I did
7 ask him that; and he pronounces it Ruggiero --

8 MR. GANNAM: Ruggiero, okay.

9 MR. WILLIAMS: -- as opposed to Ruggiero,
10 which is the way it's spelled. So I'm going to go with
11 Sal's pronunciation since it's his name --

12 MR. GANNAM: Sounds good.

13 MR. WILLIAMS: -- and I highly recommend
14 that we all do that.

15 MR. GANNAM: Understood.

16 BY MR. GANNAM:

17 Q. How many times did you meet with Mr. Ruggiero?

18 A. I briefly spoke with him over the phone once --

19 Q. And when was that?

20 A. -- maybe twice. I can't remember.

21 Maybe a week ago. I don't remember specifically.

22 Q. Now, was that for you to prepare for your
23 testimony or for him to prepare for his testimony; or
24 was it mutual?

25 A. Well, I can't speak to what his thoughts were. I

Page 20

1 mean, I was calling because I knew that I was going to
2 be a representative of the City; and there could be some
3 questions about enforcement and just wanted to get an
4 understanding on some things so that I could speak as a
5 representative of the organization.

6 Q. Okay. So, besides meetings with Mr. Williams,
7 Mr. Harvey, Mr. Mueller and Mr. Ruggiero, did you meet
8 with anyone else to prepare for your testimony today?

9 A. No.

10 Q. Okay. When you said earlier that there were
11 other people present at at least some of your meetings
12 with Mr. Williams, are those other people limited to
13 Mr. Harvey, Mr. Mueller, Mr. Ruggiero?

14 A. No.

15 Q. Who else was in any of those meetings with
16 Mr. Williams?

17 A. Jerry Gowartz (phonetic).

18 Q. Anyone else?

19 A. I don't believe so.

20 Q. In connection with the document production that
21 occurred in this case, were you asked to search your
22 files for responsive documents by anyone else?

23 A. Yes.

24 Q. Okay. Who asked?

25 A. Rob's paralegal sent out a memo that I received

Page 21

1 that requested documents to be produced and preserved as
2 part of this litigation. And I did receive that.

3 MR. WILLIAMS: "Rob," referring to
4 Rob Williams, just for the record.

5 BY MR. GANNAM:

6 Q. Did you, in fact, follow whatever instructions
7 were in that memo?

8 A. Yes.

9 Q. And did you provide documents to Mr. Williams'
10 office in response to that memo?

11 A. Yes.

12 Q. And were those documents limited to the thirty
13 search terms that were ordered by the Court?

14 A. I provided my entire file.

15 Q. Okay. Can you give me an idea -- let me strike
16 that.

17 Your file, was it kept on paper, electronically
18 or some combination of --

19 A. Electronic.

20 Q. Electronic. Okay.

21 Approximately how many documents were in your
22 file?

23 A. I can't say with certainty. I don't know.

24 Q. Okay. Would you have any more certainty if I
25 asked you approximately how many pages' worth of

Page 22

1 documents?

2 A. No, it's electronic. So...

3 Q. And, it's a long shot; but would you have more
4 certainty if I asked you how many, you know, kilobytes
5 or megabytes those files consisted of?

6 A. No.

7 Q. Let me talk about your position with the City.
8 What is your official title?

9 A. I'm an assistant city attorney.

10 Q. How long have you been in that position?

11 A. For three years.

12 Q. And have you ever worked as an attorney anywhere
13 else?

14 A. No.

15 Q. And when did you graduate from law school?

16 A. 2015.

17 Q. And which school?

18 A. It's the Cooley Law School. It's the Western
19 Michigan University Cooley Law School. There's a campus
20 here in Riverview.

21 Q. Are you from Florida? Or are you from --

22 A. Yes.

23 Q. Okay. Apart from -- I assume you had an
24 undergraduate degree too. Any other education after
25 high school besides an undergraduate degree and your law

Page 23

1 school degree?

2 A. I don't know what you mean by, "education," I
3 guess, to clarify.

4 Q. Any degrees --

5 A. School of hard knocks.

6 Q. Did you earn a bachelor's degree somewhere before
7 law school?

8 A. Yes.

9 Q. And you have your law degree, correct?

10 A. Yes.

11 Q. Any other degrees that you've received?

12 A. No.

13 Q. When did you pass the Florida Bar exam?

14 A. 2015.

15 Q. Are you admitted in the Bars of any other states?

16 A. No.

17 Q. Do you hold any other professional licensure or
18 certifications besides your -- your Bar --

19 A. No.

20 Q. Do you engage in litigation on behalf of the City
21 of Tampa?

22 A. Not usually.

23 Q. Have you ever?

24 A. Yes.

25 Q. What kinds of cases have you been involved in?

Page 24

1 A. I've done some responses for writs for certiori
2 involving rezoning decisions. I've taken part in code
3 enforcement appeals. And then I am the municipal
4 prosecutor for the City, and I handle the prosecution of
5 code enforcement matters that are done in county court.

6 Q. You ever been involved in cases involving First
7 Amendment rights?

8 A. In litigation?

9 Q. In litigation.

10 A. Yes.

11 Q. What kinds of cases or what cases were those?

12 A. I was not an attorney of record, but I was
13 somewhat involved in a case where it was Homeless
14 Helping Homeless. It was a First Amendment lawsuit in
15 the Middle District.

16 Q. Is Homeless Helping Homeless the name of an
17 entity?

18 A. Yes. I believe the case style was Homeless
19 Helping Homeless v. City of Tampa.

20 Q. Any others involving First Amendment rights?

21 A. No.

22 Q. What about, more generally, civil rights other
23 than First Amendment rights?

24 A. Again, you're referring -- are you referring to
25 litigation --

Page 25

1 Q. Litigation, right. Right.

2 A. -- specifically?

3 No.

4 Q. Prior to the enactment of the ordinance, were you
5 involved in any advocacy for LGBT organizations or
6 causes?

7 A. No.

8 Q. How about since the enactment of the ordinance?

9 A. No.

10 Q. Have you received any education or training in
11 counseling or mental health?

12 A. No.

13 Q. What is Mr. Mueller's position in the City
14 Attorney's Office?

15 A. His current position is the Chief Assistant City
16 Attorney over the Administrative Division.

17 Q. Is that the division that you're in?

18 A. Yes.

19 Q. Is he your direct supervisor?

20 A. No.

21 Q. Who is your direct supervisor?

22 A. Rebecca Kert.

23 Q. How do you spell her last name?

24 A. K-e-r-t.

25 Q. What's her title?

Page 26

1 A. Senior Assistant City Attorney.

2 Q. At the time that this ordinance originated, was
3 Mr. Mueller in that same chief assistant position?

4 A. I believe he was a Senior Assistant City Attorney
5 at the time.

6 Q. When did he take on that chief assistant
7 designation or title?

8 A. I don't know specific dates.

9 Q. During the period of time from the first proposal
10 of the ordinance by Council Member Maniscalco to its
11 enactment, was Mr. Mueller a Senior Assistant City
12 Attorney during that entire time?

13 A. I believe so.

14 Q. And, at that time, was he your direct supervisor?

15 A. No.

16 Q. Was it Ms. Kert?

17 A. Yes.

18 Q. Okay. Did Mr. Mueller work on drafting of the
19 ordinance?

20 A. Yes.

21 Q. And did you work on drafting the ordinance?

22 A. Yes.

23 Q. If I were just to ask you who drafted the
24 ordinance, was there a principal drafter or one person
25 who is more responsible than anyone else?

Page 27

1 A. I guess I would need to know what you mean by,
2 "drafting," in order to answer that.

3 Q. Who took the first crack at it? Does that help?

4 A. No.

5 Q. Okay. Tell me about the process of drafting the
6 ordinance.

7 A. The motion came in. The motion specifically
8 referenced City of Miami Beach, I believe, as a point of
9 clarification for what it was that the council member
10 was seeking to do. And the City Attorney gets to make
11 the assignment of who is going to be the staff person
12 that responds to the councilman's motion.

13 Q. Who was the City Attorney at that time?

14 A. If you don't mind me referring to the -- to the
15 ordinance, maybe I can --

16 Q. Sure.

17 A. -- refresh my recollection?

18 Q. We're talking about Exhibit -- is that Exhibit 4?

19 A. 4.

20 It's approved as to legal sufficiency by
21 Ernest Mueller who was a Senior Assistant City Attorney
22 at the time. I don't recall specifically if
23 Julia Mandell was still the City Attorney at the time or
24 if Sal Territo had become the City Attorney at that
25 time. I don't remember. It would have been one of the

1 two.

2 Q. Mr. Territo is the City Attorney now, right?

3 A. Yes.

4 Q. And who is -- you said Julia Mandell?

5 A. Julia Mandell was the City Attorney prior to --

6 Q. Okay.

7 A. -- Sal Territo.

8 Q. So you just don't -- as you sit here, you just
9 don't remember which one it was at that time?

10 A. I don't recall the specific dates, and I didn't
11 look at anything to refresh my recollection on that
12 point.

13 Q. Mr. Mueller, in his chief assistant position, is
14 his -- does he report directly to the City Attorney?

15 A. Yes.

16 Q. Okay. Getting back to the drafting of the
17 ordinance. So the motion by Mr. Maniscalco was made.
18 The City Attorney has the discretion to assign that --
19 that drafting assignment to someone. So what happened
20 in this case?

21 A. So Ernest Mueller was assigned the lead role in
22 drafting and presenting the staff report. And then he
23 reached out to me and assigned to me assistance in
24 researching the issues in the ordinance.

25 Q. When we talk about this staff report, is that a

Page 29

1 document?

2 A. No.

3 Q. Okay. What is a staff report?

4 A. In the usual course of business for the City
5 Council, they have the authority to, by motion, order I
6 guess you could say a -- a member of the City staff to
7 report to the council during a -- during a public
8 meeting. And so that would be a staff report.

9 Q. So it can be a completely verbal report without
10 any written document to accompany it?

11 A. Correct.

12 Q. Is that the usual way it's done is through some
13 kind of verbal report?

14 A. I don't know if I can say that there's a usual
15 way or not a usual way. It would depend on the nature
16 of the -- of their request for information that the
17 council member is trying to get.

18 Q. In this case, was there a document prepared
19 called the staff report --

20 A. No.

21 Q. -- in connection with this ordinance?

22 A. No.

23 Q. So, when the staff report was delivered to the
24 council, who delivered it?

25 A. Ernest Mueller presented the staff report.

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1 Q. And this would have been verbally on his -- as
2 part of the public record of the City Council meeting?

3 A. Correct.

4 Q. Were you at that meeting?

5 A. Yes.

6 Q. What participation did you have in preparing the
7 content of that staff report?

8 A. I assisted with the research on the legal issues
9 and met with Ernie, discussing those. And then we
10 looked at the other ordinances that were being passed in
11 the other jurisdictions in Florida. We looked at the
12 California bill, the New Jersey bill. We looked at that
13 case law, talked about it like lawyers do.

14 Q. What was the specific charge given to the legal
15 department regarding the -- what needed to be in this
16 particular staff report?

17 A. I can't say -- it would be a matter of public
18 record, the motion that the council member made. And we
19 would have been looking at that specific language of
20 that motion and following that to hopefully bring
21 information that was pertinent to that request.

22 Q. And did the staff report provided to the council
23 satisfy what Mr. Maniscalco had requested?

24 A. I can't speculate to whether or not he was
25 satisfied with our --

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1 Q. I just mean --

2 A. -- our presentation.

3 Q. -- in the sense of there's a public record of
4 what he requested, and then the staff report was
5 delivered. Is it, generally speaking, your position
6 that whatever he requested was satisfied, that whatever
7 information he asked for was given?

8 A. He made a motion for a staff report.
9 Ernest Mueller provided the staff report at the public
10 hearing.

11 Q. And then it's my understanding that, following
12 that hearing a -- or, at that hearing, a vote was taken
13 to move to the next step; is that correct?

14 A. Correct.

15 Q. And what was the next step in the drafting of the
16 ordinance?

17 A. It's my understanding that the next motion that
18 was made -- and, again, this would all be part of the
19 record; so, if I misspeak on a specific, then it's in
20 the record somewhere. But it's my understanding that it
21 was moved forward to what they call first reading of the
22 ordinance. And we were directed to bring back a -- a
23 draft in ordinance form that would be in a proper form
24 to go to that step of first reading.

25 Q. And who prepared that draft?

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1 A. There were three people that I know that were
2 involved in -- in preparing the draft. That would be
3 Ernest Mueller, myself and Erin Bradley.

4 Q. Who is Erin Bradley?

5 A. I believe that her title is paralegal. I don't
6 know what specifically her title is. But she's one of
7 the assistants with -- at the City Attorney's Office.

8 Q. Is she assigned to a particular city attorney?

9 A. Yes.

10 Q. Who is that?

11 A. Ernest Mueller is one of her attorneys that she
12 works for. I think she works for other attorneys, as
13 well; but I don't know --

14 Q. Okay.

15 A. -- specifically who.

16 Q. Okay. What was your role in drafting that
17 ordinance for the first reading?

18 A. Just research assistance.

19 Q. Did you draft any of the language?

20 A. I believe I may have drafted some of the whereas
21 clauses -- one of the whereas clauses. I can't recall
22 specifically. There was some discussion about -- about
23 that.

24 Q. About the whereas clauses?

25 A. Right.

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1 Q. What was the discussion?

2 A. Just -- there's lots of discussion, I mean, you
3 know, the nature of them, what they -- what they're
4 referring to. I looked at the papers to make sure that
5 the language that we were quoting that was coming from
6 was actually contained in those research papers. And
7 then, of course, the whereas clause being the predicate
8 for the ordinance and also the articulation of the
9 intents and purposes of the ordinance, it was a pretty
10 important aspect of the ordinance.

11 Q. Did your research lead you to discuss with any
12 persons outside of the City, you know, any of the
13 content or potential content of the draft ordinance?

14 A. No. Well, let me see if I understand your
15 question. Are you -- when you refer to my research, are
16 you talking about more generally? And...

17 Q. I'm speaking of -- you know, you mentioned that
18 you provided -- your role in drafting that first draft
19 of the ordinance included research assistance.

20 And so my question is: Did that -- did your
21 research lead you to discuss what should be in the
22 ordinance with anyone outside the City?

23 A. No.

24 Q. Okay. Do you know whether anyone else involved
25 in the drafting of the ordinance discussed the content

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1 of that draft with persons outside of the City? And I
2 mean just outside of the City's employment, not
3 necessarily outside the City's limits.

4 A. Yes. I'm of the understanding that Ernie had a
5 discussion with one of the attorneys from one of the
6 jurisdictions down south that we were directed by
7 council to look at as model -- as a model ordinance.

8 Q. Do you remember which jurisdiction it was?

9 A. I believe it was Palm Beach County.

10 Q. And do you know who the attorney was in Palm
11 Beach?

12 A. Ms. Hvizd.

13 Q. H-v-i-z-d. It's Helene -- she pronounces it
14 Hvizd.

15 A. Hvizd. Okay. I'm not sure how she pronounces it
16 exactly.

17 Q. I assume we're talking about the same person.

18 A. Yes. I assume so, as well. But I never spoke
19 with her personally. But it's my understanding that
20 Ernie may have had a conversation with her.

21 Q. Do you know whether Ernie or Ms. Bradley or
22 anyone else involved in drafting the ordinance had
23 conversations with, for example, Equality Florida
24 regarding the content of the ordinance?

25 A. Do I know? I don't know of any conversations

Page 35

1 between --

2 Q. What about -- same question but, instead of
3 Equality Florida, Southern Poverty Law Center?

4 A. No. I'm not aware of any conversations between
5 the City Attorney and that organization.

6 Q. How about the NCLR or National Center for Lesbian
7 Rights?

8 A. Same.

9 Q. How about a man named Rand Hoch from Palm Beach
10 County?

11 A. Same.

12 Q. All right. So who -- at some point, a draft of
13 the ordinance was prepared, correct?

14 A. I'm not sure exactly what -- what do you mean by,
15 "draft"? You know, obviously, at some point, we came to
16 council with an ordinance in ordinance form, yes.

17 Q. Right. Okay. So let's work backwards from
18 there. At the meeting that we'll call the first reading
19 of the ordinance, a draft in ordinance form was
20 presented to the council for vote, correct?

21 A. Correct.

22 Q. Who prepared that document, that draft ordinance?

23 A. The scrivener's work was done by Erin Bradley and
24 then under the direction of myself and Ernest Mueller.

25 Q. Okay. Were there multiple versions or multiple

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1 drafts prepared before the final one that went to the
2 City was done?

3 A. I don't -- I don't know about that. I mean, I'm
4 not sure how to answer that question.

5 Q. Did you ever take a draft of the ordinance and
6 mark it up or make changes to it for Ms. Bradley, you
7 know, to work on or to, you know, get the final version
8 done?

9 A. No.

10 Q. Do you know whether anyone else did that?

11 A. I don't know.

12 Q. And, from the time that it was voted on at the
13 first reading to the enactment at the second reading,
14 were any changes made to the ordinance?

15 A. Yes.

16 Q. And what changes were those?

17 A. Well, I can't -- I don't recall specifically word
18 for word what the changes would be. And that would also
19 be something that would be a record that you could look
20 at to get the specifics. But I know that there was some
21 discussion about the enforcement process and some of the
22 enforcement provisions.

23 Q. All right. In the process of getting the draft
24 from, you know, first created for that first reading
25 meeting and then ultimately enacted at the second

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1 reading meeting, were there meetings between members of
2 the City Attorney's Office and individual council
3 members regarding the ordinance?

4 A. Yes.

5 Q. Can you generally tell me, you know, how many
6 meetings occurred and who was involved in those?

7 A. Just rough estimate that there would have been at
8 least one meeting with each individual council member.
9 There may have been two, but I don't recall.

10 Q. What would be the point of that at least one
11 meeting that you're aware of or believe happened?

12 A. The point would be for us to advise our clients
13 on all of the legal issues and just generally provide
14 legal advice to our client.

15 MR. WILLIAMS: And that's as far as we go on
16 that. As far as the attorney-client privilege.

17 BY MR. GANNAM:

18 Q. Is that part of the normal course of developing a
19 piece of legislation, for there to be a -- a meeting at
20 some point before enactment between City Attorney staff
21 and individual council members?

22 A. Yes.

23 Q. And is it also part of that general practice that
24 all the council members will receive the same
25 information at their individual meetings?

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1 A. The council members will receive information
2 based on what questions that they ask in the meetings
3 that we have. So I don't know if I can answer your
4 question the way that you phrased it.

5 Q. Okay.

6 A. You meet with someone. They might have different
7 questions, and that might result in different
8 information being provided.

9 Q. Fair enough. Is it the general practice that
10 each council member will have the same access to
11 information from the City Attorney's Office as all the
12 other council members?

13 A. Yes.

14 Q. In this case, was that the case that each council
15 member had an opportunity or the same access to
16 information from the City Attorney's Office regarding
17 this ordinance?

18 A. We met with each of the council members. And I
19 guess you should know that, you know, the Sunshine Law
20 prohibits us from being conduits or channels. So to the
21 extent that, you know, we're bound to those legal
22 requirements.

23 Q. And just so I can clarify. What you mean is that
24 Council Member Maniscalco would not -- it wouldn't be
25 proper for him to tell you, hey, pass a message along to

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1 council member so and so that I'm going to support the
2 bill; and I think he should too? Just for example.

3 A. Yes.

4 Q. That would be an improper practice?

5 A. Correct.

6 Q. So, apart from, you know, sort of being a conduit
7 or passing messages between council members, each
8 council member had the same opportunity to ask questions
9 about whatever they needed to know in connection with
10 the ordinance, correct?

11 MR. WILLIAMS: Or she.

12 MR. GANNAM: He or she. Very good.

13 BY MR. GANNAM:

14 Q. In this case, you know there was at least one
15 meeting, possibly more than one. But, in any case, it
16 would have been the same number of meetings with each
17 council member, correct?

18 A. I can't recall specifically if another council
19 member had requested a follow-up meeting or if there
20 was -- if there were more -- if there was more than one
21 meeting. It would have all been calendared --

22 Q. Okay.

23 A. -- in the public -- in -- and, therefore, a
24 public record would have been created of those meetings.
25 But I don't recall specifically if anyone requested a

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1 follow-up. Our office arranged a meeting with each of
2 the council members.

3 Q. And that was as a matter of a normal practice?

4 A. That's correct.

5 Q. Would it be accurate to say then that whatever
6 information was delivered to council members at any one
7 of those meetings would be fairly viewed as information
8 considered by the council in connection with the
9 enactment of this ordinance?

10 A. Well, I think that depends on how you're defining
11 considered. As a legal matter -- I mean, I guess I
12 don't really understand the question.

13 Q. Okay. Fair enough.

14 In deciding what did the City of Tampa consider
15 in connection with the enactment of this ordinance, just
16 trying to figure out where to draw the line. I think
17 it's obvious that anything shared at a public meeting of
18 all the council members would be fairly said information
19 considered by the council. Do you agree with that?

20 A. Anything provided at a public hearing during the
21 course of the enactment would be -- would be part of the
22 consideration, the legal considerations of the body.

23 Q. So to what extent is information shared with an
24 individual council member at one of these series of
25 meetings that occur with all the council members

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1 considered -- information considered by the council?

2 A. Again, I'm just struggling with your -- what's
3 considered -- it seems like you're asking for me to
4 speculate on what -- whether or not a council member was
5 -- what they were thinking or what they weren't thinking
6 and -- about a meeting that my attorney is telling me is
7 privileged. And so I'm not sure --

8 Q. Okay.

9 A. -- I still don't understand your question.

10 Q. Fair enough. Is there any record kept or minutes
11 taken at these individual meetings of council members?

12 A. No.

13 Q. So the only way to know what was said at any one
14 of these meetings would be to ask either the council
15 member or the City Attorney staff members who were
16 present, correct?

17 A. Right.

18 Q. How many of these meetings did you personally
19 attend?

20 A. I don't remember. Maybe three.

21 Q. And how many council members are there?

22 A. Seven.

23 Q. Seven? Okay.

24 And is that -- would that be usual that you
25 wouldn't necessarily go to all of them yourself, that

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1 you guys split them up?

2 A. Yes. Being that I was not the actual lead
3 attorney of record presenting the -- the ordinance, I
4 was just a secondary assisting with research, it's usual
5 that I would come as available to the meetings with
6 council members.

7 Q. I'm going to show you a document that I'll mark
8 as Exhibit 20 -- I'm sorry, 19.

9 (Plaintiffs' Exhibit No. 19 marked for identification)

10 THE WITNESS: This is -- mine is marked as
11 19.

12 MR. GANNAM: 19, yes. 19 is correct. I
13 misspoke.

14 BY MR. GANNAM:

15 Q. This was produced as COT PRODUCTION 001736. The
16 first page shows it's from Heather Herlene or Herlein.
17 It's dated Tuesday, February 6, 2018, to
18 Kimber Spitsberg. The subject says, restricted, per
19 your request. And it refers to about seven attachments
20 that are all .msg files, which I understand to be
21 Microsoft Outlook e-mail messages.

22 First, let me ask you is: Is this document
23 familiar to you at all?

24 A. No.

25 Q. Before today, have you ever seen it before?

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1 A. Not to my knowledge.

2 Q. I'm going to ask you to flip to the second page.

3 Says, subject, meeting with Charlie Miranda, dash,
4 conversion therapy; location, Councilman Miranda's
5 office; start, February 27, 2017, ten-thirty a.m. And
6 it has, organizer, Heather Herlein; required attendees,
7 Ernest Mueller; and resources, Councilman Miranda's
8 office.

9 I know I didn't read everything. But the
10 portions that I did read, did I read them correctly?

11 A. Yes.

12 Q. Do you recognize the format of this document to
13 the extent you could identify, you know, what it is or
14 where it came from?

15 A. No.

16 Q. Do you know who Heather Herlein is?

17 A. Yes.

18 Q. Who is that?

19 A. I believe her title is executive aide.

20 Q. Is that executive aide to any particular person?

21 A. Yes. The executive would be the City Attorney.
22 And, again, I don't recall at the time whether that was
23 Sal Territo or Julia Mandell.

24 Q. So Ms. Herlein works directly for the City
25 Attorney?

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1 A. Yes.

2 Q. Who is Kimber Spritzberg?

3 A. She's a paralegal at the City Attorney's Office.

4 Q. Is she assigned to any particular attorney?

5 A. Yes.

6 Q. Who is that?

7 A. Yeah. I don't know specifically who she's
8 assigned to.

9 Q. This subject on the first page, it says,
10 restricted per your request. Have you ever seen that
11 before on a -- on a city e-mail or e-mail within the
12 City Attorney's Office?

13 A. I've seen restricted.

14 Q. Is that a -- is that some kind of term of art
15 used within the City Attorney's Office, or is that
16 pursuant to some internal procedure that certain e-mails
17 should be designated restricted?

18 A. I don't know that there's any written procedure
19 within the office. But the -- the intent of flagging a
20 message with restricted is to sort of put a person who
21 is going to be reviewing a public records request that
22 the nature of this communication might fall under one of
23 the exemptions under public records. So it could be --
24 it could not -- it might not be a public record. But
25 the paralegals don't make that decision. But they --

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1 here, it says, per your request. I think the
2 implication is that someone informed the sender of this
3 message that it could potentially be restricted content.
4 It doesn't mean that it is or isn't. That would be
5 determined at the time that the document was requested.

6 Q. Going back to that -- let me ask you to go to the
7 third page. It shows --

8 MR. WILLIAMS: For the record, that's
9 001738?

10 MR. GANNAM: That's correct.

11 BY MR. GANNAM:

12 Q. Appears to be an e-mail message from
13 Heather Herlein dated February 24, 2017, to Mary Bryan.
14 Do you know who Mary Bryan is?

15 A. Yes.

16 Q. Who's that?

17 A. She's a legislative aide.

18 Q. For whom?

19 A. Charlie Miranda.

20 Q. Is Charlie Miranda one of the council members --

21 A. Yes.

22 Q. -- at this time?

23 It reads, hey Mary, when you get a chance, could
24 you give me a call. I'm trying to find a few minutes
25 for Charlie and Ernie to discuss conversion therapy

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1 before the March 2nd meeting.

2 Would this be the way that one of these meetings
3 with an individual council member is set up by your
4 office to discuss pending legislation?

5 A. Did you say would this be one of the ways? Is
6 that your question or --

7 Q. Yes.

8 A. Yes.

9 Q. I take it you've never seen this particular
10 message before?

11 A. No.

12 Q. Okay. So, as you sit here, you're -- strike
13 that.

14 This would be consistent with the practice of
15 your office in setting up meetings with individual
16 council members to discuss pending legislation, correct?

17 A. This would be one of the ways that we would set
18 up a meeting with a council member.

19 Q. Okay. What other ways might it be done?

20 A. Over the phone requesting a date. They may even
21 just rely on the Outlook calendars that are publicly
22 available and send an invite.

23 Q. So there's no policy that you only do it this way
24 or you only do it another way?

25 A. Not that I'm aware of.

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1 Q. Okay. We can move on.

2 (Plaintiffs' Exhibit No. 20 marked for identification)

3 BY MR. GANNAM:

4 Q. Show you a document that I'll mark as Exhibit 20.

5 This is marked as COT PRODUCTION 004832. It says, from

6 Tatiana Henao; dated February 13, 2017, to

7 Ernest Mueller; subject, conversion therapy, West Palm

8 Beach, Business Regulation. And there's an attachment.

9 Do you recognize this document?

10 A. I believe I do, yes.

11 Q. What is it, to your knowledge?

12 A. It's an e-mail.

13 Q. What is the -- the e-mail concerning -- or strike

14 that.

15 Does this concern the ordinance?

16 A. Yes.

17 Q. Who is Tatiana Henao?

18 A. She is a -- was a legal intern for the City.

19 Q. Is she still a legal intern with the City?

20 A. No.

21 Q. What was her involvement in the drafting of the

22 ordinance?

23 A. Ernie assigned research -- a couple of research

24 topics to her to look at.

25 Q. Are you familiar with why the West Palm Beach

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1 Business Regulation Ordinance was being looked at in
2 connection with Tampa's conversion therapy ordinance?

3 A. Yes.

4 Q. What was the purpose of that?

5 A. It was part of our discussion about overall
6 enforcement methods.

7 Q. When you say, "our discussion," who are you
8 talking about?

9 A. The legal department.

10 Q. And what was -- what was the -- what was that
11 discussion about? Were different kinds of enforcement
12 considered?

13 A. Yes.

14 Q. Well, what was considered?

15 A. Well, here, she was looking at what they call --
16 what some people refer to as business operating permits,
17 whether or not you could require a permit to engage in
18 certain activity within the City; and then the
19 enforcement mechanism then becomes revocation of the
20 permit.

21 Q. And did the City consider or -- I'll ask you
22 specifically. Did the City -- strike that. I'll start
23 again.

24 Did the City of Tampa consider as an alternative
25 to its conversion therapy ban instead creating some kind

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1 of licensing or permitting scheme for providers of
2 conversion therapy within the City of Tampa?

3 A. Again, your -- it gets to -- it's sort of the
4 same issue that I had with the previous question about
5 what it means to consider.

6 Q. Okay.

7 A. I don't really understand.

8 Q. Was there ever any formal request from the City
9 Council to examine any alternative to the ban that was
10 enacted, such as, for example, a licensing or permitting
11 scheme that would apply to providers of conversion
12 therapy?

13 A. No. We were not formally directed by the City
14 Council to -- to consider a permitting scheme.

15 Q. And, in the general course of -- of researching
16 and drafting legislation for the City Council, does the
17 City Attorney's Office undertake research on its own
18 initiative to look at alternatives to what the City
19 Council has requested just as part of its
20 responsibilities to the council?

21 A. We follow the professional rules of
22 responsibility in advising an organizational client.
23 And so that would mean providing advice on multiple
24 facets, not just the legal issues, but what other issues
25 that might be tangential to the -- the issue that's --

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1 that's at hand. So...

2 Q. I don't know if you were in here when Council
3 Member Maniscalco testified that, from his perspective,
4 what he asked for was an ordinance comprehensively
5 banning all conversion therapy; and that's what the City
6 enacted. Who would have initiated this line of research
7 or considered of let's look at permitting as a possible
8 means of enforcement against conversion therapy?

9 A. Well, Ernest Mueller was the lead attorney
10 responsible for presenting the ordinance. So he would
11 have been the one directing the members of the legal
12 department with various issues. Myself being an
13 attorney, as well, I would have followed whatever lead
14 that I felt was appropriate in order to give my client,
15 the City, comprehensive advice.

16 Q. Was information about permitting or licensing
17 included in the staff report, the initial staff report
18 to the City Council?

19 A. I don't recall all of the specifics of what Ernie
20 presented to the City Council. So I would -- I would
21 just refer you to the -- to that public hearing for what
22 was presented on that.

23 (Plaintiffs' Exhibit No. 21 marked for identification)

24 BY MR. GANNAM:

25 Q. Let's look at Exhibit 21. This is an e-mail

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1 dated February 24 from Mr. Mueller to Tatiana Henao,
2 subject, assignment. This was produced as COT
3 PRODUCTION 004830. Do you recognize this e-mail?

4 A. Yes.

5 Q. And what's going on in this e-mail?

6 A. Ernie's giving an assignment to an intern.

7 Q. And what is the nature of that assignment?

8 A. To research whether including enforcement of the
9 conversion therapy ordinance against religious
10 organizations would violate the Religious Freedoms Act.

11 Q. And do you know whether Ms. Henao delivered an
12 answer to Mr. Mueller on this question?

13 A. Yes.

14 Q. And what was the answer?

15 A. She provided a memo, and I believe the general
16 answer was no.

17 Q. And was this information shared with the City
18 Council?

19 A. Not to my knowledge.

20 Q. Was there a reason that information wasn't shared
21 with the council?

22 A. I don't know if there was a reason. I would just
23 say that, generally speaking, we don't provide
24 information that they don't ask for or that we don't
25 feel is pertinent and relevant to what they're asking us

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1 to do. And, if we came to the decision that it was not
2 going to violate that particular act, then we wouldn't
3 discuss that with them if we didn't feel like it was
4 going to be something that was going to be an issue,
5 unless, of course, they thought it was an issue and
6 asked us for it.

7 (Plaintiffs' Exhibit No. 22 marked for identification)

8 BY MR. GANNAM:

9 Q. Here's Exhibit 22. It's an e-mail from
10 Jerrod Simpson dated February 27, 2017, to
11 Ernest Mueller at Bates number COT PRODUCTION 004840.
12 Do you recognize this communication?

13 A. Yes.

14 Q. And this is a -- an e-mail you sent to
15 Mr. Mueller, correct?

16 A. Yes.

17 Q. It reads, looking at the literature from the
18 professional communities, it seems that conversion
19 therapy, in quotes, is a layman term and that the proper
20 term would be sexual orientation change efforts, or
21 SOCE, which is also referred to as reparation therapy or
22 conversion therapy. I don't know if you want to change
23 that or not.

24 Were you presenting this as a question to
25 Ernest Mueller in connection with drafting the

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1 ordinance?

2 A. Yes.

3 Q. And did he answer the question?

4 A. Not in an e-mail.

5 Q. Did he answer it in some other way?

6 A. We discussed it as part of our general
7 discussion; and we ended up, obviously, keeping the
8 conversion therapy being that that's the -- the term
9 that's generally used even though, in the medical
10 literature, it seems that sexual orientation change
11 efforts was the more proper way to refer to it. But we
12 feel like that was kind of covered in the definitions.

13 Q. What literature from the professional communities
14 were you referring to?

15 A. The literature that's cited in the ordinance.

16 Q. Anything besides the literature cited in the
17 ordinance?

18 A. No.

19 Q. The second paragraph reads, also I'm creating a
20 k:drive folder where I'm saving all the resolutions from
21 the various professional organizations that have
22 formally opposed the practice.

23 First of all, what is a k:drive folder?

24 A. It's a shared network that everyone in the legal
25 department has access to.

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1 Q. And is that limited to the legal department?

2 A. I don't know.

3 Q. That's not a -- I guess what I'm getting at is
4 there's not one k:drive for the whole City of Tampa,
5 correct?

6 A. Correct. As far as I understand, there's -- I
7 mean, I don't know -- I don't work for the Tech -- T&I
8 department, Technology & Innovation department. So I
9 can't speak to that. And it wasn't on the topics, so I
10 didn't prepare myself on that subject. But --

11 Q. Okay.

12 A. -- the k:drive is a drive that everyone in the
13 legal department can -- I can put a document in there,
14 and anyone in the legal department can access it.

15 Q. Earlier when you talked about your file that you
16 reviewed, you said that that was an electronic file. Is
17 it located on the k:drive?

18 A. Yes.

19 Q. Now, when you said all the resolutions from the
20 various professional organizations, is that synonymous
21 with literature from the professional communities in the
22 paragraph before?

23 A. Well, I don't know if it's synonymous. But just
24 to say that the gist of what I was saying is that I was
25 trying to obtain the literature that we were going to

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1 rely on and put it in a file where Ernie and I could
2 both access it. That was what I was trying to convey
3 there.

4 Q. Okay. Is there any literature or resolution
5 identified in the ordinance that's not covered by these
6 two descriptions in this e-mail, being, literature from
7 the professional communities and resolutions from the
8 various --

9 A. I don't --

10 Q. -- professional organizations?

11 A. I'm sorry. I don't know.

12 Q. Did you read any professional literature or
13 resolutions from professional organizations that did not
14 end up being identified in the ordinance ultimately?

15 A. I guess you'll have to clarify that question for
16 me. Like, organization, professional organiz -- like,
17 what would be considered --

18 Q. Okay.

19 A. -- an organization?

20 Q. The ordinance recites several papers and studies
21 and resolutions from various organizations like the
22 American Psychological Association. Are you with me so
23 far?

24 A. Uh-huh.

25 Q. I'm asking you did you personally read or look

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1 for papers or studies or resolutions relating to
2 conversion therapy that are not recited in the ordinance
3 itself?

4 A. Yes.

5 Q. And what did you -- what did you look at in terms
6 of literature that's not recited in the ordinance
7 itself?

8 A. Well, I recall reading some -- maybe some news
9 articles. I read a -- I think the White House had a
10 position statement on the issue. I was looking for
11 other -- other relevant literature. I don't know,
12 again, what literature exactly -- what that means. But
13 I was researching as part of the issue a number of
14 things that were not ultimately references in the
15 ordinance.

16 Q. And assuming those things were relevant to the
17 issues covered by the ordinance, why were they not
18 included in the recitals of the final ordinance?

19 A. We included everything that we felt was necessary
20 to both establish the predicate, reenforce the
21 compelling interest. If, in fact, the ordinance would
22 be subject to strict scrutiny -- I don't know that we
23 had a clear answer to that at the time -- but the
24 whereas clauses would be part of establishing what the
25 City, as a body, considered. And using that -- the term

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1 considered in the legal sense that, you know, we cited
2 to it in the whereas clauses; therefore, it becomes part
3 of the predicate of the ordinance. So we put what we
4 felt was necessary in there. I don't think we -- I
5 don't think we went above and beyond. We wouldn't cite
6 to something that we didn't feel was necessary or
7 helpful to what we were doing.

8 Q. Who ultimately had the authority to make that
9 call as to whether a particular piece of literature went
10 into the whereas clauses or didn't make it in there?

11 A. Well, the City Council, as a body, has control
12 over the ordinances that they pass.

13 Q. Who would have had the authority to make the call
14 as to whether it went into the draft that was first
15 presented to the City Council?

16 A. Ernest Mueller would have been the one who would
17 have, you know, signed off on what the document that was
18 presented to City Council to consider.

19 (Plaintiffs' Exhibit No. 23 marked for identification)

20 BY MR. GANNAM:

21 Q. This is Exhibit 23. This is another e-mail from
22 Jerrod Simpson to Ernest Mueller dated February 27,
23 2017, Bates number COT PRODUCTION 004839. Do you
24 recognize this e-mail?

25 A. Yes.

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1 Q. What are you talking about in this e-mail?

2 A. Conversion therapy.

3 Q. And it refers, again, to all the policy
4 statements from the various medical and professional
5 organizations on conversion therapy. I placed them in
6 my k:drive folder labeled conversion therapy. I can
7 draft a much more robust set of whereas clauses with
8 these than the other cities. Let me know if you'd like
9 me to do that.

10 Did I read that correctly?

11 A. Yes.

12 Q. Did Mr. Mueller respond to your offer to draft
13 more robust whereas clauses?

14 A. I don't recall whether he did or not.

15 Q. Did you, in fact, draft more robust whereas
16 clauses than other cities had done?

17 A. Like I stated earlier, I believe that I may have
18 added one additional whereas clause. But I don't recall
19 specifically which -- which one that I -- that I added.

20 Q. Which other cities did you have in mind when you
21 wrote this e-mail?

22 A. The ones -- the cities that we were -- that we
23 had -- looked at for ordinances that we had already were
24 kind of looking at as sort of a template to follow,
25 which would be Palm Beach County, Miami Beach. There's

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1 another one that I can't remember right now off the top
2 of my head.

3 Q. Okay. But it was more than two?

4 A. Yeah. I think there were three or four
5 ordinances that had been passed. There were also the
6 two state -- statewide bans in California and
7 New Jersey. All of those things were things that we
8 were looking at for the model language.

9 Q. In terms of the whereas clauses in the other
10 cities' ordinances that you had looked at, were they
11 generally the same in those other cities as compared to
12 each other?

13 A. Generally, yes. I think all the ordinances were
14 -- yeah, even the state bills themselves were very --
15 were generally similar in their definitions of
16 conversion therapy and the language of the ban, the
17 actual prohibition language.

18 Q. And, having reviewed those other cities' whereas
19 clauses, did you conclude that there was a need for
20 Tampa's ordinance to have a more robust set of whereas
21 clauses?

22 A. No.

23 Q. Why did you offer to draft more robust whereas
24 clauses?

25 A. Well, because the whereas clauses, again, they're

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1 kind of -- they act as the legislative findings of the
2 body. And if we -- if the City Council wanted to have a
3 more extensive set of findings -- there's much more
4 information in the literature that we were citing than
5 what we quote -- in what we ultimately quoted. So
6 those -- we could have put more information from the
7 literature in there which could have further I guess
8 just reiterated our predicate and also help to guide the
9 intents and purposes portions of the ordinance for the
10 administration that we -- once they begin to enforce the
11 ordinance.

12 Q. Can you give me an example of the kind of
13 information that you had in mind that you could have
14 included in the whereas clauses?

15 A. No.

16 Q. Did you have something specific in mind when you
17 wrote this e-mail?

18 A. Not to my recollection.

19 Q. At the end of the day, when Tampa's ordinance was
20 enacted, did its whereas clauses look similar to the
21 whereas clauses of the other cities in Florida that had
22 already enacted ordinances?

23 A. Generally speaking, yes. We kept most of the
24 language that was included in the other ordinances.

25 MR. GANNAM: Why don't we take a break, a

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1 comfort break. We'll try to come back soon.

2 (Recess)

3 BY MR. GANNAM:

4 Q. Mr. Simpson, can you get Exhibit 4, the ordinance
5 itself, back in front of you, please.

6 A. I have it.

7 Q. Let's talk about what's actually prohibited by
8 this ordinance. Can we go to the definitions on page
9 five. So this reads: "Conversion therapy or reparative
10 therapy means, interchangeably, any counseling, practice
11 for treatment performed with the goal of changing an
12 individual's sexual orientation or gender identity."

13 I'm going to stop there. Did I read that
14 correctly?

15 A. Yes.

16 Q. So, when it says performed with the goal of
17 changing an individual's sexual orientation or gender
18 identity, whose goal is relevant to determining whether
19 a violation of this ordinance has occurred? And when I
20 say, "whose," I mean, the provider's goal or the
21 client's goal?

22 A. The provider's.

23 Q. So, if a provider of counseling or therapy has no
24 particular goal at all regarding changing an
25 individual's sexual orientation or gender identity by a

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1 client presents to that provider -- and let's say it's
2 a teen-age boy -- and he tells the provider, I would
3 like to change my sexual orientation because I don't
4 like my -- my attraction to -- my same-sex attraction.
5 If the counselor obliges the client, obliges the
6 client's goal, that is, has the provider violated the
7 ordinance?

8 MR. WILLIAMS: Object to the form of the
9 question as being overly broad and imprecise. And, to
10 the extent that it purports to be a hypothetical, it's
11 incomplete and improper.

12 You may give it your best shot, Mr. Simpson.

13 THE WITNESS: Well, yeah, I mean, I -- if he
14 hadn't objected, I would have just pointed out a few
15 points of confusion that I have with your question. But
16 one of the issues that I have with your question is that
17 it seems that you seem to be isolating -- isolating the
18 goal as if -- as if the -- when the patient comes to the
19 provider with a goal and then the -- from your hypo, it
20 sounded almost like the provider would then adopt that
21 goal and then carry forward with the therapy. So that's
22 what I'm -- I'm a little unclear with the way that you
23 present the hypothetical, whether or not in your -- in
24 your scenario, that the provider is then adopting that
25 goal.

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1 BY MR. GANNAM:

2 Q. I think you've identified the crux of the issue.

3 So I'll ask it, again. Maybe try to clarify.

4 If the provider's goal is simply to accommodate
5 whatever the client wants and -- let me back up.

6 If the provider's goal is to accommodate whatever
7 the client wants to relieve, whatever distress the
8 client is experiencing, and the client presents with the
9 goal expressed to the provider that I want to change my
10 sexual orientation, will you help me, does -- is it the
11 City's position that, if the provider then obliges that
12 client, that it then becomes the provider's goal to
13 change the child's sexual orientation and, therefore, is
14 violating the ordinance?

15 MR. WILLIAMS: Same objection.

16 I'll use the phrase same objection to refer
17 to the objection that I made to the prior question.
18 That might save some time.

19 THE WITNESS: I mean, there's a lot of --
20 just to flat answer your question, no, that the City
21 would not assume one thing or another based on the hypo
22 as you present it. There's going to be a lot of facts
23 in any of these cases. And the City would have to look
24 at all the totality of the circumstances to determine to
25 what extent there was coercion or what goals were had,

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1 what was consented, what wasn't consented to. So I
2 don't think that I -- based on how you present it, that
3 I could take a position as to whether or not that would
4 be the goal of the provider.

5 BY MR. GANNAM:

6 Q. Now, when I read the ordinance, I don't see the
7 word coercion or consent in this definition of
8 conversion therapy. So my question would be: What do
9 those concepts have to do with whether a provider is
10 violating this ordinance or not?

11 A. What does coercion and client consent have to do
12 with the violation of the ordinance?

13 Q. Right.

14 A. Well, I mean, if you look at -- I'll just refer
15 you to the definitions here. It says that conversion
16 therapy -- in the definition of conversion therapy or
17 reparative therapy it says that it does not include
18 counseling that provides support and assistance to a
19 person undergoing gender transition or counseling that
20 provides acceptance, support and understanding of a
21 person or facilitates a person's coping, social support
22 and development.

23 So I'm a little confused in the context that
24 you're presenting to me of whether or not the therapist
25 is providing that acceptance support and understanding,

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1 social support and development or if they're providing
2 therapy that is seeking to change sexual orientation.

3 Q. In the example I gave you, the -- as I said, the
4 provider does not have a predetermined goal when the
5 client enters the office. The therapist or the
6 provider -- the provider's only goal is to accommodate
7 whatever help the client wants. And so the client
8 expresses a desire to change sexual orientation. And
9 the therapist is -- you know, supports and accepts and
10 affirms that goal of the client. Is that -- is that
11 therapist going to violate this ordinance by giving the
12 client the therapy or the help that the client wants?

13 A. I mean, I take a little -- I just still can't
14 really understand your question. But I'll try to answer
15 it another way and see if I can give you something that
16 you -- that you find acceptable.

17 MR. WILLIAMS: Subject to my same objection,
18 by the way.

19 Go ahead, please.

20 THE WITNESS: If the goal of the treatment
21 is to change the sexual orientation, whether that is the
22 goal from the outset or at the moment that that becomes
23 the goal, that -- then that creates a violation of the
24 ordinance as it's written. So if the client -- or the
25 patient comes in and then articulates a goal and then it

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1 becomes the therapist's goal to change the patient's --
2 the therapist is the one who's subject to violating the
3 ordinance, not the patient. So it's the goal of the
4 therapy that they're providing. They're the one that
5 would be the potential violators. So, once it becomes
6 their goal to change sexual orientation or gender
7 identity, then it becomes a violation of the ordinance.

8 BY MR. GANNAM:

9 Q. So, if the City determines that the therapist has
10 adopted the client's goal of changing sexual orientation
11 or gender identity, then it's the therapist at that
12 point is subject to liability under the ordinance for
13 providing therapy the goal of which is to change sexual
14 orientation or gender identity?

15 A. If the therapist has adopted the goal of changing
16 sexual orientation or gender identity, then they have
17 violated the ordinance.

18 Q. And, just to clarify, that would be true even if
19 the goal initially came from the client's request and
20 not -- and was not initiated by the therapist?

21 A. Yes.

22 Q. Give you a little bit different scenario.
23 Suppose a prepubertal child about ten years old who was
24 born biologically as a boy but has expressed a female
25 gender identity, does the ordinance prohibit a therapist

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1 from encouraging that child to embrace, you know, his
2 given male body and to align with a male gender role?

3 A. I can only speak to the -- your kind of
4 paraphrasing the definitions and the terms of art within
5 the ordinance. And so I don't think that they're really
6 -- the terms that are chosen in the ordinance were
7 chosen for a reason. So I don't know that I would
8 characterize it like that. I'm not sure I understand
9 exactly what you're asking also. If you could rephrase,
10 maybe I can understand.

11 Q. Yeah. I'll break it up. So we start with a
12 ten-year-old boy. Okay? Are you following me so far?

13 A. Right.

14 Q. And, when I say, "a ten-year-old boy," born
15 biologically as a boy. So far so good?

16 A. Uh-huh.

17 Q. But that boy has expressed a female gender
18 identity. Are you with me?

19 A. Not entirely. I mean, what do you mean by that?

20 Q. Well, what does gender identity mean in this
21 ordinance?

22 A. Gender identity isn't defined in the ordinance.

23 Q. How does the City interpret it?

24 A. The City would interpret it based on Webster's
25 Ninth Dictionary.

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1 Q. And what does Webster's Ninth Dictionary say?

2 A. I don't know off the top of my head. But I -- if
3 you want to pull it up, we can look at it.

4 Q. I'm asking you, you know, as the City's designee
5 to answer questions about interpretation of the
6 ordinance.

7 A. Right.

8 Q. So, as we sit here right now, do you know how the
9 City would interpret gender identity as that term is
10 used in this ordinance?

11 A. Based on Webster's Ninth Edition.

12 Q. Is that something you've looked at before?

13 A. I have not looked -- I mean, I think, at some
14 point, I looked at the definition of gender identity in
15 Webster's Ninth. But I can't recall -- you know, I
16 can't recite to you what Webster's Ninth says about
17 gender identity.

18 Q. And who at the City has determined that -- I'll
19 start over. Who at the City determined that the
20 definition of gender identity in Webster's Ninth
21 Dictionary is the controlling definition for purposes of
22 this ordinance?

23 A. Well, in the general provisions of the City's
24 code, if a term is not defined within a chapter
25 specifically or within an ordinance or wherever the term

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1 might be defined more specifically, if the term isn't
2 defined in one of those ways, then, under our default
3 general provisions, it would default to the Webster's
4 Ninth definition.

5 Q. That's provided explicitly in the City ordinance
6 code?

7 A. Yeah. I believe it's Chapter 1, somewhere in
8 Chapter 1.

9 Q. Do you know whether what's considered the
10 Webster's Ninth Dictionary is -- it's the same as what
11 would be available on the merriam-webster.com internet
12 site?

13 A. No, I don't know.

14 Q. So, as the City's designee to answer questions
15 regarding interpretation of the ordinance and also
16 enforcement of the ordinance, did you review this
17 definition prior to your testimony today? That is, the
18 definition of gender identity.

19 A. Of gender identity? Yes, at some point, I've
20 reviewed the Webster definition in preparation for this.
21 But I can't say again -- I can't recite the definition
22 with precision.

23 Q. As you sit here today, you can't recite what that
24 definition is?

25 A. Well, I can't -- yeah, I can't verbatim recite to

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1 you what the definition in Webster's is.

2 Q. So, as we sit here right now, do you -- do you
3 recall enough of the definition to be able to answer my
4 question about how does the City identify gender --
5 define gender identity as that term is used in this
6 ordinance?

7 A. Yeah. I mean, I can generally talk about gender
8 identity. But, again, I would just say that the
9 definition would be -- that the City would rely on in
10 making a determination of a violation would be -- we
11 would look to the dictionary definition in Webster's
12 Ninth.

13 And then also, ultimately, it would be a question
14 of interpretation for the administrative official who
15 would consult with me to look at the facts, the totality
16 of the facts. We don't parse out specific facts in most
17 cases in determining whether to move forward with a
18 case. So the official would determine based on the
19 totality of the circumstances and with guidance from
20 legal and the dictionary definition to determine what
21 that meant and whether or not it would -- whether or not
22 the facts that we were looking at constituted a
23 violation of the ordinance.

24 Q. Are there any other terms in this -- in the
25 ordinance that you would have to resort to Webster's

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1 Ninth Dictionary for the definition of in order to
2 continue answering questions about the City's
3 interpretation of the ordinance?

4 A. I don't know -- I mean, I don't know to what
5 extent you're going -- what terms you're going to ask me
6 about and which ones you aren't. The only reason --

7 Q. How about sexual orientation?

8 A. I guess it depends on how you ask it. I mean,
9 the only reason I refer to the dictionary in the context
10 of the question that you asked is because the way that
11 you asked it was unclear to me what exactly you meant
12 when you were referring to expression of gender
13 identity.

14 Q. So, going back to this hypothetical that we
15 began, if we have a ten-year-old biological boy who has
16 expressed a female gender identity -- meaning, however
17 the City defines gender identity -- would the ordinance
18 prohibit a therapist from encouraging that child who
19 expresses a female gender identity to embrace the
20 child's biological male body and to align with the --
21 with a male gender role?

22 MR. WILLIAMS: Object to the form.

23 Overly vague, improper hypothetical.

24 THE WITNESS: If the -- when you say
25 encouragement, if it -- when you refer to encouragement,

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1 if what you're saying is that the therapist was
2 providing therapy with a goal of changing the gender
3 identity, then that would be a violation.

4 BY MR. GANNAM:

5 Q. What if that is not the therapist's goal but,
6 nonetheless, encourages this biological boy who
7 identifies as female to embrace the child's male body
8 and to align with the child's male gender role?

9 MR. WILLIAMS: Same objection.

10 I'll add that the hypothetical, as worded by
11 counsel, also includes a conclusion without a factual
12 foundation, thereby makes the hypothetical even more
13 incomplete and, therefore, improper.

14 Please answer the question, if you can.

15 THE WITNESS: The ordinance says that it's a
16 practice or treatment performed with the goal of
17 changing an individual's sexual orientation or gender
18 identity. So the therapy -- and I read that to mean
19 that the conversion therapy as defined by the ordinance
20 is a therapy, practice or treatment that has to have the
21 goal of changing the orientation or the gender identity.
22 So encouragement of something is different. Those are
23 different words. So I'd -- I don't know how to answer
24 you other than to repeat -- I don't mean to go back and
25 forth. I don't want to make this difficult. But the

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1 ordinance is pretty clear in the terms that it uses.

2 And it does say performed with the goal of changing.

3 BY MR. GANNAM:

4 Q. In the context of enforcement, if the only
5 information that the City received was -- in a complaint
6 was the hypothetical that I gave you that a ten-year-old
7 biological boy who identifies as a female went to a
8 therapist or a counselor and that counselor encouraged
9 the child to embrace his male biological body and to
10 align with his -- with a male gender role, if that was
11 the only information you received from the complaint,
12 how would the City go about determining whether a
13 violation had occurred?

14 A. Well, how the City pursued a complaint or
15 investigated a complaint would be dependent on the
16 source of the complaint, the nature of the complaint.
17 If what you said -- what you're asking me doesn't
18 include a source, so I don't know if you want to help me
19 there.

20 Q. Why does that matter?

21 A. Because the -- you have to follow the lead. If
22 an anonymous complaint came in, then, you know, I don't
23 know where -- where -- in your question, I mean, I
24 don't -- there's a lot of things that I have to assume
25 in order to answer your question. So that's why I can't

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1 really answer it precisely.

2 Q. If the complainant is not anonymous but known to
3 the City, what would the City -- how would the City
4 respond to the complainant?

5 A. We have a known complainant?

6 Q. Right.

7 A. Okay. I don't -- yeah. I don't think that that
8 necessarily would have an affect, whether the
9 complainant was known or not, unless the -- what would
10 be more relevant is how close the complainant was to the
11 situation that they're complaining about. If an
12 anonymous complaint came in from a patient, for example,
13 that might change the circumstances as opposed to an
14 anonymous complaint that doesn't identify any context of
15 how the information was obtained or whether it was
16 hearsay or firsthand or how they knew about what they --
17 what they were complaining about. All those things
18 would be considered when we looked at -- when we would
19 look at a complaint for enforcement purposes.

20 Q. Suppose the complaint came from a -- from a next
21 door neighbor who told the City that he was -- you know,
22 had been told by the child everything that had happened,
23 what would be the City's response?

24 A. Well, I -- it would be up to the -- to the Code
25 Enforcement department to decide, within their

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1 prosecutorial discretion, whether or not they would want
2 to pursue the complaint if they felt that it was -- it
3 had the -- the veracity and the -- you know, all the
4 prosecutorial decisions that any law enforcement officer
5 would make for beginning an investigation. They would
6 consider all of those things and then make a decision
7 based on all of those -- all of those considerations.

8 Q. In your review of the literature, did you come
9 across -- strike that.

10 In your review of the various literature,
11 studies, et cetera, that are recited in the ordinance,
12 did you see information regarding how common is it for
13 a -- a prepubertal child who experiences some kind of
14 gender dysphoria to essentially outgrow that or for that
15 gender dysphoria to desist once that child reached a
16 certain age?

17 A. I recall something of that being discussed, but I
18 don't know specifically. I'm happy to -- if you're
19 thinking of something specific, I'm happy to look at it
20 to refresh.

21 Q. Let me ask you this. If a -- using a similar
22 hypothetical, if this ten-year-old biological boy who
23 was experiencing gender dysphoria to the extent that he
24 had adopted a female gender identity sees a provider and
25 that provider believes that it's in the child's best

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1 interest to speed up the desistance of that gender
2 dysphoria, in other words, to speed up the process where
3 that child would revert back to his biological gender
4 identity because the provider believes that that's
5 usually what happens, if the provider provides that kind
6 of help to speed up the desistance of the cross-gender
7 identity or the cross-gender feelings, would that be
8 considered a violation of the ordinance?

9 A. If the provider is providing support in a
10 sexual -- in a neutral intervention, is what the
11 ordinance uses, then it would not be a violation. If
12 they're helping the child cope with or manage these
13 feelings in a neutral way without -- without a goal in
14 mind of changing the identity, then that's not a
15 violation.

16 Q. What if the provider's goal is to simply speed up
17 what the provider believes is going to happen anyway and
18 actually encourages this -- this biological boy who
19 identifies as a girl to focus on male behaviors and male
20 gender roles, would that be a violation of the
21 ordinance?

22 MR. WILLIAMS: Same objection.

23 THE WITNESS: I don't think that there are
24 specific behaviors -- the City hasn't identified
25 specific behaviors that define gender identity. Again,

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1 I can't recite to you verbatim the dictionary definition
2 of gender identity; but I can tell you with certainty
3 that that dictionary definition does not include a list
4 of specific behaviors that meet the term gender
5 identity. So I just -- I keep finding myself a little
6 bit confused by your hypotheticals because they seem to
7 be predicated on the specific behaviors; whereas, I
8 think gender identity is probably a little bit broader
9 than a specific thing like boys wear blue or, you know,
10 I have a purple tie. I don't think that has anything to
11 do with my gender identity under the ordinance.

12 BY MR. GANNAM:

13 Q. What if the therapist's goal in the hypothetical
14 I gave is simply to cause the desistance of the child
15 identifying as a girl?

16 A. Can you repeat that? I'm sorry.

17 Q. The goal of the therapist is to bring about the
18 desistance of the child identifying as a girl.

19 A. The goal of the therapy -- just to use a
20 different word than desistance because I'm not familiar
21 with that term -- is to end the identification of the
22 child with the opposite -- with a different -- with a
23 different gender than the biological gender? Is that
24 your question?

25 Q. Yes.

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1 A. Yeah. If the goal is to change the -- the gender
2 identification, then that's a violation.

3 Q. Just so I don't have to show the Court all these
4 pages -- because I know we've gone back and forth. And,
5 fair enough, you've asked me to clarify. Just to kind
6 of reset the hypothetical, if the ten-year-old
7 biological boy identifies as a girl and presents to a
8 therapist and the therapist's goal is to -- is to end
9 the boy's identifying as a girl so that he, again,
10 identifies as his biological sex and the therapist
11 accomplishes this by encouraging the boy to do boy
12 things or to act like a boy, however that is envisioned
13 by the therapist, would that be a violation of the
14 ordinance?

15 A. Yes. The goal to change identity would be the
16 violation. If the City were enforcing it, obviously, it
17 would have to use specific instances of facts that were
18 evidence of that -- of that goal.

19 Q. Let's use a different hypothetical. Suppose
20 there is a -- a teen-age girl. Say she's sixteen years
21 old. And when I say, "teen-age girl" -- strike that.

22 Suppose we have a sixteen-year-old biological
23 girl who, for some period of time, has been identifying
24 as a boy, has adopted a male gender identity, and that
25 child presents to a therapist and expresses to the

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1 therapist, I've been living as a boy for some time, I
2 don't want to anymore, I want to change back to my
3 biological female gender identity I was born with, will
4 you help me and the therapist agrees to help and engages
5 in therapy to -- to help that child readopt or return to
6 a female gender identity that aligns with her biological
7 sex, would that be a violation of the ordinance?

8 MR. WILLIAMS: Incomplete hypothetical, so I
9 object. And an improper hypothetical as worded.

10 But you may give it your best shot.

11 THE WITNESS: I'm not sure I understand the
12 distinction that you're -- between this hypothetical and
13 the last hypothetical. The only difference that I
14 understand -- maybe you can clarify for me -- is that,
15 in your previous hypothetical, one was biologically a
16 boy and then now, in this hypothetical, one was
17 biologically a girl. Are those the only things that you
18 changed in the hypothetical?

19 BY MR. GANNAM:

20 Q. Well, maybe. Maybe not. I just want you to
21 answer the one I asked you. Do you want me to say it
22 again?

23 MR. WILLIAMS: Let's have her read it back.

24 THE WITNESS: Yeah. That would be good.

25 MR. GANNAM: Okay.

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1 (Requested portion read back by the court reporter)

2 MR. WILLIAMS: Note my continuing objection.

3 Go ahead.

4 THE WITNESS: Yeah. There's -- there's
5 still an issue with your -- because your hypos are so
6 limited in what you're presenting to me. There's an
7 issue of what's -- you know, what's changing and what
8 the goals are.

9 But, again, if the goal is -- if a female
10 patient comes in and presents a goal of changing her
11 gender identity, the therapist adopts the goal and then
12 provides treatment with the goal of changing the
13 identity, then that would be a violation of the
14 ordinance.

15 BY MR. GANNAM:

16 Q. And, just so I'm clear, the answer is the same
17 that, if the goal is to change gender identity, it's a
18 violation of the ordinance even in the case of a -- of a
19 child who has once, apart from this therapist, changed
20 gender identity and now comes to the therapist to change
21 back to a prior gender identity? It's still a violation
22 if changing gender identity is the goal?

23 A. I think that, you know, there is -- yeah, I mean,
24 I think the ordinance is pretty clear. If the goal is
25 to change an individual's sexual orientation or gender

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1 identity, then that's what the ordinance bans.

2 I'll just, you know, volunteer to you some
3 information that the -- which is totally not what my
4 lawyers told me to ever do in this deposition. But the
5 literature does talk about, you know, these -- I think
6 you used the term gender dysphoria. And, you know,
7 it's -- the whereas clauses would also guide the
8 decision of making a determination of whether or not
9 there's a violation that would be prosecuted. And part
10 of the whereas clauses -- and I'll just kind of point
11 you to some of the ones that I think are kind of
12 relevant to the hypos that you're presenting to me right
13 now are -- basically, the very first one where it says
14 that: Major professional -- and I'm on page one of the
15 ordinance 2017-47. And this is page one of your Exhibit
16 4. And, it says: As recognized by major professional
17 associations of health practitioners and researchers in
18 the United States and elsewhere -- and I'll just skip
19 forward there -- lesbian, gay, bisexual, transgender or
20 gender nonconforming or questioning is not a mental
21 disease, disorder or illness, deficiency or shortcoming.
22 So I think that's an important predicate, as well, that
23 would guide the decision in defining what the goals of
24 the therapy were.

25 Q. How does what you just read to me relate to the

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1 prior hypothetical?

2 A. In defining how -- what the goal is.

3 Q. And, just so I'm being clear, the goal in the
4 hypothetical was to help this -- this child change her
5 gender identity to female from male in accordance with
6 her desires. But it's given that it is the goal of the
7 therapy to change gender identity. So I believe your
8 answer was that would be a violation of the ordinance
9 because the goal is to change gender identity. Am I
10 correct?

11 A. Right. And what I'm saying is trying to just add
12 a little bit of nuance to your basic hypothetical
13 that -- that with the goal being to change the gender
14 identity. And the ordinance references that any of
15 these nonbinary -- just to use that term -- any of these
16 nonbinary identifications, that those are not mental
17 diseases. They're not disorders or illnesses or
18 deficiencies or shortcomings.

19 Q. In my hypothetical, I did not -- I did not
20 provide that anyone claimed that the gender identity or
21 the desired gender identity of the client was somehow a
22 mental disease or disorder or illness. I simply said
23 that the client wanted to change it.

24 And so to what -- how is this information that
25 you're providing or that you're reading to me from the

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1 first recital relevant to the determination of whether a
2 change requested by the client and adopted by the
3 therapist violates the ordinance or not?

4 A. Well, all the whereas clauses are going to be
5 relevant as part of the ordinance in determining whether
6 or not a violation of the ordinance has occurred. So
7 this would be part of the consideration in trying to
8 determine what the goal of the therapy was. It's fine,
9 I guess, for a law school exam to just assume certain
10 things. But we don't have the luxury of doing that in
11 the enforcement world. So, when we determine what the
12 goal is, we have to look at whether or not these things
13 were considered and -- and why the patients were -- the
14 patient was in that position and why the therapist
15 was -- what their goal was.

16 These -- the whereas clauses lay out all of that
17 both as a predicate for why conversion therapy is
18 harmful and presents a serious critical health risk to
19 youth, but also I think, as what the predicate for most
20 conversion therapy is based on, I think the literature
21 talks about that where it says -- in fact, I'll just
22 cite to you the whereas clause number three where it
23 says, the American Psychiatric Association published in
24 opposition to any psychiatric treatment including
25 reparative or conversion therapy which therapy regime is

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1 based on the assumption that homosexuality is a mental
2 disorder, per se, and that a patient should change his
3 or her homosexual orientation. So the whereas clauses
4 lay that out for us, and that's part of our
5 consideration when we determine whether or not there's a
6 violation.

7 Q. So, in my hypothetical, neither the therapist nor
8 the client expressed any position on whether or not the
9 gender identity that the client desired had anything to
10 do with a mental disease, disorder or illness or
11 deficiency or shortcoming but only that it was the --
12 the therapist's desire to provide the client what the
13 client wanted. And what the client wanted is to change
14 gender identity to match her biological sex.

15 So, based on that hypothetical -- and I believe
16 your answer was, if the goal was to change gender
17 identity, then it's a violation of the ordinance. I
18 don't think I understand what you're telling me from
19 these recitals this idea that some people think -- might
20 think gender identity or homosexuality is a result of a
21 mental disease, disorder or illness. I don't see where
22 those enter into the determination of whether the goal
23 was to change gender identity.

24 Is there anything else you can tell me as to how
25 -- how these concepts, you know, fit together?

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1 MR. WILLIAMS: Which concepts specifically?

2 MR. GANNAM: The concepts expressed in these
3 recitals that certain organizations reject the idea that
4 being LGBTQ is somehow a mental disease, disorder,
5 illness, deficiency or shortcoming as one set of
6 concepts. On the other hand, what the ordinance
7 prohibits, which is therapy the goal of which is to
8 change gender identity.

9 MR. WILLIAMS: If you understand the
10 question, Mr. Simpson, feel free to try.

11 THE WITNESS: Not entirely. But I'll try to
12 answer and just say that the literature that we cite in
13 the whereas clauses is also relevant in determining what
14 the ordinance means. And so it's important because --
15 first of all, because we -- we cite to it; and we say
16 that it's important. And it's important of where I
17 think the literature is saying that these therapies are
18 misguided because they're predicated often on this idea
19 that homosexuality is a mental disorder. And so they're
20 relevant in that sense.

21 And so, you know, with your hypothetical --
22 I'm trying to answer your hypothetical. But, again, in
23 any enforcement situation, the City would look at the
24 totality of the facts, every fact that we could find
25 relevant to the situation. And then we would determine

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1 whether or not we thought it was a violation and then,
2 secondly, what action that we would take after that if
3 we determined that there was probable cause for a
4 violation.

5 BY MR. GANNAM:

6 Q. Okay. So, with that in mind then, if we simply
7 take that off of the table where neither the therapist
8 nor the client believes that the client's identification
9 as a boy for some period of time is the result of any
10 mental disease, disorder or illness, deficiency or
11 shortcoming, neither the therapist nor the client
12 believes that, and the therapist's only goal is to give
13 the client what the client wants and the client's only
14 goal is to return to a female gender identity that the
15 client believes will -- she will like better and will be
16 more comfortable with, in that scenario, is it correct
17 that the City would consider that to be a violation of
18 the ordinance for the therapist to provide therapy that
19 the goal of which is to accomplish that change?

20 MR. WILLIAMS: Same objection.

21 Incomplete and incompetent hypothetical,
22 involving too many assumptions.

23 That's my objection. Please answer, if you
24 can.

25 THE WITNESS: The answer is the same that,

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1 if the therapist is providing therapy that is -- has the
2 goal of changing the gender identification, then that --
3 that constitutes a violation of the ordinance.

4 BY MR. GANNAM:

5 Q. And, to follow up, is it the City's position that
6 its enforcement decision -- or strike that.

7 Is it the City's position that whether a
8 violation of the ordinance has occurred depends on
9 whether the therapist subjectively believes that a
10 nonconforming gender identity or homosexuality is
11 somehow a deficiency or something that -- that the
12 patient should desire to change compared to a therapist
13 who doesn't believe those things? So just, if I can
14 recap, is it the City's position that whether a
15 violation has occurred depends on the -- the state of
16 mind of the therapist in terms of whether they believe
17 any of these things that are highlighted in the first
18 and third recitals?

19 A. I think that you could read a certain mens rea,
20 if you will, requirement into a violation of the
21 ordinance that there would be some -- the City would
22 need to provide facts, obviously, in any enforcement
23 action to show what the goal of the therapy was because
24 the ordinance is clear that the goal has to be to change
25 the identity . So the City would need some facts that

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1 were relevant to establishing that goal. And those
2 facts could, I think, include facts that the City could
3 have obtained within the legal restrictions on the City
4 for gathering evidence that were relevant to the state
5 of mind of the therapist when providing the therapy.
6 Those would be relevant to what the goal was and whether
7 or not a violation occurred.

8 Q. Would those facts that are considered relevant by
9 the City include prior speeches or writings by the
10 therapist that touch on the subjects of the first and
11 third recitals in the ordinance?

12 A. I think that those facts, to the extent that they
13 were -- you know, subject to the rules of evidence and
14 the rules of evidence gathering by the City, those
15 things could be relevant to the state of mind of the --
16 of the alleged violator, potential violator.

17 (Recess)

18 BY MR. GANNAM:

19 Q. I think I asked you a little bit about this
20 earlier, but I want to explore it a little. Council
21 Member Maniscalco by motion asked for a staff report on
22 a ban of all types of conversion therapy; is that
23 correct?

24 A. As I recall, the motion just said generally a ban
25 on conversion therapy . He didn't elaborate what he

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1 meant by conversion therapy. He directed us to look at
2 -- I believe it was the City of Miami Beach for
3 clarification on what he -- what he meant by that.

4 Q. Okay. And I don't know if you were in the room
5 for the discussion of aversive versus non-aversive
6 therapies to change sexual orientation or gender
7 identity. Do you understand what I'm talking about --

8 A. Yes. I was in the room for that.

9 Q. Were you in here when we talked about coercive
10 and involuntary therapy versus voluntary therapy?

11 A. I believe I was. I do recall some discussion
12 that you had with him about that.

13 Q. So I just want to ask. At anytime from the
14 initial request for a staff report regarding a ban on
15 conversion therapy through the enactment of the
16 ordinance that was enacted, did the council as a whole
17 consider banning something less than all conversion
18 therapy, for example, banning only aversive types of
19 therapy?

20 A. To the extent that those topics are covered in
21 the literature, it was -- it was considered.

22 Q. Okay. But did any -- did the council ever ask
23 the legal department to prepare a draft of an
24 alternative ordinance that only covered aversive
25 therapy?

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1 A. No.

2 Q. Did the council ever ask the legal department to
3 draft an ordinance that would only prohibit coercive or
4 involuntary types of therapy?

5 A. No.

6 Q. Could the legal department have done that if
7 asked to do that?

8 A. I don't know. I have -- I haven't considered
9 that.

10 Q. Generally speaking, is there any -- is there any
11 reason why the legal department would not have been able
12 to draft a different ordinance if asked to do so by the
13 council?

14 A. The legal department could have drafted a
15 different ordinance, yeah.

16 Q. And, for example, could the legal department have
17 drafted an ordinance that only banned aversive therapy
18 or only banned coercive types of therapy?

19 A. I don't know the answer to that. I mean, the
20 legal department drafted what we were directed to draft,
21 which was a ban on conversion therapy. We were directed
22 to follow a model for guidance and clarification on what
23 the council member intended. That model included
24 references to quite a bit of literature that does
25 discuss aversive versus non. And, ultimately, what

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1 happened was that the City banned conversion therapy;
2 and that would include all forms of it, whether it's
3 talk therapy or aversive.

4 Q. So do you know of any reason, as we sit here
5 today, why the legal department would not have been able
6 to draft an ordinance that only banned aversive therapy
7 or that only banned coercive therapy?

8 MR. WILLIAMS: If asked, you mean?

9 BY MR. GANNAM:

10 Q. If asked to could so?

11 A. Well, there would be some question, I suppose, in
12 whether or not the -- in relying on the literature that
13 the City relied on, whether or not the goal was
14 accomplished in eliminating -- or attempting to deter
15 what the City has determined to be a harmful practice
16 that presents a significant risk of harm to youth. And
17 so because the literature doesn't -- doesn't really
18 properly distinguish in a way that would be something
19 that the City could rely on, I'm not sure. I don't know
20 the answer to that because we would have to -- I guess
21 we would have to find other literature that supports
22 what you're saying. The literature, as I understand it,
23 includes all types of conversion therapy; and that was
24 the literature that the City relied on.

25 Q. If another council member -- at the same time

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1 that Mr. Maniscalco requested what he requested, if
2 another council member at the same time said, I don't
3 think we should go that far, can you prepare a staff
4 report regarding a ban only on aversive methods of
5 conversion therapy, would there have been any reason why
6 the legal department couldn't have prepared that staff
7 report as requested?

8 MR. WILLIAMS: Object to that question as an
9 improper hypothetical because it assumes something that
10 didn't happen in terms of the process. I'll be happy to
11 elaborate, if you want, to help you, Roger. But I --

12 MR. GANNAM: I think that's what makes it a
13 hypothetical.

14 MR. WILLIAMS: No, no, because -- let me
15 just help you. The legal department does what the
16 council. You're saying an individual councilman.

17 MR. GANNAM: Fair enough.

18 BY MR. GANNAM:

19 Q. So Mr. Maniscalco motions for the council to ask
20 for a staff report on a conversion therapy ban and
21 another council member, through the -- through the
22 appropriate rules of order and parliamentary procedure,
23 adds an amendment to say we'd like you to prepare an
24 order banning it all and -- or prepare a staff report on
25 an ordinance banning it all and a staff report on an

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1 ordinance banning only aversive methods and present them
2 both to us. And that motion carries by a majority of
3 the council. Is there any reason why the legal
4 department would not have been able to comply with that
5 request from the council?

6 A. Well, so I haven't -- the City relied on this
7 literature to produce this ordinance. And this
8 literature, to my understanding, doesn't really
9 distinguish when it defines conversion therapy --

10 Q. Well --

11 A. -- so I -- just -- I'm sorry to interrupt. But
12 -- and we weren't asked to identify specific literature
13 on -- based on the hypothetical that you present. And
14 the models that we followed identified this literature.
15 And it was our position that we didn't have to try to
16 one-up the American Psychological Association and the
17 finding of their task force. The City could rely on
18 those findings and cite to them, and we did. So that
19 was -- I mean, I guess that's how I would answer your
20 question.

21 Q. So there would have been nothing preventing the
22 legal department from reviewing this literature that it
23 was asked to review and in a staff report saying, hey,
24 we think you can rely on this literature to support an
25 entire ban, we don't think you can rely on this

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1 literature to support only a partial ban because that's
2 just not supported by the literature? Would there have
3 been anything preventing you from providing that in a
4 staff report if you were asked to do so?

5 A. I'll try to answer the question, and I'm not sure
6 if I totally understand it. But, if a council member
7 made a motion and the motion passed to direct the legal
8 department to parse out the literature and to present
9 the literature in a more detailed format, we could have
10 done that. We could have come to council and presented
11 a more thorough presentation on the -- on the American
12 Psychological Association's Task Force, for example. We
13 weren't asked to do that. But we -- but we provided
14 that report, and we cite to it in our whereas clauses.
15 And we weren't asked to specifically explain all the
16 nuances of the report in a public hearing.

17 Q. If directed by the council as a whole to prepare
18 a staff report, you know, comparing the possibility of a
19 total ban compared to a ban of only aversive therapies,
20 for example, the legal department could have prepared
21 the report it was asked to prepare, correct, and then
22 let the council decide whether to move forward or not?

23 A. The legal department can prepare all kinds of
24 reports based on direction of the council.

25 Q. So is the answer to my question yes?

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1 A. I'm not sure I completely understand. But, if
2 the question is -- well, I'll just ask you for
3 clarification. Are you asking could the -- could the
4 legal department have prepared a report on whether or
5 not the literature addresses aversive versus non and
6 then report to council on that issue? Is that the
7 question?

8 Q. Yeah. That is -- you can answer that question.

9 A. Yes. The legal department could have -- with any
10 one of the numerous pieces of literature that we cite
11 to, the -- the City staff could have reported to council
12 and discussed any one of those reports in greater
13 detail?

14 Q. And did the City Council, in this case at any of
15 the public meetings where the ordinance was discussed or
16 debated, hold any kind of debate among the council
17 members as to whether a -- a complete ban or a -- or a
18 ban only of certain kinds of conversion therapy would be
19 better for the City?

20 A. I don't recall the specifics of which council
21 members said what, but I don't recall there being any
22 specific -- any council member raising a specific issue
23 with the nuances that you're pointing out.

24 Q. All right. I'm going to ask you to look at an
25 exhibit marked yesterday as Plaintiffs' Exhibit 2. This

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1 is a document that was produced yesterday in the course
2 of the deposition of Sal Ruggiero. It was identified by
3 Mr. Ruggiero as a PowerPoint presentation. And, on the
4 cover, it reads, Code Enforcement Update, Jerrod
5 Simpson, Assistant City Attorney. Have you ever seen
6 this document before?

7 A. Yes.

8 Q. What is this document?

9 A. It is a PowerPoint presentation that I had
10 prepared for the Code Enforcement department.

11 Q. And did you make a presentation to the Code
12 Enforcement department using this PowerPoint?

13 A. Yes.

14 Q. Do you remember when that happened?

15 A. I don't recall the specific date. I would say,
16 roughly, it was -- it was a few months after the
17 enactment or -- I'm not sure exactly when it would be.

18 Q. There are -- this presentation includes several
19 slides regarding the conversion therapy ordinance,
20 correct?

21 A. Yes.

22 Q. And, unfortunately, these pages are not numbered;
23 so I'm going to try to direct you to a -- to a
24 particular page. It reads at the top Conversion Therapy
25 and it asks the question, how is it enforced?

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1 A. Okay.

2 Q. It's about maybe two-thirds of the way into the
3 presentation. But if you could try to find that.

4 A. Okay. I'm there.

5 Q. Now, the first bullet under the question reads,
6 enforce through the special magistrate process. What is
7 the special magistrate process?

8 A. It is a quasi-judicial enforcement process that
9 is statutorily prescribed. The City has adopted State
10 Statute Chapter 162 under the Florida Statutes where
11 that chapter lays out a set of procedures that the City
12 can follow. And the mayor appoints a special
13 magistrate. And we have numerous special magistrates
14 that are appointed by the mayor and confirmed by City
15 Council. And it's a quasi-judicial enforcement process.

16 Q. So can you walk me through an example of how a
17 complaint under the conversion therapy ordinance would
18 be prosecuted or enforced through the special magistrate
19 process. I assume it would be initiated by some kind of
20 complaint under the ordinance?

21 A. The statute contemplates a document that I think
22 you could consider to be the charging document for this
23 process. It's labeled as a notice of violation.

24 Q. Okay.

25 A. So the first step in the process, once the City

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1 has determined, the officials, Code Enforcement
2 department in consultation with legal for -- for more
3 complicated questions, the -- it's determined that -- in
4 fact, the statute uses the word reasonable suspicion,
5 reasonable belief. So, if the City determines that
6 there's a reasonable belief that a violation has
7 occurred and the City choses to take action, exercising
8 its prosecutorial discretion, the City would issue a
9 notice of violation. And that would put the alleged
10 violator on notice of what exactly the violation is that
11 the City's alleging, what the nature of it is and what
12 they can do to correct the violation.

13 Here, in this context, the City has legally
14 determined it to be irreparable, irreversible, which,
15 operatively under the statute, the City is normally
16 required to give the alleged violator a cure period. If
17 the City determines that it's irreparable or incurable,
18 essentially, then we're not obligated to give that cure
19 period. We can immediately resort to taking legal
20 action beyond the notice of violation, which, in the
21 context of the special magistrate process, means we
22 can -- in addition to notifying them of the violation,
23 we notify them of the hearing date. We can schedule a
24 hearing, give them a reasonable time to prepare for that
25 hearing; and then they would appear in front of the

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1 hearing -- the hearing master.

2 Q. As an irreparable or irreversible violation, if
3 the City determines that a violation has occurred, does
4 it have any discretion in the matter of whether to go
5 ahead and notice it for the hearing? Or is there some
6 alternative that the City could elect in connection with
7 that notice of violation?

8 A. I'm not sure I completely understand the
9 question. But I'll try to answer anyway and just say
10 that, once the notice of violation has been issued, the
11 City I think at all times retains prosecutorial
12 discretion whether or not to pursue a violation based on
13 the circumstances of the situation.

14 Q. But, if the notice of violation is issued
15 indicating that the City has determined that a --
16 there's a reasonable belief that a violation has
17 occurred, what is the next step after issuing that
18 notice of violation?

19 A. The next step is that there has to be a hearing
20 by the special magistrate who is to be the independent
21 fact finder. And the City cannot impose a fine
22 without -- without the special magistrate making a
23 finding of fact that there has indeed been a violation.
24 And then, of course, the special magistrate is then the
25 authority that would determine the fine amount.

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1 Q. So, prior to going through the special magistrate
2 process, is there ever a circumstance where -- where a
3 Code Enforcement official could simply levy a fine
4 against someone based on the initial determination that
5 a violation has occurred?

6 A. Not that I'm aware of. There's fundamental due
7 process that everyone's entitled to. So there -- if
8 a -- we have a separate process for enforcement with
9 civil citation where, if it's a repeat violation, that
10 the City can immediately write a citation; and that
11 citation would have a fine amount and the person can pay
12 that. But, if the person doesn't think that the -- that
13 it's proper or they want to contest it, they're entitled
14 to due process. So it has to go in front of a judge or,
15 in this case, a magistrate to determine whether or
16 not -- in this particular set of circumstances, the City
17 could not send a notice of violation to an alleged
18 violator and also say pay us a thousand dollars. They
19 have to go to the magistrate in order to determine that
20 a violation did, in fact, occur; and then the magistrate
21 would issue an order that would determine the fine
22 amount.

23 Q. Does the case under the -- or would a case under
24 the conversion therapy ordinance go to a particular
25 special magistrate or a particular group of special

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1 magistrates, or can it be heard by any special
2 magistrate that Tampa employs?

3 A. There hasn't been any determination, under the
4 conversion therapy ordinance, of which special
5 magistrate would hear these cases. As a general matter,
6 there are -- there are different topics that are
7 assigned to different magistrates currently. And it
8 hasn't been decided which magistrate would -- that
9 these -- these types of violations would be assigned to.

10 Q. And what determines what kinds of subject matter
11 or topics get assigned to a particular special
12 magistrate?

13 A. There's no legal -- Chapter 162 does not
14 articulate any specific requirements for how the City
15 chooses which magistrate to hear which case. Generally
16 speaking, it would be determined by the legal department
17 based on the nature of the case, the experience of the
18 magistrate and then in consultation with the alleged
19 violator as to whether or not they had a particular
20 issue or conflict of interest or something like that.

21 Q. So, in any case brought under this conversion
22 therapy ordinance, the legal department would decide
23 which special magistrate heard the case?

24 A. The ultimate -- the ultimate decision would be
25 made in consultation with -- for example, if the alleged

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1 violator was represented by an attorney, or not, if they
2 had a specific issue with a particular magistrate, we're
3 obviously bound to the Constitutional due process. So,
4 if there's a question of bias or appearance of bias or
5 conflict of interest or those things, we would be
6 subject to those sorts of things. If a doctor had a
7 relationship with a special magistrate, for example,
8 then that would guide the --

9 Q. Subject to, you know, rules of ethics that may --
10 that may arise if there's conflicts, subject to
11 considerations like that, it's the legal department that
12 will chose the special magistrate to hear a particular
13 case under the conversion therapy ordinance; is that
14 generally correct?

15 A. Yeah. Generally speaking, the legal department
16 would look to the roster, if you will, of special
17 magistrates and determine who was best suited, most
18 qualified to hear a case and be impartial and thorough
19 and then in consultation with the alleged violator, if
20 there's an issue. Now, there are -- like I said, there
21 are specific subjects that are allotted to specific
22 magistrates currently. And conversion therapy has not
23 been given a -- a designation at this time.

24 Q. Are there any special magistrates currently
25 employed by the City -- strike that.

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1 Is my assumption correct that special magistrates
2 are city employees?

3 A. They're not. They're unpaid volunteers. I think
4 that the only compensation that they are provided is
5 parking validation.

6 Q. Okay. Thank you for that.

7 A. There's some language in the statute that talks
8 about that. And I don't know if -- I can't give an
9 opinion today whether or not we could pay them.

10 Q. Okay.

11 A. But we do not consider them employees.

12 Q. So the special magistrates are unpaid volunteers
13 who have -- who have requested I guess the -- the -- to
14 serve in that capacity?

15 A. They've been appointed by the mayor --

16 Q. Okay.

17 A. -- and there's a confirmation process. And the
18 subjects of their appointment are written out in the --
19 in the resolution adopting the confirmation of the
20 magistrate.

21 Q. Are there any -- is there any set of mandatory
22 qualifications for someone to serve as a special master?
23 For example, do they have to be a licensed attorney or
24 something like that?

25 A. They are not required to be an attorney. There

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1 is some language in the -- in the state statute that --
2 that lists some preferential occupations. I'll put it
3 that way I think is a good way to put it. And I'm not
4 specifically aware of whether or not -- if there's a --
5 if the City posts, like, a job description and then
6 there's -- you know, these are the requirements. I'm
7 not aware of that, if there is -- I'm not sure if
8 there's one or not.

9 Q. Are any of the special masters currently on the
10 City's roster roll for special masters licensed mental
11 health providers?

12 A. I don't know.

13 Q. Is there any plan in connection with the
14 conversion therapy ordinance to recruit or appoint a
15 special master who is a licensed mental health provider?

16 A. There's no -- not that I'm aware of.

17 Q. In the special master proceeding, are the rules
18 of evidence more lenient than in a regular civil
19 proceeding in county court or circuit court?

20 A. Yes.

21 Q. In what ways are the rules of evidence more
22 lenient?

23 A. Well, the statute and the City ordinance adopting
24 the statute explicitly states that the formal rules of
25 evidence do not apply.

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1 Q. That's provided by statute?

2 A. Correct.

3 Q. The evidentiary standards are specified by the
4 statute?

5 A. In Chapter 162, it specifically states that the
6 formal rules of evidence do not apply to these types of
7 hearings.

8 Q. Was the decision -- or who made the decision
9 initially to run enforcement of the conversion therapy
10 ordinance through the special magistrate process as
11 opposed to some other enforcement process that may have
12 been available to the City?

13 A. Ultimately, council makes the decision through
14 the ordinance. But I know what you're saying --

15 Q. By passing the ordinance --

16 A. -- so I'll elaborate further. And the answer is
17 that Ernest Mueller, in making his initial draft to
18 present for their consideration, made the determination
19 to apply it through the Chapter 9 special magistrate.

20 Q. Was there any discussion at the council meeting
21 as to which that was presented or questions directed to
22 Mr. Mueller about why that process versus another
23 process?

24 A. I can say that, generally -- and I think that
25 you'll see this when you look at the hearings, that

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1 enforcement was -- was a discussion that we were having.
2 Ernest Mueller, his background is in enforcement. I'm
3 in the enforcement. So we're both enforcement-minded
4 attorneys. And we were trying to consider all the
5 possibility of what sets of facts would be prosecutable,
6 what -- how would we be able to obtain evidence, how
7 would we present that and what -- what processes that we
8 had available for enforcement that would be appropriate.
9 So I would say that we thoroughly considered all aspects
10 of enforcement and all of the methods that are available
11 to the City.

12 Q. When you say, "we," you're talking about the
13 legal department?

14 A. Correct.

15 Q. As far as what the City Council considered, it
16 considered what Mr. Mueller presented to them?

17 A. Well, there was some discussion, I recall, at one
18 of the hearings or maybe even both of the hearings about
19 some of this enforcement language with the -- with the
20 fine amounts and then also with the irreparable
21 language.

22 Q. Okay.

23 A. So it was discussed at council. I would just --
24 I don't recall specifically, so I would refer you to
25 that hearing.

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1 Q. Whatever's in the record?

2 A. Yeah, right.

3 Q. Can you flip the page onto the next slide. Still
4 says Conversion Therapy at the top. And the slide reads
5 all, in all caps, possible conversion therapy cases must
6 be referred to legal for review prior, again in all
7 caps, to the issuance of a notice of violation. Tell me
8 what is the -- what does this indicate as far as a
9 policy for -- for enforcement?

10 A. Well, this was -- this was my suggestion and
11 advice to my client that -- the Code Enforcement
12 department that -- that it's safe to assume that all of
13 these cases are going to be complicated to the extent
14 that they should consult with us on their actions --

15 Q. And so --

16 A. -- prior to taking the first legal --
17 legally-operative action in enforcement, which is the
18 notice of violation.

19 Q. So, when you made this presentation that's
20 reflected in this PowerPoint to all of the -- or to the
21 Code Enforcement department and it includes this
22 statement that all possible conversion therapy cases
23 must be referred to legal for review prior to the
24 issuance of a notice of a violation, does that reflect a
25 policy decision made by the head of Code Enforcement; or

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1 does that reflect a policy decision made by the legal
2 department?

3 A. I don't know that I would characterize it as a
4 policy position. Ultimately, the code enforcement
5 official would -- has the discretion to consult with
6 legal or not to consult with legal. And I don't know --
7 don't believe that there was ever any standard operating
8 procedures developed for conversion therapy. What this
9 is -- what this was me trying to convey is that it would
10 be helpful for the -- the department, if a complaint
11 came in, conversion therapy related complaint, to
12 consult with legal so that we could help guide them in
13 both determining whether or not the complaint and the
14 evidence that they had met the threshold of being a
15 violation and, if it didn't, what information they would
16 need to gather in order to obtain the determination --
17 make the determination of a violation and then also what
18 sort of constraints that they would have in gathering
19 evidence.

20 Q. So I understand you just answered that -- and you
21 determined it would be helpful for legal to be consulted
22 prior to the issuance of a violation. But this slide
23 says quite clearly that all possible conversion therapy
24 cases must be referred to legal for review. That's a
25 little stronger, isn't it, than just that it would be

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1 helpful?

2 A. Sure.

3 Q. So under whose authority was the directive given
4 to the entire Code Enforcement department that all cases
5 must be referred to legal for review prior to the
6 issuance of a notice of violation?

7 A. Under my authority as the -- as one of the
8 prosecuting attorneys for the City, I was trying to
9 emphasize the importance of consulting with legal in the
10 investigation of these cases. That's why I chose that
11 language.

12 Q. Did Mr. Ruggiero or anyone acting on his behalf
13 ever tell you, no, we'll decide when to consult legal
14 before we issue a notice of violation because that's our
15 jurisdiction?

16 A. No.

17 Q. And, to date, it's my understanding there have
18 been no cases either referred to legal or in which a
19 notice of violation was issued under this ordinance; is
20 that correct?

21 A. That's my understanding, as well.

22 Q. Are you aware of any other city ordinance where
23 there is a -- a directive in place such as this one
24 where the Code Enforcement department has been told that
25 all cases must be referred to legal for review prior to

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1 the issuance of a notice of violation?

2 A. I just want to look at this here because -- is
3 this the entire presentation that was given that day?

4 Q. Couldn't tell you.

5 A. Here you go. This is it. I just didn't know --
6 you printed it out. I didn't know if you printed out
7 the whole thing.

8 Q. This was actually printed out for us by your
9 lawyer.

10 A. Yeah, it looks like it is. I just couldn't find
11 what was there.

12 I'll just refer you to another slide in this
13 presentation. And it's under the mobile home park's
14 slide. And, at the top, it says, Florida Statute
15 723.083.

16 Q. Let me catch up. Okay.

17 A. At the bottom there, you can see, it says, all
18 orders to vacate or demolish on a mobile home must be
19 referred to legal for review prior to taking any action.

20 Q. So is that -- is that similar to an initial
21 notice of violation, or is that something -- or would an
22 order to vacate or demolish be something that happens
23 further down in the line in the mobile home process?

24 A. It would be subject to the facts of the
25 situation. An order to vacate could be the first legal

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1 action that a city takes on a particular property,
2 dependent on the circumstances.

3 Q. Okay. So that's an example. Are there any other
4 examples you can think of where a -- there's a directive
5 in place to consult legal before -- before action can be
6 taken under any circumstances?

7 A. I can't recall specifically one. I only recalled
8 this one because it's in this presentation that you have
9 here. I'll just say, as a general matter, we advise the
10 department, for any issue that gets complicated or
11 unusual, that they -- that they consult with us from the
12 very beginning of the situation.

13 Q. Would you consider a complaint of a violation of
14 the conversion therapy ban to be a complicated or
15 unusual case?

16 A. Yes.

17 Q. And why?

18 A. Well, it's unusual because it's the only thing in
19 the code that deals with this -- things of this nature
20 for the department.

21 Q. When you say, "things of this nature," do you
22 mean mental health issues or counseling issues?

23 A. Right, with mental health and with LGBT issues.
24 Those are not -- those are obviously not day-to-day,
25 everyday issues for the Code Enforcement department.

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1 Q. Any other reason you consider a potential
2 violation of the conversion therapy ban to be a
3 complicated or unusual case?

4 A. Well, because you're dealing with minors and
5 you're dealing with patient/provider privilege. You're
6 dealing with -- so complicated evidentiary issues that
7 every case is going to have.

8 Q. Does the City consider its Code Enforcement
9 department competent to deal with conversion therapy
10 cases without consulting legal beforehand?

11 A. Yes. I would just add to that that -- that, you
12 know, again, consulting with legal is a very strong
13 suggestion. And I don't -- I don't believe that
14 they would undertake any action. And it's my
15 understanding that -- in conversations with the
16 department that their plan is not to. But that policy
17 has never been formalized in any written standard
18 operating procedure, as far as I'm aware.

19 Q. Does the directive reflected in your slide here
20 about referring all cases to legal for review prior to
21 the issuance of a notice of violation, does this also
22 require Code Enforcement to refer a possible conversion
23 therapy case to legal if the Code Enforcement official's
24 initial determination is that this is not a meritorious
25 complaint and we should take no further action? Does

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1 that also need to come to legal for review?

2 A. I would not include that in my consider --
3 because, ultimately, if the department -- if they're
4 determination is that the City's not going to -- to do
5 anything, then there's nothing to consult legal about if
6 they're not going to do anything.

7 Q. So the City is entrusting the Code Enforcement
8 officials to make an initial determination as to whether
9 a violation has occurred, a violation based on this
10 ordinance where the City has determined that significant
11 harm could result as a result of conversion therapy; and
12 the City would allow the Code Enforcement Board -- or
13 Code Enforcement officials to determine there is no
14 violation and take no action without consulting the
15 legal department first?

16 A. Yes. If a random anonymous call came in and
17 provided zero information, I would not expect the Code
18 Enforcement department to call me and give me all the
19 details of a -- of an anonymous meritless complaint. I
20 would expect that they would decide not to pursue that
21 and decide not to take my time up with that -- with
22 telling me about it.

23 Q. Show you another document. This was previously
24 marked as Plaintiffs' Exhibit 3. This was also produced
25 yesterday by your attorney in the course of

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1 Mr. Ruggiero's deposition. This appears to be some
2 subset of the slides in the presentation we were just
3 looking at as Plaintiffs' Exhibit 2. But, on the cover,
4 it reads Code Enforcement Conversion Therapy instead of
5 Code Enforcement Update. Did you prepare this -- this
6 second document marked as Exhibit 3?

7 A. This appears to be a -- maybe an earlier draft
8 version of what ultimately became the -- the
9 presentation that I gave.

10 Q. So did you ever give a presentation based on this
11 Exhibit 3 document?

12 A. I only gave one presentation. And the Exhibit --
13 Plaintiffs' Exhibit 2 I think you've marked it as, I
14 think that this is fairly and accurately depicting the
15 presentation that I -- the one presentation that I gave.

16 Q. Exhibit 2 is?

17 A. Right. The one that you've just handed me that
18 has Conversion Therapy on the title appears to be an
19 earlier draft of what ultimately became the presentation
20 that was given.

21 Q. Okay. Apart from the training that you gave --
22 or the presentation that you gave to Code Enforcement
23 based on the PowerPoint of Exhibit 2, apart from that
24 training, have you had any other -- have you held any
25 other training sessions with Code Enforcement personnel

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1 regarding the conversion therapy ban?

2 A. No.

3 Q. Are there any plans to hold any additional
4 training?

5 A. Not that I'm aware of.

6 Q. Why were you selected for the training?

7 A. Because I'm one of the municipal prosecutors.

8 Q. If a Code Enforcement official has a potential
9 conversion therapy case and follows the directive from
10 your presentation to call legal first, are you the
11 person that that complaint would come to?

12 A. It could -- it could come to either myself, or it
13 could come to an attorney by the name of Colin Rice.

14 Q. Colin, R-i-c-e?

15 A. Yes, Patrick Colin Rice.

16 Q. And what is Mr. Rice's position or title?

17 A. He's a municipal prosecutor, as well. We're in
18 the same division under Rebecca Kert.

19 Q. Okay. Anyone else that that complaint could come
20 to?

21 A. Well, I mean, I -- theoretically, they could call
22 anyone at the City Attorney's Office. But, ultimately,
23 Colin and I are the legal advisors who are assigned to
24 the Code Enforcement department as legal advisors. And
25 Colin and I are the attorneys that would prosecute a

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1 case once legal action was taken. And, once the case
2 was brought into the legal forum, then we would have the
3 prosecutorial discretion to decide what was appropriate.

4 Q. Is there any formal or informal policy at the
5 City Attorney's Office to send all conversion therapy
6 ban cases to you or to you or Colin or something along
7 those lines?

8 A. There's no formal policy; but it's likely, being
9 that I've been involved with this ordinance from the
10 beginning, that I would be involved with -- with any
11 case that came out of it.

12 Q. Earlier we talked about the -- is it k:drive at
13 the City Attorney's Office as the computer drive that's
14 accessible by all personnel in the City Attorney's
15 Office; is that correct?

16 A. Yes. The k:drive is our shared -- our shared
17 storage device that's cloud-based storage.

18 Q. And does Ernest Mueller have access to documents
19 and files that are on the k:drive?

20 A. I believe so. It's my understanding that
21 everyone in the legal department has access to what we
22 call the k:drive. I believe other departments might
23 have other shared drives that are not accessible by all
24 departments, but I can't really speak to all the details
25 of those files and folders.

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1 Q. As far as the legal department's k:drive, it's
2 your understanding that Ernest Mueller has access to
3 files on that drive?

4 A. Yes.

5 Q. And is it also your understanding that
6 Salvatore Territo would have access to files on that
7 drive?

8 A. Yes.

9 Q. I mentioned -- the PowerPoint presentation that
10 we identified as Exhibit 2, the one that you believe
11 represents the presentation you gave to the Code
12 Enforcement department, is that on the k:drive?

13 A. I believe so.

14 Q. You had an opportunity to review your -- your
15 file, what you call your file, regarding the conversion
16 therapy ordinance before you testified today; is that
17 correct?

18 A. Yes.

19 Q. And you also responded to Plaintiffs' written
20 discovery requests -- at least you verified the factual
21 answers that were contained in the City's response to
22 Plaintiffs' discovery requests; is that correct?

23 A. I signed the interrogatories, yes.

24 Q. Okay. Did you review -- had an opportunity to
25 review the document requests that are in the written

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1 discovery requests from Plaintiffs to the City of Tampa?

2 A. I've reviewed the order that limited the scope of
3 discovery to the twenty custodians and the thirty search
4 terms and then the dates. I've also reviewed the memos
5 that were sent out by our outside counsel's assistant
6 requesting the production of documents. And I've
7 been -- had discussions with -- with outside counsel
8 about our process for producing discovery.

9 Q. In the course of reviewing your file and
10 reviewing the Court's order that specified the
11 custodians and search terms and date ranges, do you know
12 whether there are documents in your conversion therapy
13 ban file that would be responsive to the various search
14 terms but were not produced because they were not deemed
15 to be in the custody of one of the twenty identified
16 custodians?

17 A. It's my understanding that everything that was
18 responsive to the order has been provided.

19 Q. That's not quite my question.

20 My question is: Are you aware of any documents
21 in your file, what you call your file, that would
22 contain any of the search terms that are in the order
23 but were nonetheless not produced because they were not
24 deemed by the City to be held by one of the twenty
25 custodians?

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1 A. I believe you asked me something like this
2 earlier. I haven't compared my file to what's been
3 produced. It's my understanding that there was
4 something like nine to ten thousand pages of documents
5 that were produced, many of which were not really
6 relevant to the case. But they were produced
7 nonetheless because the search terms that you selected
8 and that the Court put into the order. And so --
9 because I haven't compared nor was I of the
10 understanding that I was supposed to compare what was in
11 my file with what was produced. So I don't know -- as I
12 stated earlier, I don't know if there's a document in my
13 file that was not produced to you. But I do -- I am of
14 the understanding that everything that was relevant to
15 the order was produced.

16 Q. And I think there's two different questions here.
17 One is -- that you answered earlier and I think that's
18 answered again, which is you don't know whether any
19 documents in your file were produced because you haven't
20 reviewed the whole production to reach a conclusion one
21 way or the other. Is that a fair statement?

22 A. Right. I haven't reviewed the -- everything that
23 was produced to you.

24 Q. My question -- my second question is: Do you
25 know whether there are documents in your file that were

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1 withheld from production even though they contain one of
2 the thirty search terms because the City determined that
3 they were not in the custody of one of the twenty
4 identified custodians?

5 A. No. My -- my understanding is that everything
6 that was -- everything that was subject to the order
7 that limited the scope of discovery was provided. And I
8 haven't compared what's in my file with what was
9 produced or with what the limited scope of the order
10 was.

11 Q. Was the document produced yesterday that was
12 marked has Plaintiffs' Exhibit 2, the PowerPoint
13 presentation, in the -- the set of documents that you
14 referred to as your file?

15 A. Yes. It's in my file because I saved e-mails in
16 my file that were related to conversion therapy and
17 because I e-mailed this presentation both to myself so
18 that I could pull it up at the City building where we
19 were, so I could access it through the internet because
20 not all computers have access to the k:drive, like I
21 said earlier.

22 In order to access it, I e-mailed it to myself,
23 opened up my e-mail, pulled it up that way so that I
24 could present it. And then, following the presentation,
25 one of the supervisors -- her name's Susan Wenrick --

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1 asked me if a code enforcement officer wants to see the
2 presentation, how can they get it? And I told her that
3 I would e-mail it to her, and then she could be the
4 point of contact for distributing it to anyone that
5 would be interested or had any questions and wanted to
6 refer to it. So I e-mailed it to her, and that was the
7 only person that I ever sent it to apart from myself.

8 Q. So the set of documents that you referred to --
9 that we referred to several times today as your file --

10 A. Right.

11 Q. -- would include that PowerPoint presentation we
12 marked as Exhibit 2?

13 A. I believe, in my file, it's included as an
14 attachment to an e-mail that was saved into my file
15 along with all the other e-mails that I saved in there.

16 Q. Does it exist in your file simply as a PowerPoint
17 presentation that's sitting there in what you determine
18 to be your file? Not as an e-mail attachment but just
19 standing alone?

20 A. I don't believe so, but I'm not sure about that.

21 Q. But does the -- regardless of whether it's in the
22 set of documents you're calling your file, does this
23 PowerPoint presentation exist as a -- simply as a
24 PowerPoint document on the k:drive and in some folder on
25 the k:drive?

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1 A. I don't know. I mean, it exists. It's there as
2 an attachment. So I'm not sure -- I'm not --

3 Q. You initially created it in PowerPoint, though,
4 correct?

5 A. Yes.

6 Q. And saved what you created somewhere, I presume?

7 A. Right. It would have been saved on my computer
8 and then moved into the k:drive or maybe saved into the
9 k:drive.

10 Q. Is your normal practice to save documents you
11 create for work on the k:drive, or do you usually save
12 them to a local drive that's only on your PC or the
13 computer that you use?

14 A. I don't know that I have a normal practice for --
15 when it comes to that, that type of thing. I mean, for
16 this, the only goal that I had was -- I mean, obviously,
17 I was going to make a presentation; so I just needed to
18 have that file. So, obviously, it had to have been
19 saved at some point or else I could not have e-mailed
20 it. But I don't know to what extent I saved it on the
21 desktop or I saved it in the k:drive. I don't know.

22 Q. I'm going to show you a document now I'm going to
23 mark as Exhibit 24.

24 (Plaintiffs' Exhibit No. 24 marked for identification)

25 BY MR. GANNAM:

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1 Q. This is an e-mail produced at COT PRODUCTION
2 004938 from Helene Hvizd to Ernest Mueller with a copy
3 to Jerrod Simpson. That's the latest message in the
4 string. The earlier message appears about halfway down
5 the page, says, from Ernest Mueller to Helene Hvizd,
6 copy it Jerrod Simpson.

7 And that earlier e-mail, says, Ms. Hvizd, at long
8 last, I'm sending you a copy of our proposed conversion
9 therapy ordinance. It passed first reading today and is
10 scheduled for second reading on April 6, 2017.

11 Did I read that correctly?

12 A. Yes.

13 Q. And then the later message at the top, says,
14 thank you so much, Ernie. I look forward to reading
15 your ordinance and examining your unique take on the
16 enforcement concerns.

17 Now, it showed that you're copied on this e-mail
18 conversation. Do you recall receiving this e-mail?

19 A. Yes.

20 Q. Do you know what Ms. Hvizd is referring to when
21 she says, your unique take on the enforcement concerns?

22 A. I wasn't -- I wasn't in the conversations between
23 Ernie and Ms. Hvizd. But it's my understanding that
24 they discussed both the City's language -- and you can
25 see for yourself in the enforcement provisions that the

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1 City's language is slightly different than the other
2 ordinances in that the City declares a violation of this
3 nature to be irreparable or irreversible. And so --
4 and, in speaking with Ernie to prepare for this
5 deposition as a representative of the City, it's my
6 understanding that they did have a conversation about
7 process -- enforcement process from the standpoint of
8 the -- of 162 -- Chapter 162 of the Florida Statutes.

9 Q. Do you know what the enforcement concerns were
10 that Ms. Hvizd is referring to in her e-mail to
11 Mr. Mueller?

12 A. Again, I believe it's related to the irreparable,
13 irreversible language. When I was explaining the
14 Chapter 162 earlier, the City is normally -- if a
15 violation is curable, then the City is obligated under
16 the code enforcement statutes to give the alleged
17 violator time to cure prior to taking action. And so,
18 by declaring a violation of this nature to be
19 irreparable, the City has determined that these
20 violations will not be subject to cure periods, that,
21 once a notice of violence is issued, the City can
22 immediately bring an alleged violator in front of a
23 magistrate to prosecute the violation. There would be
24 no obligatory cure period.

25 Q. In your conversation with Mr. Mueller, did you

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1 ask him specifically about this e-mail?

2 A. Yes.

3 Q. And did you ask him if he knew what Ms. Hvizd
4 meant by enforcement concerns?

5 A. I did not ask that specific question about her
6 specific words.

7 (Plaintiffs' Exhibit No. 25 marked for identification)

8 BY MR. GANNAM:

9 Q. I'm going to hand you Exhibit 25. This is
10 produced as COT PRODUCTION 001706. And it is an e-mail
11 string, the earlier message of which is from
12 Erin Bradley to Jerrod Simpson -- I'm sorry. The
13 earliest message is from Jerrod Simpson to
14 Ernest Mueller dated March 9, 2017, at eleven-seventeen
15 a.m. Do you see that?

16 A. Yes.

17 Q. And the question you pose is: Do you have the
18 draft done yet? I spoke with Carrie, and some of the
19 advocates are asking for a draft prior to the council
20 hearing. Do you remember sending this e-mail?

21 A. I don't remember seeing this e-mail. But I --
22 sending the e-mail. But I am familiar with its content.

23 Q. Okay. Who is Carrie?

24 A. Carrie is Carrie Henriquez.

25 Q. When you say the draft, are you referring to a

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1 draft of the conversion therapy ordinance?

2 A. Yes. I'm referring to the draft ordinance that
3 is going -- is going to be presented to the City
4 Council. And it looks like, according to the date here,
5 I'm most likely referring to the -- what is going to be
6 presented for first reading.

7 Q. And the portion that says, some of the advocates
8 are asking for a draft prior to the council hearing, who
9 are the advocates?

10 A. I don't recall specifically who the advocates
11 were. All I -- and I don't know how I spoke with
12 Carrie. If I bumped into her in the hallway or if we
13 spoke over the phone, I don't recall. But some of the
14 people that were contacting her were asking for a draft,
15 and so she was asking me if I could get her the draft.
16 And I don't know who the advocates were, whether -- or
17 what side of the issue they were on.

18 Q. Is this a common request to provide a sort of a
19 preview of draft legislation before it's presented to
20 the council?

21 A. Yes.

22 Q. And did you, in fact, provide Carrie with a
23 draft?

24 A. I believe so. As soon as we had a draft that was
25 essentially what was going to be presented to the

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1 public, I believe -- I'm not -- I'm not sure exactly how
2 it was provided or what it exactly was that was
3 provided. It could have been as simple as in an e-mail
4 or as a paper copy in passing in the hallway. I don't
5 recall.

6 Q. As you sit here today, you don't know what
7 advocates Carrie was referring to when she said they
8 wanted copies?

9 A. I don't -- no, I don't. In relation to this
10 e-mail and this conversation, I don't -- I don't know
11 what advocates I was referring to.

12 Q. Apart from the e-mail, are you aware, as you sit
13 here, of any particular advocates who were looking for
14 drafts of the ordinance before it was voted on by the
15 City Council?

16 MR. WILLIAMS: Does he remember that? Is
17 that what your question is?

18 MR. GANNAM: Right.

19 BY MR. GANNAM:

20 Q. Do you know? Can you remember any?

21 A. Can you repeat the question? I'm sorry.

22 MR. GANNAM: Can you just read that back.

23 (Requested portion read back by the court reporter)

24 THE WITNESS: I'm only aware that Carrie had
25 requested a draft for me to -- to give to her so that

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1 she could distribute it. That's the only thing I'm
2 aware of.

3 BY MR. GANNAM:

4 Q. Okay. I'm handing you Exhibit 26.

5 (Plaintiffs' Exhibit No. 26 marked for identification)

6 BY MR. GANNAM:

7 Q. This is a document produced in this case at COT
8 PRODUCTION 005651. At the top, it reads, Considerations
9 for Conversion Therapy Ordinance. Do you recognize this
10 document?

11 A. No.

12 Q. Does the format or the way it's written indicate
13 to you who the author is?

14 A. No.

15 MR. GANNAM: All right. I'm going to hand
16 you Exhibit 27 then.

17 (Plaintiffs' Exhibit No. 27 marked for identification)

18 BY MR. GANNAM:

19 Q. Before I leave Exhibit 26, if you needed to
20 determine who wrote that document, who would you ask?

21 A. I would go to Ernest Mueller.

22 Q. Do you think it's something he wrote or authored?

23 A. I do, based on the lists of things that are being
24 considered. It sounds like, if this was something that
25 was drafted by the City, then it would -- it could very

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1 well be Ernest Mueller.

2 Q. Okay. I'm going to show you Exhibit 27 now.

3 This is a document produced in discovery as COT
4 PRODUCTION 004427. At the top, it says, good morning
5 council. The next line says, Ernest Mueller with the
6 legal department. Do you know what this document is?

7 A. No.

8 Q. The third paragraph says, I am here with
9 Jerrod Simpson on Item 80 where the council asked the
10 legal department to appear and present a draft ordinance
11 regarding conversion therapy to minors. Then it reads,
12 the draft ordinance is being passed out to you.

13 Does that content help you to determine what this
14 document is?

15 A. Yes.

16 Q. What do you think it is?

17 A. Well, I think -- and without knowing anything
18 about it really, it appears to be a guide for a
19 presentation, maybe some bullet points that Ernie could
20 have been referring to. But, again, I'm not familiar
21 with it; so I can't really authenticate it in any way.

22 MR. GANNAM: All right. I'm going to take
23 five minutes with my colleague and see if we have
24 anything else.

25 MR. WILLIAMS: All right.

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1 (Recess)

2 MR. GANNAM: Rob, I have a question for you
3 before we go on.

4 MR. WILLIAMS: Sure.

5 MR. GANNAM: We've heard some testimony
6 regarding the k:drive that is accessible to the legal
7 department. My question for you, if you know, is:
8 Were -- were the entire contents of the k:drive searched
9 for the thirty search terms within the date parameters
10 established by the Court?

11 MR. WILLIAMS: The thirty search terms were
12 done by a gentleman by the name of Jim Crew. Jim Crew
13 is the head of the IT Department or -- I'm not sure what
14 his normal title is. But --

15 THE WITNESS: I can speak to that if you
16 prefer to have it from a fact witness.

17 MR. GANNAM: Let Rob finish, and then I'll
18 come back to you.

19 MR. WILLIAMS: So that's who got the thirty
20 search terms. And that's what produced all those pieces
21 of paper. Okay?

22 So I can't answer your question specifically
23 without talking to my paralegal Coralane (phonetic), and
24 I'll do that immediately. She was in charge of all of
25 this and had multiple conversations with various people

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1 to make sure that she -- and she's very good at this.

2 And I'm sure she can provide the answer -- the answer to
3 that question specifically.

4 MR. GANNAM: Okay.

5 MR. WILLIAMS: But I can't do it off the top
6 of my head.

7 MR. GANNAM: Understood.

8 BY MR. GANNAM:

9 Q. I'm going to turn to you now, Mr. Simpson, as the
10 City's designee on the issue of the production that
11 occurred in this case. Were all documents on the
12 k:drive responsive to the thirty search terms identified
13 by the Court produced in the course of the document
14 production in this case?

15 A. I would -- I can -- can I just confirm what he
16 said is true. The only correction that I would make for
17 the record is that Jim Crew is with the City Clerk's
18 office.

19 Q. So, as you sit here, you don't know whether all
20 documents on the k:drive, the legal department's
21 k:drive, responsive to the thirty search terms were
22 produced?

23 A. The City complied with the order that limited the
24 scope of discovery. So, to the extent that there are --
25 are items on the k:drive that aren't under the purview

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1 of that, then I don't believe that those were produced.

2 Q. And I want to be clear. I know you haven't been
3 party probably to the various, you know, disputes and
4 discovery discussions that we've had. We might have a
5 different interpretation of what that order requires as
6 compared to the City's lawyers. And so, to cut through
7 whose interpretation is right, I just want to establish
8 as a factual matter whether all documents on the k:drive
9 that are responsive to the thirty search terms were
10 produced?

11 A. I don't know the answer to that.

12 MR. WILLIAMS: My paralegal would.

13 MR. MIHET: Is she still here?

14 MR. WILLIAMS: She's gone now.

15 MR. GANNAM: She just walked in the door.

16 MR. MIHET: Okay. Just, Mr. Williams, we
17 would take the position that the documents on that
18 k:drive that are responsive to the search terms should
19 have been produced. If they were not, we would like
20 them to be produced immediately so that we have a chance
21 to review them well in advance of the hearing. So, if
22 possible, by tomorrow we'd like to have an idea whether
23 or not the documents were produced. If not, will you be
24 willing to produce them immediately? And, if not, we'll
25 try to get the issue before the court right away.

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1 MR. WILLIAMS: My answer is that, to the
2 extent that the k:drive has documents that weren't
3 produced as a result of what Mr. Crew did and are
4 responsive under the order, I will request and direct my
5 paralegal to figure that out immediately. And I will
6 not be in the office tomorrow because I've got a court
7 hearing out of the office.

8 MR. HARVEY: If I can speak to that too,
9 Rob.

10 MR. WILLIAMS: Okay. Go head.

11 MR. HARVEY: Because, if I'm understanding
12 your issue correctly, the k:drive, the twenty custodians
13 on a list were provided with directions to search their
14 personal -- not personal -- but their work, finding the
15 documents; and so those documents were produced. And
16 so, if you're taking the position that somebody should
17 go through every k:drive, even for the attorneys in our
18 office who were not among those twenty --

19 MR. MIHET: I think the testimony has been
20 that at least two people from the twenty have access to
21 the k:drive.

22 MR. HARVEY: Everybody -- my understanding
23 is everybody in the legal department has access to
24 everything on the k:drive, which would be all the city
25 attorneys, every document under every file in the

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1 k:drive, which would be God knows how many documents.

2 MR. MIHET: Sure. So, to that extent, the
3 entire k:drive should have been searched.

4 MR. HARVEY: That's what I'm clear about.
5 So you're taking the position that people beyond the
6 twenty should be searched?

7 MR. MIHET: No. If Mr. Territo and
8 Mr. Mueller have access to the k:drive, because they are
9 part of the custodians, then the k:drive should have
10 been searched because the documents on the k:drive are
11 within their custody, possession or control.

12 MR. HARVEY: That's what I'm saying. So
13 you're taking the position that everybody -- every
14 document is in the custody and control of every attorney
15 in our office because everybody has access to the
16 k:drive?

17 MR. MIHET: On the k:drive, if they have
18 access to it, that is our position. And I --

19 MR. HARVEY: Well, let's just clarify what
20 happened is the twenty custodians were contacted to
21 produce what documents they got.

22 MR. MIHET: So the question is: Was the
23 k:drive searched?

24 MR. HARVEY: I don't know that there's a way
25 to search the entire k:drive like you can search the

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1 e-mail search. But the answer is, no. I mean, the
2 people beyond the twenty were not.

3 MR. WILLIAMS: Well, let's refine it
4 further. You know, not only were memos sent out to the
5 individuals, okay, my paralegal made direct inquires,
6 okay, to make sure that the responses were forthcoming.
7 We're talking about a lot of people who have a lot of
8 other things to do. So we did that. And she is the one
9 who did it, not me. And that's why I'm referring to
10 her, and I will direct her to do whatever she needs to
11 do. And it may well be that those documents that you're
12 generally alluding to may have been produced as a result
13 of other stuff. You know?

14 MR. MIHET: Well, we know that at least one
15 wasn't. And so, yesterday, the reason --

16 MR. WILLIAMS: Which one are you talking
17 about?

18 MR. MIHET: The PowerPoint presentation.

19 MR. WILLIAMS: Actually, that wasn't -- that
20 wasn't produced because it was determined that it wasn't
21 within the ambit. And let me finish, if I may.
22 Different people could disagree with that. But, when it
23 came up yesterday, as I said, I recommended to the City
24 and we immediately produced it. You have it. And you
25 talked to Mr. Ruggiero, and you talked to Mr. Simpson.

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1 I don't know if you talked to Guido or not. So it's an
2 imperfect process.

3 MR. MIHET: Sure.

4 MR. WILLIAMS: And I think we can all agree,
5 right?

6 MR. MIHET: Yeah. All I'm saying is we know
7 the PowerPoint is on the k:drive. We believe --

8 MR. WILLIAMS: He wasn't sure if it is. I
9 think that's what he testified.

10 MR. MIHET: Well, okay, we can go back and
11 parse his testimony --

12 MR. WILLIAMS: We'll find out. We'll find
13 out.

14 MR. MIHET: -- but it's our position that,
15 by virtue of it being on the k:drive coupled with the
16 fact that at least two of the custodians have access to
17 the k:drive, it was responsive and should have been
18 produced.

19 What we want to know is, now that we know
20 that, have all the other documents --

21 MR. WILLIAMS: Sure.

22 MR. MIHET: -- on the k:drive been produced?

23 And so, if the answer is yes, then the
24 answer is yes. If the answer is no, then the question
25 is: Would they be searched and produced without us

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1 going back to the court? And we'd like know that by
2 tomorrow if possible because the time is very short.

3 MR. WILLIAMS: All right. The time is
4 short. But I'm not going to be in the office tomorrow.
5 I'll direct my paralegal to do it, and then she can deal
6 with perhaps David or Friday when I get back to the
7 office. She is very very competent. And I'm sure she
8 can figure all of this out. And, to the extent that we
9 agree that certain documents should have been produced
10 and for whatever reason were not, probably an
11 interpretation issue, we'll discuss the interpretation.
12 But, if there's no interpretive issue and some were
13 missed, then we will rectify that because, as I just
14 said and you agree, this is an imperfect process. Is
15 that fair enough?

16 MR. MIHET: We'll wait to hear hopefully
17 from you tomorrow, but, at the latest, from you first
18 thing on Friday morning?

19 MR. WILLIAMS: Yes.

20 MR. GANNAM: That's all we have. No further
21 questions.

22 MR. WILLIAMS: Thank you. All witnesses
23 will read.

24 (Proceedings concluded at 5:29 o'clock p.m.)

25

Page 138

CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF PALM BEACH)

I, Rachele L. Cibula, the undersigned authority,
certify that JERROD SIMPSON personally appeared before
me and was duly sworn.

Witness my hand and official seal this 6th day of
November, 2018.



Rachele L. Cibula

RACHELE L. CIBULA
Notary Public, State of Florida
My Commission #FF 936928
Expires: December 14, 2019

Page 139

1 C E R T I F I C A T E

2 THE STATE OF FLORIDA)

3 COUNTY OF PALM BEACH)

4

5 I, Rachele Lynn Cibula, Notary Public, State of
6 Florida at Large,

7 DO HEREBY CERTIFY that I was authorized to and did
8 stenographically report the foregoing deposition; and
9 that the transcript is a true and correct transcription
10 of the testimony given by the witness.

11 I FURTHER CERTIFY that I am not a relative, employee,
12 attorney or counsel connected with the action, nor am I
13 financially interested in the action.

14 Dated this 6th day of November, 2018.

15

16

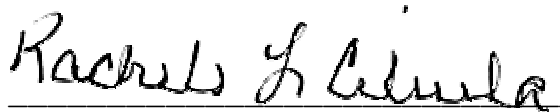
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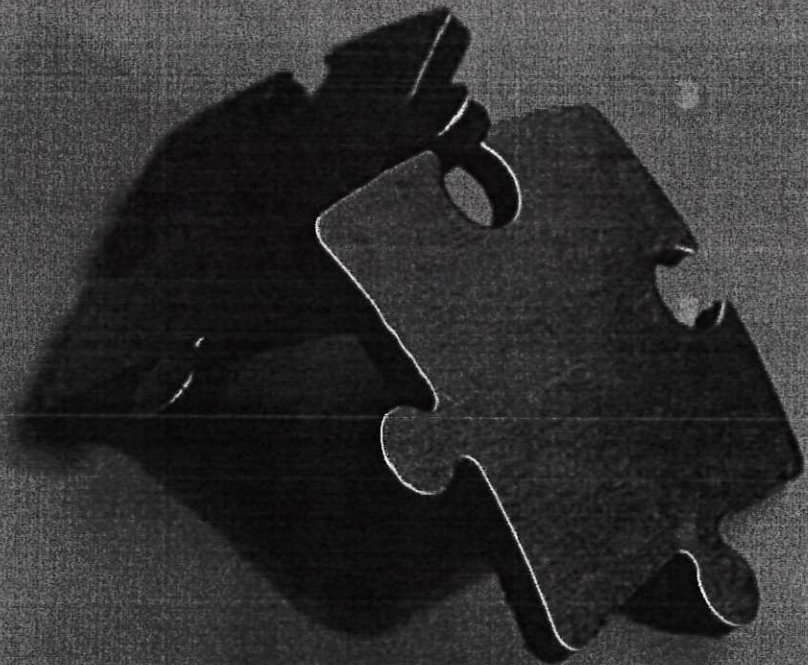
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AMERICAN
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ASSOCIATION

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation



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Report of the American Psychological Association Task Force on
**Appropriate Therapeutic Responses
to Sexual Orientation**



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Report of the American Psychological Association Task Force on
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ABSTRACT

The American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation conducted a systematic review of the peer-reviewed journal literature on sexual orientation change efforts (SOCE) and concluded that efforts to change sexual orientation are unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates. Even though the research and clinical literature demonstrate that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity, the task force concluded that the population that undergoes SOCE tends to have strongly conservative religious views that lead them to seek to change their sexual orientation. Thus, the appropriate application of affirmative therapeutic interventions for those who seek SOCE involves therapist acceptance, support, and understanding of clients and the facilitation of clients' active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome.



EXECUTIVE SUMMARY

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation and charged the task force with three major tasks:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998).
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
 - The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.

- Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

As part of the fulfillment of its charge, the task force undertook an extensive review of the recent literature on psychotherapy and the psychology of sexual orientation. There is a growing body of evidence concluding that sexual stigma, manifested as prejudice and discrimination directed at non-heterosexual sexual orientations and identities, is a major source of stress for sexual minorities.* This stress, known as *minority stress*, is a factor in mental health disparities found in some sexual minorities. The minority stress model also provides a framework for considering psychotherapy with sexual minorities, including understanding stress, distress, coping, resilience, and recovery. For instance, the affirmative approach to psychotherapy grew out of an awareness that sexual minorities benefit

* We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of their own and of the other sex. This term is used because we recognize that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

when the sexual stigma they experience is addressed in psychotherapy with interventions that reduce and counter internalized stigma and increase active coping.

The task force, in recognition of human diversity, conceptualized affirmative interventions within the domain of cultural competence, consistent with general multicultural approaches that acknowledge the importance of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. We see this multiculturally competent and affirmative approach as grounded in an acceptance of the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences (e.g., minority stress) throughout the life span.
- Same-sex sexual attractions and behavior occur in the context of a variety of sexual orientations and sexual orientation identities, and for some, sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) is fluid or has an indefinite outcome.
- Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to heterosexual relationships and families in essential respects.
- Some individuals choose to live their lives in accordance with personal or religious values (i.e., telic congruence).

Summary of the Systematic Review of the Literature

Efficacy and Safety

In order to ascertain whether there was a research basis for revising the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998) and providing more specific recommendations to licensed mental health practitioners, the public, and policymakers, the task force performed a systematic

review of the peer-reviewed literature to answer three questions:

- Are sexual orientation change efforts (SOCE)** effective at changing sexual orientation?
- Are SOCE harmful?
- Are there any additional benefits that can be reasonably attributed to SOCE?

The review covered the peer-reviewed journal articles in English from 1960 to 2007. Most studies in this area were conducted before 1981, and only a few studies have been conducted in the last 10 years. We found serious methodological problems in this area of research; only a few studies met the minimal standards for evaluating whether psychological treatments such as efforts to change sexual orientation are effective. Few studies—all conducted in the period from 1969 to 1978—could be considered true experiments or quasi-experiments that would isolate and control the factors that might effect change (Birk, Huddleston, Miller, & Cohler, 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975). Only one of these studies (Tanner, 1974) actually compared people who received a treatment with people who did not and could therefore rule out the possibility that other things, such as being motivated to change, were the true cause of any change the researchers observed in the study participants.

None of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety. The few high-quality studies of SOCE conducted recently are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001); although they aid in an understanding of the population that undergoes sexual orientation change, they do not provide the kind of information needed for definitive answers to questions of safety and efficacy. Given the limited amount of methodologically sound research, claims that recent SOCE is effective are not supported.

We concluded that the early high-quality evidence is the best basis for predicting what the outcome of valid interventions would be. These studies show that

** In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

enduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE and did not report significant change to other-sex attractions that could be empirically validated, though some showed lessened physiological arousal to sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE.

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies documented iatrogenic effects of aversive forms of SOCE. These negative side effects included loss of sexual feeling, depression, suicidality, and anxiety. High dropout rates characterized early aversive treatment studies and may be an indicator that research participants experienced these treatments as harmful. Recent research reports on religious and nonaversive efforts indicate that there are individuals who perceive they have been harmed. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they been harmed by SOCE.

Individuals Who Seek SOCE and Their Experiences

Although the recent SOCE research cannot provide conclusions regarding efficacy or safety, it does provide some information on those individuals who participate in change efforts. SOCE research identified a population of individuals who experienced conflicts and distress related to same-sex attractions. The vast majority of people who participated in the early studies were adult White males, and many of these individuals were court-mandated to receive treatment. In the research conducted over the last 10 years, the population was mostly well-educated individuals, predominantly men, who consider religion to be an extremely important part of their lives and participate in traditional or conservative faiths (e.g., The Church of Jesus Christ of Latter-Day Saints, evangelical Christianity, and Orthodox Judaism). These recent

studies included a small number of participants who identified as members of ethnic minority groups, and a few studies included women.

Most of the individuals studied had tried a variety of methods to change their sexual orientation, including psychotherapy, support groups, and religious efforts. Many of the individuals studied were recruited from groups endorsing SOCE. The relation between the characteristics of the individuals in samples used in these studies and the entire population of people who seek SOCE is unknown because the studies have relied entirely on convenience samples.

Former participants in SOCE reported diverse evaluations of their experiences: Some individuals perceived that they had benefited from SOCE, while others perceived that they had been harmed. Individuals who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional and spiritual distress and negative self-image. Other individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom they could identify. These effects are similar to those provided by mutual support groups for a range of problems, and the positive benefits reported by participants in SOCE, such as reduction of isolation, alterations in how problems are viewed, and stress reduction, are consistent with the findings of the general mutual support group literature. The research literature indicates that the benefits of SOCE mutual support groups are not unique and can be provided within an affirmative and multiculturally competent framework, which can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs.

Recent studies of participants who have sought SOCE do not adequately distinguish between *sexual orientation* and *sexual orientation identity*. We concluded that the failure to distinguish these aspects of human sexuality has led SOCE research to obscure what actually can or cannot change in human sexuality. The available evidence of both early and recent studies suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (e.g., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (e.g., values and behavior). They did so in a variety of ways and with varied and

unpredictable outcomes, some of which were temporary. For instance, in some research, individuals, through participating in SOCE, became skilled in ignoring or tolerating their same-sex attractions. Some individuals reported that they went on to lead outwardly heterosexual lives, developing a sexual relationship with an other-sex partner, and adopting a heterosexual identity. These results were less common for those with no prior heterosexual experience.

Literature on Children and Adolescents

To fulfill part of the task force charge, we reviewed the limited research on child and adolescent issues and drew the following conclusions: There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation. There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation. We have concerns that such interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents.

We were asked to report on adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. The limited published literature on these programs suggests that many do not present accurate scientific information regarding same-sex sexual orientations to youths and families, are excessively fear-based, and have the potential to increase sexual stigma. These efforts pose challenges to best clinical practices and professional ethics, as they potentially violate current practice guidelines by not providing treatment in the least-restrictive setting possible, by not protecting client autonomy, and by ignoring current scientific information on sexual orientation.

Recommendations and Future Directions

Practice

The task force was asked to report on the appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual

orientation or their behavioral expression of their sexual orientation, or both. The clinical literature indicated that adults perceive a benefit when they are provided with client-centered, multicultural, evidence-based approaches that provide (a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development. Acceptance and support include unconditional acceptance of and support for the various aspects of the client; respect for the client's values, beliefs, and needs; and a reduction in internalized sexual stigma. Comprehensive assessment involves an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation. Active coping includes both cognitive and emotional strategies to manage stigma and conflicts, including the development of alternative cognitive frames to resolve cognitive dissonance and the facilitation of affective expression and resolution of losses. Social support, which can mitigate distress caused by isolation, rejection, and lack of role models, includes psychotherapy, self-help groups, or welcoming communities (e.g., ethnic communities, social groups, religious denominations). Identity exploration and development include offering permission and opportunity to explore a wide range of options and reducing the conflicts caused by dichotomous or conflicting conceptions of self and identity without prioritizing a particular outcome.

This framework is consistent with multicultural and evidence-based practices in psychotherapy and is built on three key findings:

- Our systematic review of the early research found that enduring change to an individual's sexual orientation was unlikely.
- Our review of the scholarly literature on individuals distressed by their sexual orientation indicated that clients perceived a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns.
- Studies indicate that experiences of stigma—such as self-stigma, shame, isolation and rejection from relationships and valued communities, lack of emotional support and accurate information, and conflicts between multiple identities and between values and attractions—played a role in creating distress in individuals. Many religious individuals desired to live their lives in a manner consistent with their values (telic congruence); however, telic

congruence based on stigma and shame is unlikely to result in psychological well-being.

Research indicates that family interventions that reduce rejection and increase acceptance of their child and adolescent are helpful. For parents who are concerned or distressed by their child's sexual orientation, licensed mental health providers (LMHP) can provide accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation (e.g., communication, understanding, and empathy) and maintenance of the child's total health and well-being.

Additionally, the research and clinical literature indicates that increasing social support for sexual minority children and youth by intervening in schools and communities to increase their acceptance and safety is important. Services for children and youth should support and respect age-appropriate issues of self-determination; services should also be provided in the least restrictive setting that is clinically possible and should maximize self-determination. At a minimum, the assent of the youth should be obtained, including whenever possible a developmentally appropriate informed consent to treatment.

Some religious individuals with same-sex attractions experience psychological distress and conflict due to the perceived irreconcilability of their sexual orientation and religious beliefs. The clinical and research literature encourages the provision of acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. This includes an understanding of the client's faith and the psychology of religion, especially issues such as religious coping, motivation, and identity. Clients' exploration of possible life paths can address the reality of their sexual orientation and the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives; increase positive religious coping; foster an understanding of religious motivations; help integrate religious and sexual orientation identities; and reframe sexual orientation identities to reduce self-stigma.

LMHP strive to provide interventions that are consistent with current ethical standards. The APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) are resources for psychologists, especially Ethical Principles A (Beneficence and Nonmaleficence), D (Justice), and E (Respect for People's Rights and

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. Other potential targets of treatment are emotional adjustment, including shame and self-stigma, and personal beliefs, values, and norms.

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose parent or guardian expresses a desire for the minor to

For parents who are concerned or distressed by their child's sexual orientation, licensed mental health providers (LMHP) can provide accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation.

change. The framework proposed for adults (i.e., acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development) is also pertinent—with unique relevant features—to children and adolescents. For instance, the clinical

literature stresses interventions that accept and support the development of healthy self-esteem, facilitate the achievement of appropriate developmental milestones—including the development of a positive identity—and reduce internalized sexual stigma.

Dignity, including self-determination). For instance, LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and actions on the most current and valid scientific evidence, such as the evidence provided in this report (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgments). LMHP enhance principles of social justice when they strive to understand the effects of sexual stigma, prejudice, and discrimination on the lives of individuals, families, and communities. Further, LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.

Self-determination is the process by which a person controls or determines the course of her or his own life (according to the *Oxford American Dictionary*, 2007). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. Although some accounts suggest that providing SOCE increases self-determination, we were not persuaded by this argument, as it encourages LMHP to provide treatment that has not provided evidence of efficacy, has the potential to be harmful, and delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and type of therapy. Rather, therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

Education and Training

The task force was asked to provide recommendations on education and training for LMHP working with this population. We recommend that mental health professionals working with individuals who are considering SOCE learn about evidence-based and multicultural interventions and obtain additional knowledge, awareness, and skills in the following areas:

- Sexuality, sexual orientation, and sexual identity development.
- Various perspectives on religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion.

- Identity development, including integration of multiple identities and the resolution of identity conflicts.
- The intersections of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
- Sexual stigma and minority stress.

We also recommend that APA (a) take steps to encourage community colleges, undergraduate programs, graduate school training programs, internship sites, and postdoctoral programs in psychology to include this report and other relevant material on lesbian, gay, bisexual, and transgender (LGBT) issues in their curriculum; (b) maintain the currently high standards for APA approval of continuing professional education providers and programs; (c) offer symposia and continuing professional education workshops at APA's annual convention that focus on treatment of individuals distressed by their same-sex attractions, especially those who struggle to integrate religious and spiritual beliefs with sexual orientation identities; and (d) disseminate this report widely, including publishing a version of this report in an appropriate journal or other publication.

The information available to the public about SOCE is highly variable and can be confusing and misleading. Sexual minorities, individuals aware of same-sex attractions, families, parents, caregivers, policymakers, the public, and religious leaders can benefit from accurate scientific information about sexual orientation and the appropriate interventions for individuals distressed by their same-sex attractions. We recommend that APA take the lead in creating informational materials for sexual minority individuals, families, parents, and other stakeholders, including religious organizations, on appropriate multiculturally competent and client-centered interventions for those distressed by their sexual orientation and who may seek SOCE. We also recommended that APA collaborate with other relevant organizations, especially religious organizations, to disseminate this information.

Research

The task force was asked to provide recommendations for future research. We recommend that researchers and practitioners investigate multiculturally competent and affirmative evidence-based treatments for sexual

minorities that do not aim to alter sexual orientation. For such individuals, the focus would be on frameworks that include acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development without prioritizing one outcome over another.

The research on SOCE has not adequately assessed efficacy and safety. Any future research should conform to best-practice standards for the design of efficacy research. Research on SOCE would (a) use methods that are prospective and longitudinal; (b) employ sampling methods that allow proper generalization; (c) use appropriate, objective, and high-quality measures of sexual orientation and sexual orientation identity; (d) address preexisting and co-occurring conditions, mental health problems, other interventions, and life histories to test competing explanations for any changes; (e) address participants' biases and potential need for monitoring self-impression and life histories; and (f) include measures capable of assessing harm.

Council of Representatives adopt a new resolution, the **Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts**, to address these issues. [The Council adopted the resolution in August 2009.] (See Appendix A.)

Policy

The task force was asked to inform (a) the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and (b) public policy that furthers affirmative therapeutic interventions. We encourage APA to continue its advocacy for LGBT individuals and families and to oppose stigma, prejudice, discrimination, and violence directed at sexual minorities. We recommend that APA take a leadership role in opposing the distortion and selective use of scientific data about homosexuality by individuals and organizations and in supporting the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias. We encourage APA to engage in collaborative activities with religious communities in pursuit of shared prosocial goals when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles.

The 1997 Resolution on Appropriate Responses to Sexual Orientation (APA, 1998) focuses on ethical issues for practitioners and still serves this purpose. However, on the basis of (a) our systematic review of efficacy and safety issues, (b) the presence of SOCE directed at children and adolescents, (c) the importance of religion for those who currently seek SOCE, and (d) the ideological and political disputes that affect this area, the task force recommended that the APA

PREFACE

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation and charged the task force with three major tasks:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998);
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 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.

- Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

Nominations of task force members were solicited through an open process that was widely publicized through professional publications, electronic media, and organizations. The qualifications sought were (a) advanced knowledge of current theory and research on the development of sexual orientation; (b) advanced knowledge of current theory and research on therapies that aim to change sexual orientation; and (c) extensive expertise in affirmative mental health treatment for one or more of the following populations: children and adolescents who present with distress regarding their sexual orientation, religious individuals in distress regarding their sexual orientation, and adults who present with desires to their change sexual orientation or have undergone therapy to do so. An additional position was added for an expert in research design and methodology.

Nominations were open to psychologists, qualified counselors, psychiatrists, or social workers, including members and nonmembers of APA. Nominations of

ethnic minority psychologists, bisexual psychologists, psychologists with disabilities, transgender psychologists, and other psychologists who are members of underrepresented groups were welcomed. In April 2007, then-APA President Sharon Stephens Brehm, PhD, appointed the following people to serve on the task force: Judith M. Glassgold, PsyD (chair); Lee Beckstead, PhD; Jack Drescher, MD; Beverly Greene, PhD; Robin Lin Miller, PhD; and Roger L. Worthington, PhD.

The task force met face-to-face twice in 2007 and supplemented these meetings with consultation and collaboration via teleconference and the Internet. Initially, we reviewed our charge and defined necessary bodies of scientific and professional literature to review to meet that charge. In light of our charge to review the 1997 resolution, we concluded that the most important task was to review the existing scientific literature on treatment outcomes of sexual orientation change efforts (SOCE).

We also concluded that a review of research before 1997 as well as since 1997 was necessary to provide a complete and thorough evaluation of the scientific literature. Thus, we conducted a review of the available empirical research on treatment efficacy and results published in English from 1960 on and also used common databases such as PsycINFO and Medline, as well as other databases such as the ATLA Religion Database, LexisNexis, Social Work Abstracts, and Sociological Abstracts, to review evidence regarding harm and benefit from SOCE. The literature review for other areas of the report was also drawn from these databases and included lay sources such as GoogleScholar and material found through Internet searches. Due to our charge, we limited our review to sexual orientation and did not address gender identity, because the final report of another task force, the APA Task Force on Gender Identity and Gender Variance, was forthcoming (see APA, 2009).

The task force received comments from the public, professionals, and other organizations and read all comments received. We also welcomed submission of material from the interested public, mental health professionals, organizations, and scholarly communities. All nominated individuals who were not selected for the task force were invited to submit suggestions for articles and other material for us to review. We reviewed all material received. Finally, APA staff met with interested parties to understand their concerns.

The writing of the report was completed in 2008, with editing and revisions occurring in 2009. After a draft report was generated in 2008, we asked for professional

review by noted scholars in the area who were also APA members. Additionally, APA boards and committees were asked to select reviewers to provide feedback. After these reviews were received, the report was revised in line with these comments. In 2009, a second draft was sent to a second group of reviewers, including those who had previously reviewed the report, scholars in the field (including some who were not members of APA), representatives of APA boards and committees, and APA staff. The task force consulted with Nathalie Gilfoyle, JD, of the APA Office of General Counsel, as well as with Stephen Behnke, PhD, JD, of the APA Ethics Office. Other staff members of APA were consulted as needed.

We would like to thank the following two individuals who were essential to the accomplishment of our charge: Clinton W. Anderson, PhD, and Charlene DeLong, Dr. Anderson's knowledge of the field of LGBT psychology as well as his sage counsel, organizational experience, and editorial advice and skills were indispensable. Ms. DeLong was fundamental in providing technological support and aid in coordinating the activities of the task force.

We appreciate the assistance of Maria T. Valenti, MA, in conducting the research review and in organizing the tables. Mary Campbell also provided editorial advice on the report, and Stephanie Liotta provided assistance in preparing the final manuscript. We are grateful to David Spears for designing the report.

We would also like to acknowledge 2007 APA President Sharon Stephens Brehm, PhD, who was supportive of our goals and provided invaluable perspective at our first meeting, and to thank Alan E. Kazdin, PhD, past president, James H. Bray, PhD, president, and Carol D. Goodheart, EdD, president-elect, for their support. Douglas C. Haldeman, PhD, served as the Board of Director's liaison to the task force in 2007–2008 and provided counsel and expertise. Melba J.T. Vasquez, PhD, Michael Wertheimer, PhD, and Armand R. Cerbone, PhD, members of the APA Board of Directors, also reviewed this report and provided feedback.

We would very much like to thank Gwendolyn Puryear Keita, PhD, the executive director of the APA Public Interest Directorate, for her advice, support, and expertise. In addition, we acknowledge Rhea Farberman, executive director, and Kim Mills, associate executive director, of the APA Public and Member Communications office, for their expertise and support. Stephen H. Behnke, PhD, director of the APA Ethics

Office, and Nathalie Gilfoyle, APA Office of the General Counsel, provided valuable feedback on the report.

We acknowledge the following individuals, who served as scholarly reviewers of the first and second drafts of the report; their feedback on the content was invaluable (in alphabetical order): Eleonora Bartoli, PhD; Rosie Phillips Bingham, PhD; Elizabeth D. Cardoso, PhD; June W. J. Ching, PhD; David Michael Corey, PhD; Isiaah Crawford, PhD; Anthony D'Augelli, PhD; Sari H. Dworkin, PhD; Randall D. Ehrbar, PsyD; Angela Rose Gillem, PhD; Terry Sai-Wah Gock, PhD; Marvin R. Goldfried, PhD; John C. Gonsiorek, PhD; Perry N. Halkitis, PhD; Kristin A. Hancock, PhD; J. Judd Harbin, PhD; William L. Hathaway, PhD; Gregory M. Herek, PhD; W. Brad Johnson, PhD; Jon S. Lasser, PhD; Alicia A. Lucksted, PhD; Connie R. Matthews, PhD; Kathleen M. Ritter, PhD; Darryl S. Salvador, PsyD; Jane M. Simoni, PhD; Lori C. Thomas, JD, PhD; Warren Throckmorton, PhD; Bianca D. M. Wilson, PhD; Mark A. Yarhouse, PsyD; and Hirokazu Yoshikawa, PhD.

1. INTRODUCTION

In the mid-1970s, on the basis of emerging scientific evidence and encouraged by the social movement for ending sexual orientation discrimination, the American Psychological Association (APA) and other professional organizations affirmed that homosexuality per se is not a mental disorder and rejected the stigma of mental illness that the medical and mental health professions had previously placed on sexual minorities.¹ This action, along with the earlier action of the American Psychiatric Association that removed *homosexuality* from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*; American Psychiatric Association, 1973), helped counter the social stigma that the mental illness concept had helped to create and maintain. Through the 1970s and 1980s, APA and its peer organizations not only adopted a range of position statements supporting nondiscrimination on the basis of sexual orientation (APA, 1975, 2005a; American Psychiatric Association, 1973; American Psychoanalytic Association, 1991, 1992; National Association of Social Workers [NASW], 2000) but also acted on the basis of those positions to advocate for legal and policy changes (APA, 2003, 2005a, 2008b; NASW, 2000). On the basis of growing scientific evidence (Gonsiorek, 1991), licensed mental health providers

(LMHP)² of all professions increasingly took the perspective throughout this period that homosexuality per se is a normal variant³ of human sexuality and that lesbian, gay, and bisexual (LGB) people deserve to be affirmed and supported in their sexual orientation,⁴ relationships, and social opportunities. This approach to psychotherapy is generally termed *affirmative*, *gay affirmative*, or *lesbian, gay, and bisexual (LGB) affirmative*.

Consequently, the published literature on psychotherapeutic efforts to change sexual orientation that had been relatively common during the 1950s and 1960s began to decline, and approaches to psychotherapy that were not LGB affirmative came under increased scrutiny (cf. Mitchell, 1978; G.T. Wilson & Davison, 1974). The mainstream organizations for psychoanalysis and behavior therapy—the two types of therapeutic orientation most associated with the published literature on sexual orientation change therapies—publicly rejected these practices (American Psychoanalytic Association, 1991, 1992; Davison, 1976, 1978; Davison & Wilson, 1973; D. J. Martin, 2003).

² We use the term *licensed mental health providers* (LMHP) to refer to professional providers of mental health services with a variety of educational credentials and training backgrounds, because state licensure is the basic credential for independent practice.

³ We use the adjective *normal* to denote both the absence of a mental disorder and the presence of a positive and healthy outcome of human development.

⁴ We define sexual orientation as an individual's patterns of erotic, sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics (see pp. 29–32 for a more detailed discussion).

¹ We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of their own and of the other sex. This term is used because we recognize that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

In the early 1990s, some APA members began to express concerns about the resurgence of individuals and organizations that actively promoted the idea of homosexuality as a developmental defect or a spiritual and moral failing and that advocated psychotherapy and religious ministry to alter homosexual feelings and behaviors, because these practices seemed to be an attempt to repathologize sexual minorities (Drescher & Zucker, 2006; Haldeman, 1994; S. L. Morrow & Beckstead, 2004). Many of the individuals and organizations appeared to be embedded within conservative political and religious movements that supported the stigmatization of homosexuality (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center [SPLC], 2005).

The concerns led to APA's adoption in 1997 of the Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). In the resolution, APA reaffirmed the conclusion shared by all mainstream health and mental health professions that homosexuality is not a mental disorder and rejected any form of discrimination based on sexual orientation. In addition, APA highlighted the ethical issues that are raised for psychologists when clients present with a request to change their sexual orientation—issues such as bias, deception, competence, and informed consent (APA, 1998; Schneider, Brown, & Glassgold, 2002). APA reaffirmed in this resolution its opposition to “portrayals of lesbian, gay, and bisexual youths and adults as mentally ill due to their sexual orientation” and defined appropriate interventions as those that “counteract bias that is based in ignorance or unfounded beliefs about sexual orientation” (APA, 1998, p. 934).

In the years since APA's adoption of the 1997 resolution, there have been several developments that have led some APA members to believe that the resolution needed to be reevaluated. First, several professional mental health and medical associations adopted resolutions that opposed sexual orientation change efforts (SOCE)⁵ on the basis that such efforts were ineffective and potentially harmful (e.g., American Counseling Association, 1998; American Psychiatric Association, 2000; American Psychoanalytic Association, 2000; NASW, 1997). In most cases, these statements

were substantially different from APA's position, which did not address questions of efficacy or safety of SOCE.

Second, several highly publicized research reports on samples of individuals who had attempted sexual orientation change (e.g., Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; Spitzer, 2003) and other empirical and theoretical advances in the understanding of sexual orientation were published (e.g., Blanchard, 2008; Chivers, Seto, & Blanchard, 2007; Cochran & Mays, 2006; Diamond, 2008; Diaz, Ayala, & Bein, 2004; DiPlacido, 1998; Harper, Jernewall, & Zea, 2004; Herek, 2009; Herek & Garnets, 2007; Mays & Cochran, 2001; Meyer, 2003; Mustanski, Chivers, & Bailey, 2002; Rahman & Wilson, 2005; Savic & Lindstrom 2008; Szymanski, Kashubeck-West, & Meyer, 2008).

Third, advocates who promote SOCE as well as those who oppose SOCE have asked that APA take action on the issue. On the one hand, professional organizations and advocacy groups that believe that sexual orientation change is unlikely, that homosexuality is a normal variant of human sexuality, and that efforts to change sexual orientation are potentially harmful⁶ wanted APA to take a clearer stand and to clarify the conflicting media reports about the likelihood of sexual orientation change (cf. Drescher, 2003; Stålström & Nissinen, 2003). On the other hand, the proponents of SOCE that consist of organizations that adopt a disorder model of homosexuality and/or advocate a religious view of homosexuality as sinful or immoral wanted APA to clearly declare that consumers have the right to choose SOCE (Nicolosi, 2003; Nicolosi & Nicolosi, 2002; Rosik, 2001).

For these reasons, in 2007, APA established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, with the following charge:

1. Revise and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998);
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or

⁵ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

⁶ Two advocacy organizations (Truth Wins Out and Lambda Legal) are encouraging those who feel they were harmed by SOCE to seek legal action against their providers.

whose guardian expresses a desire for the minor to change.

- The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.
 - Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.
3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

The task force addressed its charge by completing a review and analysis of the broad psychological literature in the field. After reviewing the existing 1997 resolution in light of this literature review, we concluded that a new resolution was necessary. The basis for this conclusion, including a review and analysis of the extant research, is presented in the body of this report, and a new resolution, adopted in August 2009 by the APA Council of Representatives, is presented in Appendix A.

The report starts with a brief review of the task force charge and the psychological issues that form the foundation of the report. The second chapter is a brief history of the evolution of psychotherapy, from treatments based on the idea that homosexuality is a disorder to those that focus on affirmative approaches to sexual orientation diversity. Chapters 3 and 4 are a review of the peer-reviewed research on SOCE: Chapter 3 provides a methodological evaluation of this research, and Chapter 4 reports on the outcomes of this research. Chapter 5 reviews a broader base of literature regarding the experience of individuals who seek SOCE in order to elucidate the nature of clients' distress and identity conflicts. Chapter 6 then examines affirmative approaches for psychotherapy practice with adults and presents a specific framework for interventions. Chapter

7 returns to the 1997 APA resolution and its focus on ethics to provide an updated discussion of the ethical issues surrounding SOCE. Chapter 8 considers the more limited body of research on SOCE and reports of affirmative psychotherapy with children, adolescents, and their families. Chapter 9 summarizes the report and presents recommendations for research, practice, education, and policy. The policy resolution that the task force recommended and that was adopted by the APA Council of Representatives on August, 5, 2009, is in Appendix A.

Laying the Foundation of the Report

Understanding Affirmative Therapeutic Interventions

The task force was asked to report on appropriate application of affirmative psychotherapeutic interventions for those who seek to change their sexual orientation. As some debates in the field frame SOCE and conservative religious values as competing viewpoints to affirmative approaches (cf. Throckmorton, 1998; Yarhouse, 1998a) and imply that there is an alternative "neutral" stance, we considered it necessary to explain the term *affirmative therapeutic interventions*, its history, its relationship to our charge and to current psychotherapy literature, and our application and definition of the term.

The concept of gay-affirmative therapeutic interventions emerged in the early literature on the psychological concerns of sexual minorities (Malyon, 1982; Paul, Weinrich, Gonsiorek, & Hotvedt, 1982), and its meaning has evolved over the last 25 years to include more diversity and complexity (APA, 2000; Bieschke, Perez, & DeBord, 2007; Firestein, 2007; Herek & Garnets, 2007; Perez, DeBord, & Bieschke, 2000; Ritter & Terndrup, 2002). The affirmative approach grew out of a perception that sexual minorities benefit from psychotherapeutic interventions that address the sexual stigma⁷ they experience and the impacts of stigma on their lives (APA, 2000; Brown, 2006; Browning, Reynolds, & Dworkin, 1991; Davison, 1978; Malyon, 1982; Pachankis & Goldfried, 2004; Ritter & Terndrup, 2002; Shannon & Woods, 1991; Sophie, 1987). For example, Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) proposed that LHMP use an understanding of societal prejudice and

⁷ See p. 15 for the definition of *sexual stigma*.

discrimination to guide treatment for sexual minority clients and help these clients overcome negative attitudes about themselves.

The most recent literature in the field (e.g., APA, 2000, 2002c, 2004, 2005b, 2007b; Bartoli & Gillem, 2008; Brown, 2006; Herek & Garnets, 2007) places affirmative therapeutic interventions within the larger domain of cultural competence, consistent with general multicultural approaches. Multicultural approaches recognize that individuals, families, and communities exist in social, political, historical, and economic contexts (cf. APA, 2002b) and that human diversity is multifaceted and includes age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. Understanding and incorporating these aspects of diversity are important to any intervention (APA, 2000, 2002c, 2004, 2005b, 2007b).

The task force takes the perspective that a multiculturally competent and affirmative approach with sexual minorities is based on the scientific knowledge in key areas: (a) homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences throughout the life span (D'Augelli & Patterson, 1995, 2001); (b) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality and are not indicators of either mental or developmental disorders (American Psychiatric Association, 1973; APA, 2000; Gonsiorek, 1991); (c) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientation identities (Diamond, 2006, 2008; Klein, Sepekoff, & Wolf, 1985; McConaghy, 1999); and (d) lesbians, gay men, and bisexual people can live satisfying lives and form stable, committed relationships and families that are equivalent to heterosexuals' relationships and families in essential respects (APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).

Although affirmative approaches have historically been conceptualized around helping sexual minorities

We define an affirmative approach as supportive of clients' identity development without a priori treatment goals for how clients identify or express their sexual orientations.

identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are

accept and adopt a gay or lesbian identity (e.g., Browning et al., 1991; Shannon & Woods, 1991), the recent research on sexual orientation

labeled and expressed in many different ways, some of which are fluid (e.g., Diamond, 2006, 2008; Firestein, 2007; Fox, 2004; Patterson, 2008; Savin-Williams, 2005; R. L. Worthington & Reynolds, 2009). We define an affirmative approach as supportive of clients' identity development without a priori treatment goals for how clients identify or express their sexual orientations. Thus, a multiculturally competent affirmative approach aspires to understand the diverse personal and cultural influences on clients and enables clients to determine (a) the ultimate goals for their identity process; (b) the behavioral expression of their sexual orientation; (c) their public and private social roles; (d) their gender roles, identities, and expression⁸; (e) the sex⁹ and gender of their partner; and (f) the forms of their relationships.

EVIDENCE-BASED PRACTICE AND EMPIRICALLY SUPPORTED TREATMENTS

Interest in the efficacy,¹⁰ effectiveness, and empirical basis of psychotherapeutic interventions has grown in the last decade. Levant and Hasan (2009) distinguished between two types of treatments: empirically supported treatments (EST) and evidence-based approaches to psychotherapy (EBPP). EST are interventions for individuals with specific disorders; these interventions have been demonstrated to be effective through rigorously controlled trials (Levant & Hasan, 2009). EBPP is, as defined by APA's Policy Statement on Evidence-Based Practice in Psychology¹¹ (2005a), "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 1; see also, Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

We were not able to identify affirmative EST for this population (cf. Martell, Safran, & Prince, 2004).

⁸ *Gender* refers to the cultural roles, behaviors, activities, and psychological attributes that a particular society considers appropriate for men and women. *Gender identity* is a person's own psychological sense of identification as male or female, another gender, or identifying with no gender. *Gender expression* is the activities and behaviors that purposely or inadvertently communicate one's gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

⁹ We define *sex* as biological maleness and femaleness in contrast to gender, defined above.

¹⁰ *Efficacy* is the measurable effect of an intervention, and *effectiveness* aims to determine whether interventions have measurable effects in real-world settings across populations (Nathan, Stuart, & Dolan, 2000).

¹¹ Discussion of the overall implications for practice can be found in Goodheart, Kazdin, and Sternberg (2006) and the *Report of the 2005 Presidential Task Force on Evidence-Based Practice* (APA, 2005b).

The lack of EST is a common dilemma when working with diverse populations for whom EST have not been developed or when minority populations have not been included in trials (Brown, 2006; Martell et al., 2004; Sue & Zane, 2006; Whaley & Davis, 2007). Thus, we provide an affirmative model in Chapter 6 that is consistent with APA's definition of EBPP in that it applies the most current and best evidence available to guide decisions about the care of this population (APA, 2005a; Sackett et al., 1996). We considered the APA EBPP resolution as utilizing a flexible concept of evidence, because it incorporates research based on well-designed studies with client values and clinical expertise. Given that the distress surrounding sexual orientation is not included in psychotherapy research (because it is not a clearly defined syndrome) and most treatment studies in psychology are for specific mental health disorders, not for problems of adjustment or identity relevant to sexual orientation concerns, we saw this flexibility as necessary (Brown, 2006). However, EST for specific disorders can be incorporated into this affirmative approach (cf. Martell et al., 2004). We acknowledge that the model presented in this report would benefit from rigorous evaluation.

Affirmative approaches, as understood by this task force, are evidence-based in three significant ways:

- They are based on the evidence that homosexuality is not a mental illness or disorder, which has a significant empirical foundation (APA, 2000; Gonsiorek, 1991).
- They are based on studies of the role of stigma in creating distress and health disparities in sexual minorities (Balsam & Mohr, 2007; Cochran & Mays, 2006; Omoto & Kurtzman, 2006; Pachankis, 2007; Pachankis, Goldfried, & Ramrattan, 2008; Safren & Heimberg, 1999; Syzanski & Kashubeck-West, 2008).
- They are based on the literature that has shown the importance of the therapeutic alliance and relationship on outcomes in therapy and that these outcomes are linked to empathy, positive regard, honesty, and other factors encompassed in the affirmative perspective on therapeutic interventions (Ackerman & Hilsenroth, 2003; Brown, 2006; Farber & Lane, 2002; Horvath & Bedi, 2002; Norcross, 2002; Norcross & Hill, 2004).

The affirmative approach was the subject of a recent literature review that found that clients describe the safety, affirmation, empathy, and nonjudgmental

acceptance inherent in the affirmative approach as helpful in their therapeutic process (M. King, Semlyen, Killaspy, Nazareth, & Osborn, 2007; see also, M. A. Jones & Gabriel, 1999). M. King et al. concluded that a knowledge base about sexual minorities' lives and social context is important for effective practice.

Sexual Stigma

To understand the mental health concerns of sexual minorities, one must understand the social psychological concept of stigma (Herek & Garnets, 2007). Goffman (1963) defined stigma as an undesirable difference that discredits the individual. Link and Phelan (2001) characterized stigma as occurring when (a) individual differences are labeled; (b) these differences are linked to undesirable traits or negative stereotypes; (c) labeled individuals are placed in distinct categories that separate them from the mainstream; and (d) labeled persons experience discrimination and loss of status that lead to unequal access to social, economic, and political power. This inequality is a consequence of stigma and discrimination rather than of the differences themselves (Herek, 2009). Stigma is a fact of the interpersonal, cultural, legal, political, and social climate in which sexual minorities live.

The stigma that defines sexual minorities has been termed *sexual stigma*¹²: "the stigma attached to any non-heterosexual behavior, identity, relationship or community" (Herek, 2009, p. 3). This stigma operates both at the societal level and the individual level. The impact of this stigma as a stressor may be the unique factor that characterizes sexual minorities as a group (Herek, 2009; Herek & Garnets, 2007; Katz, 1995).

Further, stigma has shaped the attitudes of mental health professions and related institutions toward this population (Drescher, 1998b; Haldeman, 1994;

In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination by conceptualizing and treating homosexuality as a mental illness or disorder.

LeVay, 1996; Murphy, 1997; Silverstein, 1991). Moral and religious values in North America and Europe provided the initial rationale for criminalization, discrimination, and prejudice against same-

¹² Herek (2009) coined this term, and we use it because of the comprehensive analysis in which it is embedded. There are other terms for the same construct, such as Balsam and Mohr's (2007) *sexual orientation stigma*.

sex behaviors (Katz, 1995). In the late modern period, the medical and mental health professions added a new type of stigmatization and discrimination by conceptualizing and treating homosexuality as a mental illness or disorder (Brown, 1996; Katz, 1995).

Sexual minorities may face additional stigmas, as well, such as those related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. At the societal level, sexual stigma is embedded in social structures through civil and criminal law, social policy, psychology, psychiatry, medicine, religion, and other social institutions. Sexual stigma is reflected in disparate legal and social treatment by institutions and is apparent in, for example, (a) the long history of criminalization of same-sex sexual behaviors; (b) the lack of legal protection for LGB individuals from discrimination in employment, health care, and housing; and (c) the lack of benefits for LGB relationships and families that would support their family formation, in contrast to the extensive benefits that accrue to heterosexual married couples and even sometimes to unmarried heterosexual couples.¹³ The structural sexual stigma, called *heterosexism* in the scholarly literature, legitimizes and perpetuates stigma against sexual minorities and perpetuates the power differential between sexual minorities and others (Herek, 2007; see also Szymanski et al., 2008).

Expressions of stigma, such as violence, discrimination, rejection, and other negative interpersonal interactions, are *enacted stigma* (Herek, 2009). Individuals' expectations about the probability that stigma will be enacted in various situations is *felt stigma*. Individuals' efforts to avoid enacted and felt stigma may include withdrawing from self (e.g., self-denial or compartmentalization) and withdrawing from others (e.g., self-concealment or avoidance) (e.g., see Beckstead & Morrow, 2004; Drescher, 1998b; Malyon, 1982; Pachankis, 2007; Pachankis et al., 2008; Troiden, 1993).

¹³ Same-sex sexual behaviors were only recent universally decriminalized in the United States by Supreme Court action in *Lawrence v. Texas* (2003). There is no federal protection from employment and housing discrimination for LGB individuals, and only 20 states offer this protection. Only 6 states permit same-sex couples to marry; 6 states have broad recognition laws; 4 states have limited recognition laws; and 2 states recognize other states' marriages. For more examples, see National Gay and Lesbian Task Force, Reports & Research: [http:// www.thetaskforce.org/reports_and_research/reports](http://www.thetaskforce.org/reports_and_research/reports)).

In Herek's (2009) model, *internalized stigma*¹⁴ is the adoption of the social stigma applied to sexual minorities. Members of the stigmatized groups as well as nonmembers of the group can internalize these values. *Self-stigma* is internalized stigma in those individuals who experience same-sex sexual attractions and whose self-concept matches the stigmatizing interpretations of society. Examples of this self-stigma are (a) accepting society's negative evaluation and (b) harboring negative attitudes toward oneself and one's own same-sex sexual attractions. *Sexual prejudice* is the internalized sexual stigma held by the non-stigmatized majority.

The Impact of Stigma on Members of Stigmatized Groups

One of the assumptions of the stigma model is that social stigma influences the individual through its impact on the different settings, contexts, and relationships in which each human being takes part (D'Augelli, 1994). This assumption is supported by a body of literature comparing sexual minority populations to the general population that has found health disparities between the two (Cochran & Mays, 2006; Mays & Cochran, 2001). The concept of minority stress (e.g., DiPlacido, 1998; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 1995, 2003) has been increasingly used to explain these health disparities in much the same way that concepts of racism-derived stress and minority stress have been used to explain health disparities and mental health concerns in ethnic minority groups (Carter, 2007; Harrell, 2000; Mays, Cochran, & Barnes, 2007; Saldana, 1994; Wei, Ku, Russell, Mallinckrodt, & Liao, 2008). Theoretically any minority group facing social stigma and prejudice, including stigma due to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, could develop minority stress.

In theory, minority stress—chronic stress experienced by members of minority groups—causes distress in

¹⁴ Herek (2009) defined *internalization* as "the process whereby individuals adopt a social value, belief, regulation, or prescription for conduct as their own and experience it as part of themselves" (p. 7). The internalization of negative attitudes and assumptions concerning homosexuality has often been termed *internalized homophobia* (Malyon, 1982; Sophie, 1987; Weinberg, 1972). However, this term has been criticized because holding negative attitudes does not necessarily involve a phobia, in other words, "an exaggerated usually inexplicable and illogical fear of a particular object, class of objects, situation (Merriam-Webster's Online Dictionary).

certain sexual minority individuals (DiPlacido, 1998; Meyer, 1995, 2003). Meyer (2003) described these stress processes as due to (a) external objective events and conditions, such as discrimination and violence; (b) expectations of such events, and the vigilance that such expectations bring; and (c) internalization of negative social and cultural attitudes. For instance, mental health outcomes among gay men have been found to be influenced by negative appraisals of stigma-related stressors (Meyer, 1995).

The task force sees stigma and minority stress as playing a manifest role in the lives of individuals who seek to change their sexual orientation (Davison, 1978, 1982, 1991; Herek, Cogan, Gillis, & Glunt, 1998; Green, 2003; Silverstein, 1991; Tozer & Hayes, 2004). Davison, in particular, has argued that individuals who seek psychotherapy to change their sexual orientation do so because of the distress arising from the impact of stigma and discrimination. A survey of a small sample of former SOCE clients in Britain supports this hypothesis, as many of the former participants reported that hostile social and family attitudes and the criminalization of homosexual conduct were the reasons they sought treatment (G. Smith, Bartlett, & King, 2004).

One of the advantages of the minority stress model is that it provides a framework for considering the social context of stress, distress, coping, resilience (Allen, 2001; David & Knight, 2008; Herek, Gillis, & Cogan, 2009; Selvidge, Matthews, & Bridges, 2008; Levitt et al., 2009; Pachankis, 2007), and acceptance and goals of treatment (Beckstead & Israel, 2007; Bieschke, 2008; Frost & Meyer, 2009; Glassgold, 2007; Rostosky, Riggle, Horne, & Miller, 2009; Martell et al., 2004; Russell & Bohan, 2007). Some authors have proposed that LGB men and women improve their mental health and functioning through a process of positive coping, termed *stigma competence* (David & Knight, 2008). In this model, it is proposed that through actions such as personal acceptance of one's LGB identity and reduction of internalized stigma, an individual develops a greater ability to cope with stigma (cf. Crawford, Allison, Zamboni, & Soto, 2002; D'Augelli, 1994). For instance, Herek and Garnets (2007) proposed that collective identity (often termed *social identity*)¹⁵ mitigates the impact of minority stress above and beyond the effects of individual factors such as coping skills, optimism, and resiliency. Individuals with a strong sense of positive collective identity integrate their group affiliation into

their core self-concept and have community resources for responding to stigma (Balsam & Mohr, 2007; Crawford et al., 2002; Levitt et al., 2009). In support of this hypothesis, Balsam and Mohr (2007) found that collective identity, community participation, and identity confusion predicted coping with sexual stigma.

Psychology, Religion, and Homosexuality

Most of the recent studies on SOCE focus on populations with strong religious beliefs (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Ponticelli, 1999; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Spitzer, 2003; Tozer & Hayes, 2004; Wolkomir, 2001). Beliefs about sexual behavior and sexual orientation rooted in interpretations of traditional religious doctrine also guide some efforts to change others' sexual orientation as well as political opposition to the expansion of civil rights for LGB individuals and their relationships (Burack & Josephson, 2005; S. L. Morrow & Beckstead, 2004; Olyam & Nussbaum, 1998; Pew Forum on Religion and Public Life, 2003; Southern Poverty Law Center, 2005). Some authors have documented an increase in the provision of religiously-based SOCE (Burack & Josephson, 2005; Cianciotto & Cahill, 2006). Religious beliefs, motivations, and struggles play a role in the motivations of individuals who currently engage in SOCE (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001; Yarhouse, Tan, & Pawlowski, 2005). Thus, we considered an examination of issues in the psychology of religion to be an important part of fulfilling our charge.

Intersections of Psychology, Religion, and Sexual Orientation

World religions regard homosexuality from a spectrum of viewpoints. It is important to note that some religious denominations' beliefs and practices have changed over time, reflecting evolving scientific and civil rights perspectives on homosexuality and sexual orientation (see, e.g., Dorff, Nevins, & Reisner, 2006; Olyam & Nussbaum, 1998; see also Hebrew Union College, Institute for Judaism & Sexual Orientation [<http://www.huc.edu/ijso>], and Ontario Consultants on Religious Tolerance [<http://www.religioustolerance.org>]). A number of religious denominations in the United States welcome LGB laity, and a smaller

¹⁵ A collective or social identity refers to an individual's sense of belonging to a group (the collective), and the collective or social identity forms a part of his or her personal identity.

number ordain LGB clergy (e.g., Reconstructionist Judaism, Reform Judaism, Conservative Judaism, Buddhist Peace Fellowship, Buddhist Churches of America, Episcopal Church of America, Friends General Conference, Unitarian Society, United Church of Christ Congregational) (Greenberg, 2004; Olyam & Nussbaum, 1998; see also Hebrew Union College, Institute for Judaism & Sexual Orientation [http://www.huc.edu/ijso], and Ontario Consultants on Religious Tolerance [http://www.religioustolerance.org]). However, others view homosexuality as immoral and sinful (e.g., Christian Reformed Church of North America, Church of Jesus Christ of Latter-Day Saints, Eastern Orthodox Christianity, Orthodox Judaism, Presbyterian Church in American, Roman Catholicism, Southern Baptist Convention, United Methodist Church) (see Ontario Consultants on Religious Tolerance: http://www.religioustolerance.org). These issues are being discussed within numerous denominations (e.g., Van Voorst, 2005), and some views are in flux (e.g., the Presbyterian Church [USA]) (see Ontario Consultants on Religious Tolerance: http://www.religioustolerance.org).

Several professional publications (e.g., *Journal of Gay and Lesbian Psychotherapy*, 2001, 5[3/4]; *Professional Psychology*, 2002, 33[3]; *Archives of Sexual Behavior*,

Some difficulties arise because the professional psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, a moral failing, or a disorder that needs to be changed.

2003, 32[5]; *The Counseling Psychologist*, 2004, 32[5]; *Journal of Psychology and Christianity*, 2005, 24[4]) have specifically considered the interactions among scientific views of sexual orientation, religious beliefs, psychotherapy, and professional ethics. Some difficulties arise because the professional

psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, a moral failing, or a disorder that needs to be changed.

The conflict between psychology and traditional faiths may have its roots in different philosophical viewpoints. Some religions give priority to *telic congruence* (i.e., living consistently within one's valuative goals¹⁶) (W.

¹⁶ These conflicts are not unique to religious individuals but are applicable to individuals making commitments and decisions about how

Hathaway, personal communication, June 30, 2008; cf. Richards & Bergin, 2005). Some authors propose that for adherents of these religions, religious perspectives and values should be integrated into the goals of psychotherapy (Richards & Bergin, 2005; Throckmorton & Yarhouse, 2006). Affirmative and multicultural models of LGB psychology give priority to *organismic congruence* (i.e., living with a sense of wholeness in one's experiential self¹⁷) (W. Hathaway, personal communication, June 30, 2008; cf. Gonsiorek, 2004; Malyon, 1982). This perspective gives priority to the unfolding of developmental processes, including self-awareness and personal identity.

This difference in worldviews can impact psychotherapy. For instance, individuals who have strong religious beliefs can experience tensions and conflicts between their ideal self and beliefs and their sexual and affectional needs and desires (Beckstead & Morrow, 2004; D. F. Morrow, 2003). The different worldviews would approach psychotherapy for these individuals from dissimilar perspectives: The telic strategy would prioritize values (Rosik, 2003; Yarhouse & Burkett, 2002), whereas the organismic approach would give priority to the development of self-awareness and identity (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004).

It is important to note that the organismic worldview can be congruent with and respectful of religion (Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Ritter & O'Neil, 1995), and the telic worldview can be aware of sexual stigma and respectful of sexual orientation (Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). Understanding this philosophical difference may improve the dialogue between these two perspectives represented in the literature, as it refocuses the debate not on one group's perceived rejection of homosexuals or the other group's perceived minimization of religious viewpoints but on philosophical differences that extend beyond this particular subject matter. However, some of the differences between these philosophical assumptions may be difficult to bridge.

Contrasting views exist within psychology regarding religious views about homosexuality. One way in which psychology has traditionally examined the

to live according to specific ethics and ideals (cf. Baumeister & Exline, 2000; Diener, 2000; Richards & Bergin, 2005; B. Schwartz, 2000).

¹⁷ Such naturalistic and empirically based models stress the organization, unity, and integration of human beings expressed through each individual's inherent growth or developmental tendency (see, e.g., Rogers, 1961; R. M. Ryan, 1995).

intersections between religion and homosexuality is by studying the impact of religious beliefs and motivations on attitudes and framing the discussion in terms of tolerance and prejudice (Fulton, Gorsuch, & Maynard, 1999; Herek, 1987; Hunsberger & Jackson, 2005; Plugge-Foust & Strickland, 2000; J. P. Schwartz & Lindley, 2005). For instance, one finding is that religious fundamentalism is correlated with negative views of homosexuality, whereas a quest orientation is associated with decreased discriminatory or prejudicial attitudes (Batson, Flink, Schoenrade, Fultz, & Pych, 1986; Batson, Naifeh, & Pate, 1978; Fulton et al., 1999; Plugge-Foust & Strickland, 2000). However, some authors have argued, in contrast to this approach, that conservative religious moral beliefs and evaluations about same-sex sexual behaviors and LGB individuals and relationships should be treated as religious diversity rather than as sexual prejudice (e.g., Rosik, 2007; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002).

APA Policies on the Intersection of Religion and Psychology

APA has addressed the interactions of religion and psychology in two recent resolutions: the Resolution Rejecting Intelligent Design as Scientific and Reaffirming Support for Evolutionary Theory (APA, 2008a) and the Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c). The first resolution articulates psychology's epistemological commitment: Hypothesis testing through rigorous scientific methods is the best means to gain new knowledge and to evaluate current practices, and psychologists base their theories on such research:

While we are respectful of religion and individuals' right to their own religious beliefs, we also recognize that science and religion are separate and distinct. For a theory to be taught as science it must be testable, supported by empirical evidence and subject to disconfirmation. (APA, 2007a)

This is in contrast to viewpoints based on faith, as faith does not need confirmation through scientific evidence. Further, science assumes that some ideas can be rejected when proven false; faith and religious beliefs cannot be falsified in the eyes of adherents.

The APA Council of Representatives also passed a Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c). This resolution acknowledges the existence of two forms of prejudice

related to religion: one derived from religious beliefs and another directed at religions and their adherents. The APA strongly condemns both forms of prejudice. The resolution affirms APA's position that prejudices directed at individuals because of their religious beliefs and prejudices derived from or justified by religion are harmful to individuals, society, and international relations.

In areas of conflicts between psychology and religion, as the APA Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice (2008c) states, psychology has no legitimate function in "arbitrating matters of faith and theology" or to "adjudicate religious or spiritual tenets" (p. 432) and psychologists are urged to limit themselves to speak to "psychological

implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist" (p. 433). Further, the resolution states that faith traditions "have no legitimate place arbitrating behavioral or other sciences" or to "adjudicate empirical scientific issues in psychology" (p. 432).

The APA (2002b, 2008c) recommends that psychologists acknowledge the importance of religion and spirituality as forms of meaning-making, tradition, culture, identity, community, and diversity. Psychologists do not discriminate against individuals based on those factors. Further, when devising interventions and conducting research, psychologists consider the importance of religious beliefs and cultural values and, where appropriate, consider religiously and culturally sensitive techniques and approaches (APA, 2008c).

Psychology of Religion

Historically, some in psychology and psychiatry have held negative views of religion (Wulff, 1997). Yet, with the development of more sophisticated methodologies and conceptualizations, the field of the psychology of religion has flourished in the last 30 years (Emmons & Paloutzian, 2003), culminating in new interest in a diverse field (e.g., Koenig & Larson, 2001; Paloutzian & Park, 2005; Pargament, 2002; Pargament & Mahoney,

2005; Richards & Bergin, 2005; Sperry & Shafranske, 2004; Spilka, Hood, Hunsberger, & Gorsuch, 2003).

Many scholars have attempted to elucidate what is significant and unique about religious and spiritual faith, beliefs, and experiences (e.g., George, Larson, Koenig, & McCullough, 2000; McClennon, 1994). Pargament, Maygar-Russell, and Murray-Swank (2005) summarized religion's impact on people's lives as a unique form of motivation regarding how to live one's life and how to respond to self, others, and life events; a source of significance regarding what aspects of life one imbues with meaning and power; a contributor to mortality and health; a form of positive and negative coping; and a source of fulfillment and distress. Others, such as Fowler (1981, 1991) and colleagues (Oser, 1991; Streib, 2001, 2005) have posited developmental models of religious identity that are helpful in understanding personal faith.

Additionally, there is a growing literature on integrating spirituality into psychotherapy practice (Richards & Bergin, 2000, 2004, 2005; Shafranske, 2000; Sperry & Shafranske, 2004; E. L. Worthington, Kurusu, McCullough, & Sandage, 1996). These approaches include delineating how LMHP can work effectively with individuals from diverse religious traditions (Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Many of these techniques can be effective (McCullough, 1999) and improve outcomes in clinical treatment with religious clients (Probst, Ostrom, Watkins, Dean, & Mashburn, 1992; Richards, Berrett, Hardman, & Eggett, 2006; E. L. Worthington et al., 1996), even for clients in treatment with secular LMHP (Mayers, Leavey, Vallianatou, & Barker, 2007). These innovations point to ways that psychology can explore and understand religious beliefs and faith in an evidence-based and respectful manner.

There have been claims that some LMHP do not address the issues of conservative religious individuals who are distressed by their same-sex sexual attractions (e.g., Yarhouse, 1998a; Throckmorton, 2002; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). One of the problems in the field has been an either/or perspective in which sexual orientation and religion are seen as incompatible (Phillips, 2004). Certainly, some individuals may perceive their religion and their sexual orientation as incompatible, because in some faiths homosexuality is perceived as sinful and immoral. However, there is a growing body of evidence illustrating that many individuals do integrate their religious and sexual orientation identities (Coyle & Rafalin, 2000; Kerr, 1997; Mahaffy, 1996; Rodriguez,

2006; Rodriguez & Ouellete, 2000; Thumma, 1991; Yip, 2002, 2003, 2005). Thus, this dichotomy may be enabling a discourse that does not fully reflect the evidence and may be hindering progress to find a variety of viable solutions for clients.

Recently, some authors have suggested alternative frameworks, many of which are drawn from a variety of models of psychotherapy, such as multicultural views of psychology and the psychology of religion, that provide

We take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

frames for appropriate psychotherapeutic interventions seeking to bridge this divide (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Buchanon, Dzelme, Harris, & Hecker, 2001; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004;

S. L. Morrow & Beckstead, 2004; Ritter & O'Neill, 1989; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). For instance, a growing number of authors address the religious and spiritual needs of LGBT individuals from integrative and affirmative perspectives that provide resources for LMHP working with this population (Astramovich, 2003; Beckstead & Israel, 2007; Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 1996, 2004; Horne & Noffsinger-Frazier, 2003; Mark, 2008; D. F. Morrow, 2003; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). On the basis of these scholarly contributions, we take the perspective that religious faith and psychology do not have to be seen as being opposed to each other. Further, psychotherapy that respects faith can also explore the psychological implications and impacts of such beliefs.

We support affirmative and multiculturally competent approaches that integrate concepts from the psychology of religion and the modern psychology of sexual orientation. These perspectives are elaborated later in this report. In the next chapter we review the history of SOCE in order to provide a perspective on the foundation and evolution of these approaches.

2. A BRIEF HISTORY OF SEXUAL ORIENTATION CHANGE EFFORTS

Sexual orientation change efforts (SOCE)¹⁸ within mental health fields originally developed from the science of sexuality in the middle of the 19th century (Katz, 1995). At that time, same-sex eroticism and gender-nonconforming behaviors came under increased medical and scientific scrutiny. New terms such as *urnings*, *inversion*, *homosexual*, and *homosexuality* emerged as scientists, social critics, and physicians sought to make sense of what was previously defined as sin or crime (Katz, 1995). This shift to a scientific approach did not challenge the underlying social values, however, and thus continued to reflect the existing sexual stigma, discrimination, criminalization, and heterosexism. Much of the medical and scientific work at that time conceptualized homosexual attractions and behaviors as abnormal or as an illness (Katz, 1995).

In that era, homosexuality was predominantly viewed as either a criminal act or a medical problem, or both (Krafft-Ebing, 1886/1965). Homosexuality was seen as caused by psychological immaturity (i.e., as a passing phase to be outgrown on the road to adult heterosexuality) or pathology (e.g., genetic defects, gender-based confusions, intrauterine hormonal exposure, too much parental control, insufficient parenting, hostile parenting, seduction, molestation, or

decadent lifestyles) (Drescher, 1998b, 2002). The first treatments attempted to correct or repair the damage done by pathogenic factors or to facilitate maturity (Drescher, 1998b, 2002; LeVay, 1996; Murphy, 1992, 1997). These perspectives on homosexuality lasted into the first half of the 20th century, shaping the views of psychoanalysis, the dominant psychiatric paradigm of that time (Drescher, 1998b).

Homosexuality and Psychoanalysis

Initial psychotherapeutic approaches to homosexuality in the first half of the 20th century reflected psychoanalytic theory. Freud's own views on sexual orientation and homosexuality were complex. Freud viewed homosexuality as a developmental arrest and heterosexuality as the adult norm (Freud, 1905/1960). However, in a now-famous letter, Freud (1935/1960) reassured a mother writing to him about her son that homosexuality was "nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness, but a variation of sexual function" (p. 423). He further went on to say that psychoanalysts could not promise to "abolish homosexuality and make normal heterosexuality take its place" (p. 423), as the results of treatment could not be determined. Freud's only report (1920/1960) about his deliberate attempt to change someone's sexual orientation described his unsuccessful efforts at changing the sexual orientation of a young woman brought for involuntary treatment by her

¹⁸ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

parents. At the end of this case, Freud concluded that attempts to change homosexual sexual orientation were likely to be unsuccessful.¹⁹

In the psychoanalysis that dominated the mental health fields after Freud, especially in the United States, homosexuality was viewed negatively, considered to be abnormal, and believed to be caused by family dynamics (Bieber et al., 1962; Rado, 1940; Socarides, 1968). Other approaches based loosely on psychoanalytic ideas advocated altering gender-role behaviors to increase conformity with traditional gender roles (Moberly, 1983; Nicolosi, 1991). Significantly impacting psychiatric thought in the mid-20th century, these theories were part of the rationale for including homosexuality as a mental illness in both the first (1952) and second (1968) editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, thus reinforcing and exacerbating sexual stigma and sexual prejudice. It was during this period that the first attempts to study the efficacy of SOCE were conducted (e.g., Bieber et al., 1962).

Sexual Orientation Change Efforts

The pathologizing psychiatric and psychological conception of homosexuality and concomitant efforts to alter sexual orientation through psychoanalytic and behavior therapy were prevalent through the 1960s and into the early 1970s. Although behavior therapy emerged in the 1960s, adding a different set of techniques to psychotherapy, the goals of SOCE did not change. For example, Ovesey (1969) based his behavioral interventions on the belief that homosexuality developed from a phobia of taking on the normal qualities of one's gender and that sexual intercourse with the other²⁰ sex would cure the so-called phobia.

Behavior therapists tried a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the

individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts. Other examples of aversive behavioral treatments included covert sensitization, shame aversion, systematic desensitization, orgasmic reconditioning, and satiation therapy (Beckstead & Morrow, 2004; S. James, 1978; Katz, 1995; Langevin, 1983; LeVay, 1996; Murphy, 1992, 1997). Some nonaversive treatments used an educational process of dating skills, assertiveness, and affection training with physical and social reinforcement to increase other-sex sexual behaviors (Binder, 1977; Greenspoon & Lamal, 1987; Stevenson & Wolpe, 1960). Cognitive therapists attempted to change gay men's and lesbians' thought patterns by reframing desires, redirecting thoughts, or using hypnosis, with the goal of changing sexual arousal, behavior, and orientation (e.g., Ellis, 1956, 1959, 1965).

Affirmative Approaches: Kinsey; Ford and Beach; and Hooker

At the same time that the pathologizing views of homosexuality in American psychiatry and psychology were being codified, countervailing evidence was accumulating that this stigmatizing view was ill founded. The publication of *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953) demonstrated that homosexuality was more common than previously assumed, thus suggesting that such behaviors were part of a continuum of sexual behaviors and orientations. C. S. Ford and Beach (1951) revealed that same-sex behaviors and homosexuality were present in a wide range of animal species and human cultures. This finding suggested that there was nothing unnatural about same-sex behaviors or homosexual sexual orientation.

Psychologist Evelyn Hooker's (1957) research put the idea of homosexuality as mental disorder to a scientific test. She studied a nonclinical sample of homosexual men and compared them with a matched sample of heterosexual men. Hooker found, among other things, that based on three projective measures (the Thematic Apperception Test, the Make-a-Picture Story test, and the Rorschach), the homosexual men were comparable to their matched heterosexual peers on ratings of adjustment. Strikingly, the experts who examined the Rorschach protocols could not

¹⁹ Analyses of this case have focused on Freud's intense negative reactions to this young woman and his attempts to enforce social conformity—especially with regard to traditional female gender roles and sexuality (e.g., Lesser & Schoenberg, 1999; O'Connor & Ryan, 1993).

²⁰ We use *other sex* instead of *opposite sex*, as the latter term makes assumptions regarding the binary nature of male and female that are unsupported. We acknowledge that this term also has limitations, as there are fluid and diverse representations of sex and gender in many cultures.

distinguish the protocols of the homosexual cohort from the heterosexual cohort, a glaring inconsistency with the then-dominant understanding of homosexuality and projective assessment techniques. Armon (1960) performed research on homosexual women and found similar results.

In the years following Hooker's (1957) and Armon's (1960) research, inquiry into sexuality and sexual orientation proliferated. Two major developments marked an important change in the study of homosexuality. First, following Hooker's lead, more researchers conducted studies of nonclinical samples of homosexual men and women. Prior studies primarily included participants who were in distress or incarcerated. Second, quantitative methods to assess human personality (e.g., Eysenck Personality

Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning.

Inventory, Cattell's Sixteen Personality Factor Questionnaire [16PF]) and mental disorders (Minnesota Multiphasic Personality Inventory [MMPI]) were developed and were

a vast psychometric improvement over prior measures, such as the Rorschach, Thematic Apperception Test, and House-Tree-Person Test. Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning (Siegelman, 1979; M. Wilson & Green, 1971; see also the review by Gonsiorek, 1991). Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation (e.g., Bell, Weinberg, & Hammersmith, 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord, McCord, & Thurber, 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes, Ferguson, & Gillem, 1976). This research was a significant challenge to the model of homosexuality as psychopathology.

Homosexuality Removed From the Diagnostic and Statistical Manual

In recognition of the legal nexus between psychiatric diagnosis and civil rights discrimination, especially for government employees, activists within the

homophile²¹ rights movement, including Frank Kameny and the Mattachine Society of Washington, DC, launched a campaign in late 1962 and early 1963 to remove homosexuality as a mental disorder from the American Psychiatric Association's *DSM* (D'Emilio, 1983; Kameny, 2009). This campaign grew stronger in the aftermath of the Stonewall riots in 1969. Those riots were a watershed, as the movement for gay and lesbian civil rights was embraced openly by thousands rather than limited to small activist groups (D'Emilio, 1983; Katz, 1995). In the area of mental health, given the results of research, activists within and outside of the professions led a large and vocal advocacy effort directed at mental health professional associations, such as the American Psychiatric Association, the American Psychological Association, and the American Association for Behavior Therapy, and called for the evaluation of prejudice and stigma within mental health associations and practices (D'Emilio, 1983; Kameny, 2009). At the same time, some LGB professionals and their allies encouraged the field of psychotherapy to assist sexual minority clients to accept their sexual orientation (Silverstein, 2007).

As a result of the research and the advocacy outside of and within the American Psychiatric Association, that association embarked upon an internal process of evaluating the literature to address the issue of homosexuality as a psychiatric disorder (Bayer, 1981; Drescher 2003; Drescher & Merlino, 2007; Sbordone, 2003; Silverstein, 2007). On the recommendation of its committee evaluating the research, the American Psychiatric Association Board of Trustees and general membership voted to remove homosexuality per se²² from the *DSM* in December 1973 (Bayer, 1981). The American Psychiatric Association (1973) then issued a position statement supporting civil rights protection for gay people in employment, housing, public accommodation, and licensing, and the repeal of all sodomy laws.

In December 1974, the American Psychological Association (APA) passed a resolution affirming the resolution of the American Psychiatric Association. APA concluded:

²¹ *Homophile* is an early term for what would become the gay rights or gay and lesbian rights movement.

²² The diagnoses of sexual orientation disturbance and ego-dystonic homosexuality sequentially replaced homosexuality. These diagnoses, however, were ultimately removed, due to conceptual problems and psychiatry's evolving evidence-based approach to delineating a mental disorder (Drescher, Stein, & Byne, 2005).

Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities. Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations. (APA, 1975, p. 633)

Since that time, the APA has passed numerous resolutions supporting LGB civil rights and psychological well-being (see APA, 2005a).

Other mental health associations, including the National Association of Social Workers and the American Counseling Association, and medical associations, including the American Medical Association and the American Academy of Pediatrics, have passed similar resolutions. Gradual shifts began to take place in the international mental health community as well. In 1992, the World Health Organization removed homosexuality per se from the *International Classification of Diseases* (Nakajima, 2003).

Decline of Sexual Orientation Change Efforts

Following the removal of homosexuality from the *DSM*, the publication of studies of SOCE decreased dramatically, and nonaffirming approaches to psychotherapy came under increased scrutiny. Behavior therapists became increasingly concerned that aversive therapies designed as SOCE for homosexuality were inappropriate, unethical, and inhumane (Bancroft, 2003; Davison, 1976, 1978; Davison & Wilson, 1973; M. King, Smith, & Bartlett, 2004; D. J. Martin, 2003; Silverstein, 1991, 2007). The Association for Behavioral and Cognitive Therapies (formerly the Association for Advancement of Behavior Therapy) as well as other associations affiliated with cognitive and behavior therapies currently reject the use of SOCE (D. J. Martin, 2003). Behavior therapy for LGB individuals now focuses on issues of increasing adjustment, as well as on addressing a variety of their mental health concerns (Campos & Goldfried, 2001; Hart & Heimberg, 2001; Martell et al., 2004; Pachankis & Goldfried, 2004; Safren & Rogers, 2001).

Prominent psychoanalytic practitioners (see, e.g., Mitchell, 1978, 1981) began questioning SOCE within their own profession and challenged therapies that started with assumptions of pathology. However, such a movement did not take hold until the late 1980s

and early 1990s (Drescher, 1998a, 1998b; Glassgold & Iasenza, 1995). In 1991, the American Psychoanalytic Association (ApsaA) effectively ended stigmatization of homosexuality by mainstream psychoanalysis when it adopted a sexual orientation nondiscrimination policy regarding the selection of candidates for psychoanalytic training. This policy was revised in 1992 to include selection of faculty and training analysts as well (ApsaA, 1991, 1992). In 2000, ApsaA adopted a policy against SOCE, attempting to end that practice within the field:

As in all psychoanalytic treatments, the goal of analysis with homosexual patients is understanding. Psychoanalytic technique does not encompass purposeful efforts to “convert” or “repair” an individual’s sexual orientation. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized homophobic attitudes. (¶ 1)

Numerous publications document the theoretical limitations and problems with SOCE within psychoanalysis (Drescher, 1998a, 1998b; O’Connor & Ryan, 1993). In the last decade, many psychoanalytic publications have described an affirmative approach to sexual orientation variation and diversity.²³

Currently, mainstream mental health professional associations support affirmative approaches that focus on helping sexual minorities cope with the impact of minority stress and stigma (American Counseling Association Governing Council, 1998; American Psychiatric Association, 2000; APA, 1997, 2000; NASW, 1997). The literature on affirmative psychotherapy has grown enormously during this time (e.g., Bieschke et al., 2007; Eubanks-Carter, Burckell, & Goldfried, 2005; Ritter & Terndrup, 2002). Included in this literature are publications that aim to support individuals with strong religious beliefs and same-sex sexual orientation in exploring ways to integrate the two (e.g., Astramovich, 2003; Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 1996, 2004; Horne & Noffsinger-Frazier, 2003; Mark, 2008; D. F. Morrow, 2003; O’Neill & Ritter, 1992; Ritter & O’Neill, 1989, 1995; Ritter & Terndrup, 2002; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). These changes within the mental health fields are reflected in the larger society, where there have been increasing shifts in acceptance of LGB

²³ ApsaA and Divisions 39 (Psychoanalysis) and 44 (Society for the Psychological Study of Lesbian, Gay, & Bisexual Concerns) have collaborated on a bibliography of affirmative resources in psychoanalysis.

individuals (see National Gay and Lesbian Task Force: <http://www.thetaskforce.org>). For instance, in 2003, the U.S. Supreme Court made a landmark ruling in *Lawrence v. Texas* that declared as unconstitutional the sodomy laws of the 13 states that still criminalized homosexuality. However, issues such as same-sex marriage are still controversial (Phy-Olsen, 2006).

However, SOCE is still provided by LMHP. Some LMHP (Nicolosi, 2003; Nicolosi & Nicolosi, 2002; Rosik, 2001) advocate for SOCE to be provided to distressed individuals, and an organization was founded to advocate for these types of treatments (National Association for Research and Treatment of Homosexuality). Additionally, a survey of randomly selected British LMHP (psychologists, counselors, and psychiatrists) completed in 2003 found that 17% of the total sample of 1,328 had provided SOCE in the past and that 4% would consider providing such therapy upon client request in the future (Bartlett, King, & Phillips, 2001; cf. Liszcz & Yarhouse, 2005). Among those who provided such services, the number of clients provided SOCE had remained constant over time (Bartlett et al., 2001; cf. M. King et al., 2004).

their families that portray homosexuality as negative (Burack & Josephson, 2005; Cianciotto & Cahill, 2006; Wolkomir, 2006). These efforts include religious outreach, support groups, and psychotherapy (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006).

Debates between those who advocate SOCE and those who oppose it have at times become polemical, with charges that professional psychology has not reflected the concerns of religious individuals,²⁴ and both supporters and opponents of SOCE have presented themselves as advocates for consumers (cf. Brooke, 2005). Despite the polarization, there have been recent attempts to envision alternate frameworks to address these issues (e.g., Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Benoit, 2005; Haldeman, 2004; McMinn, 2005; Phillips, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006).

We concluded that these debates can only be resolved through an evidence-based appraisal of the potential benefits and harm of SOCE. In the next two chapters, we consider the research evidence on SOCE. In Chapter 3 we discuss methodological concerns, and in Chapter 4, the results that can be drawn from this literature.

Sexual Orientation Change Efforts Provided to Religious Individuals

The visibility of SOCE has increased in the last decade (Drescher, 2003; Drescher & Zucker, 2006; Herek, 2003). From our survey of recent publications and research, most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs (e.g., Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003). In an evolution for some religious communities, sexual minorities are not automatically expelled or shunned (Drescher & Zucker, 2006; Sanchez, 2007; SPLC, 2005). Instead, individuals with a same-sex sexual orientation are embraced for renouncing their homosexuality and seeking “healing” or change (Burack & Josephson, 2005; Erzen, 2006; Ponticelli, 1999). This development has led to a movement of religiously based self-help groups for distressed individuals who often refer to themselves as ex-gay (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006). Individuals and organizations that promote religion-based efforts to change sexual orientation often target messages to adults, adolescents, and

²⁴ APA has received correspondence from individuals and organizations asserting this point.



3. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SEXUAL ORIENTATION CHANGE EFFORTS: OVERVIEW AND METHODOLOGICAL LIMITATIONS

Although the charge given to the task force did not explicitly call for a systematic review of research on the efficacy and safety of sexual orientation change efforts (SOCE),²⁵ we decided in our initial deliberations that such a review was important to the fulfillment of our charge. First, the debate over SOCE has centered on the issues of efficacy, benefit, and harm. Thus, we believe it was incumbent on us to address those issues in our report. We attempted to answer the following questions in this review:

- Do SOCE alter sexual orientation?
- Are SOCE harmful?
- Do SOCE result in any outcomes other than changing sexual orientation?

Second, systematic literature reviews are frequently used to answer questions about the effectiveness of interventions in health care to provide the basis for informed treatment decisions (D. J. Cook, Mulrow, & Haynes, 1998; Petticrew, 2001). Current criteria for effective treatments and interventions are specific in stating that to be considered effective, an intervention has consistent positive effects without serious harmful side effects (Beutler, 2000; Flay et al., 2005). Based on Lilienfeld's (2007) comprehensive review of the issue of

harm in psychotherapy, our systematic review examines harm in the following ways:

- Negative side effects of treatment (iatrogenic effects)
- Client reports of perceptions of harm from treatment
- High drop-out rates
- Indirect harm such as the costs (time, energy, money) of ineffective interventions

Finally, we were given the charge to “inform APA’s response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.” We decided that a systematic review²⁶ would likely be the only effective basis for APA’s response to advocacy groups for SOCE.

In our review, we considered only peer-reviewed research, in keeping with current standards for conducting scientific reviews (see Khan, Kunz, Kleijnen, & Antes, 2003), which exclude the grey literature²⁷ and lay material. In this chapter, we provide an overview of the review and a detailed report on the methodological concerns that affect the validity²⁸ of the conclusions

²⁵ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

²⁶ A systematic review starts with a clear question to be answered, strives to locate all relevant research, has clear inclusion and exclusion criteria, carefully assesses study quality, and synthesizes study results (Petticrew, 2001).

²⁷ Grey literature refers to any publication in any format published outside of peer-reviewed scientific journals.

²⁸ *Validity* is defined as the extent to which a study or group of studies produce information that is useful for a specific purpose. It also includes an overall evaluation of the plausibility of the intended

derived from the research. In the next chapter, we present our review of the outcomes of the research.

Overview of the Systematic Review

Our review included peer-reviewed empirical research on treatment outcomes published from 1960 to 2007. Studies were identified through systematic searches of scholarly databases, including PsycINFO and Medline, using such search terms as *reparative therapy*, *sexual orientation*, *homosexuality*, and *ex-gays* cross-referenced with treatment and therapy. Reference lists from all identified articles were searched for additional nonindexed, peer-reviewed material. We also obtained review articles and commentaries and searched the reference lists of these articles to identify refereed publications of original research investigations on SOCE that had not been identified via the aforementioned procedures. As noted earlier, in keeping with standards for systematic reviews, only empirically based, peer-reviewed articles addressing the key questions of this review regarding SOCE efficacy, safety, and harm were included in this section. Other research studies of children, adolescents, and adults, including the grey literature and clinical accounts, are included in other sections of this report, most notably Chapter 5 (Research on Adults Who Undergo Sexual Orientation Change Efforts) and Chapter 8 (Issues for Children, Adolescents, and Their Families). The studies that met our criteria and are mentioned in this chapter on the systematic review are listed in Appendix B.²⁹

The vast majority of research on SOCE was conducted prior to 1981. This early research predominantly focused on evaluating behavioral interventions, including those using aversive methods. Following the declassification of homosexuality as a mental disorder in 1973 (American Psychiatric Association, 1973) and subsequent statements of other mental health

interpretations—in this case, does SOCE produce a change in sexual orientation (see American Educational Research Association, APA, & National Council on Measurement in Education, 1999).

²⁹ A meta-analytic review of 14 research articles (Byrd & Nicolosi, 2002) is not discussed in this report. The review suffers from significant methodological shortcomings and deviations from recommended meta-analytic practice (see, e.g., Durlak, Meerson, & Ewell Foster, 2003; Lipsey & Wilson, 2001) that preclude reliable conclusions being drawn from it. However, studies that were included in the meta-analysis and were published in refereed journals between 1960 and the present are included and described in the current review. Additionally, a recent study (Byrd, Nicolosi, & Potts, 2008) is not included, as it was published after the review period and appears to be a reworking of an earlier study by Nicolosi, Byrd, and Potts (2000).

professional associations, including APA (Conger, 1975), research on SOCE declined dramatically. Indeed, we found that the peer-reviewed empirical literature after 1981 contains no rigorous intervention trials on changing same-sex sexual attractions.

There is a small, more recent group of studies conducted since 1999 that assess perceived effects of SOCE among individuals who have participated in psychotherapy as well as efforts based in religious beliefs or practices, including support groups, faith healing, and prayer. There are distinct types of research within this recent literature. One type focused on evaluating individuals' positive accounts of sexual orientation change (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003). Another type examined potential harm of SOCE and experiences of those who seek sexual orientation change (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). A third type is high-quality³⁰ qualitative research investigations that provide insight into people's experiences of efforts aimed at altering their same-sex sexual attractions (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkimur, 2001).³¹

In all areas of intervention evaluation, the quality of the methods used in the research affects the validity and credibility of any claims the researcher can make about whether the intervention works, for whom it

Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

works, and under what circumstances it works. Many have described methodological concerns regarding the research literature on sexual

orientation change efforts (e.g., Cramer, Golom, LoPresto, & Kirkley, 2008; Haldeman, 1994; S. L. Morrow & Beckstead, 2004; Murphy, 1992; Sandfort, 2003). Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

As shown in Appendix B, few studies on SOCE produced over the past 50 years of research rise to current scientific standards for demonstrating the efficacy of psychological interventions (cf. Chambless & Hollon, 1998; Chambless & Ollendick, 2001;

³⁰ These studies meet the standards of research rigor that are used for the qualitative research paradigms that informed each of the studies (e.g., grounded theory, ethnomethodology, phenomenology).

³¹ These studies are discussed more thoroughly in later sections of the report.

Flay et al., 2005; Shadish, Cook, & Campbell, 2002; Society for Prevention Research, 2005) or provide for unambiguous causal evidence regarding intervention outcomes. Indeed, only six studies, all conducted in the early period of research, used rigorous experimental³² procedures. Only one of these experiments (Tanner, 1974) assessed treatment outcomes in comparison to an untreated control group. Only three additional studies used strong quasi-experimental procedures such as a nonequivalent comparison group (see Appendix B). All of these studies were also from the early period. The rest of the studies that we reviewed are nonexperimental (see Appendix B). We thus concluded that there is little in the way of credible evidence that could clarify whether SOCE does or does not work in changing same-sex sexual attractions.

The studies in this area also include a highly select group of people who are unique among those who experience same-sex sexual attractions. Thus, psychologists should be extremely cautious in attributing success to SOCE and assuming that the findings of the studies of it can be applied to all sexual minorities. An overview of the methodological problems in determining the effects of SOCE and making treatment decisions based on findings from these studies follows.

Methodological Problems in the Research Literature on Sexual Orientation Change Efforts

Problems in Making Causal Claims

A principal goal of the available research on SOCE was to demonstrate that SOCE consistently and reliably produce changes in aspects of sexual orientation. Overall, due to weaknesses in the scientific validity of research on SOCE, the empirical research does not

³² True experiments have more methodological rigor because study participants are randomly assigned to treatment groups such that individual differences are more equally distributed and are not confounded with any change resulting from the treatment. Experiments are also rigorous because they include a way for the researcher to determine what would have happened in the absence of any treatment (e.g., a counterfactual) through the use of a no-treatment control group. Quasi-experimental designs do not have random assignment but do incorporate a comparison of some kind. Although they are less rigorous than experiments, quasi-experiments, if appropriately designed and conducted, can still provide for reasonable causal conclusions to be made.

provide a sound basis for making compelling causal claims. A detailed analysis of these issues follows.

INTERNAL VALIDITY CONCERNS

Internally valid research convincingly demonstrates that a cause (such as SOCE) is the only plausible explanation for an observed outcome such as change

Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

in same-sex sexual attractions. Lack of internal validity limits certainty that observed changes in people's attitudes, beliefs, and behaviors are a function of the

particular interventions to which they were exposed. A major limitation to research on SOCE, both the early and the recent research, stems from the use of weak research designs that are prone to threats to internal validity. Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

As noted previously, true experiments and rigorous quasi-experiments are rare in the SOCE research. There are only a few studies in the early period that are experiments or quasi-experiments, and no true experiments or quasi-experiments exist within the recent research. Thus, none of these recent studies meet current best practice standards for experimental design and cannot establish whether SOCE is efficacious.

In early studies, comparison and no-treatment control groups were uncommon procedures, and early studies rarely employed multiple baseline assessments, randomization to condition, multiple long-term follow-up assessments, or other procedures to aid in making causal inferences. These procedures are widely accepted as providing the most compelling basis for ruling out the possibility that an alternative source is responsible for causing an observed or reported treatment effect.

Common threats to internal validity in early studies include history (i.e., other events occurring over the same time period as the treatment that could produce the results in the absence of the intervention), regression (i.e., extreme scores are typically less extreme on retest in the absence of intervention), and testing (i.e., taking a test once influences future scores on the test in the absence of intervention). Within-subject and patient case studies are the most common designs in the early SOCE research (see Appendix

B). In these designs, an individual's scores or clinical status prior to treatment is compared with his or her scores or status following treatment. These designs are particularly vulnerable to internal validity threats.

Sample attrition

Early research is especially vulnerable to threats to internal validity related to sample attrition. The proportions of participants in these studies who dropped out of the intervention and were lost to follow-up are unacceptably high; drop-out rates go as high as 74% of the initial study sample. Authors also reported high rates of refusal to undergo treatment after participants were initially enrolled in the studies. For instance, 6 men in Bancroft's (1969) study refused to undergo treatment, leaving only 10 men in the study. Callahan and Leitenberg (1973) reported that of 23 men enrolled, 7 refused and 2 dropped out of treatment; 8 also showed inconsistent baseline responses in penile arousal to the experimental stimuli so could not be included in the analysis, leaving only 6 subjects on whom treatment analyses could be performed. Of 37 studies reviewed by H. E. Adams and Sturgis (1977), 31 studies lost from 36% to 58% of the sample. In many studies, therefore, what appear to be intervention effects may actually reflect systematic changes in the composition of the study sample; in the handful of available comparison group studies, differences between the groups in the studies in the rate of dropout and in the characteristics of those who drop out may be the true cause of any observed differences between the groups. Put simply, dropout may undermine the comparability of groups in ways that can bias study outcomes.

Retrospective pretest

With the exception of prospective ethnographic studies (e.g., Ponticelli, 1999; Wolkomir, 2001), the recent research (e.g., Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) relies exclusively on uncontrolled retrospective pretest designs. In these studies, people who have been exposed to SOCE are asked to recall and report on their feelings, beliefs, and behaviors at an earlier age or time and are then asked to report on these same issues at present. Change is assessed by comparing contemporary scores with scores provided for the earlier time period based on retrospective recall. In a few studies, LMHP who perform SOCE reported their view of how their clients had changed. The design is problematic because all of the pretest measures are not true pretests but retrospective accounts of pretest status. Thus, the

recent research studies on SOCE have even weaker designs than do nonexperimental studies from the early period of research on SOCE. Again, none of these recent studies can establish whether SOCE is efficacious.

An extensive body of research demonstrates the unreliability of retrospective pretests. For example, retrospective pretests are extremely vulnerable to response-shift biases resulting from recall distortion and degradation (C. E. Schwartz & Rapkin, 2004; Schwarz & Clore, 1985). People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall.

Retrospective pretests are also vulnerable to biases deriving from impression management (Fisher & Katz, 2000; Schwarz, Hippler, Deutsch, & Strack, 1985; A. E. Wilson & Ross, 2001), change expectancy (Hill & Betz, 2005; Lam & Bengo, 2003; Norman, 2003; M. A. Ross, 1989; Sprangers, 1989), and effort justification (Aronson & Mills, 1959; Beauvois & Joule, 1996; Festinger, 1957). Individuals tend to want to present themselves in a favorable light. As a result, people have a natural tendency to report on their current selves as improved over their prior selves (impression management). People will also report change under circumstances in which they have been led to expect that change will occur, even if no change actually does occur (change expectancy). In addition, people will seek to justify the time and effort that they have made in treatment to reduce any dissonance they may feel at experiencing no change or less than they had expected by overestimating the effectiveness of the treatment (effort justification). Effort justification has been demonstrated to become stronger as intervention experiences become more unpleasant. In combination, these factors lead to inaccurate self-reports and inflated estimates of treatment effects, distortions that are magnified in the context of retrospective pretest designs.

CONSTRUCT VALIDITY CONCERNS

Construct validity is also a significant concern in research on SOCE. Construct validity refers to the degree to which the abstract concepts that are investigated in the study are validly defined, how well these concepts are translated into the study's treatments and measures, and, in light of these definitional and operational decisions, whether the study findings are appropriately interpreted. For

instance, do the researchers adequately define and measure sexual orientation? Are their interpretations of the study results regarding change in sexual orientation appropriate, given how the constructs were defined and translated into measures? On the whole, research on SOCE presents serious concerns regarding construct validity.

Definition of sexual orientation

Sexual orientation is a complex human characteristic involving attractions, behaviors, emotions, and identity. Research on sexual orientation is usually seen as beginning with the Kinsey studies (Kinsey et al., 1948, 1953). Kinsey used a unidimensional, 7-category taxonomic continuum, from 0 (*exclusively heterosexual*) to 6 (*exclusively homosexual*), to classify his participants. As the research has developed since the Kinsey studies, the assessment of sexual orientation has focused largely on measuring three variables—identity, behavior, and attraction. Many studies measure only one or two, but very seldom all three, of these variables.

A key finding in the last 2 decades of research on sexual orientation is that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways (Carrillo, 2002; Diamond, 2003, 2006; Dunne, Bailey, Kirk, & Martin, 2000; Laumann, Gagnon, Michael, & Michaels, 1994; Savin-Williams, 2005). For instance, individuals with sexual attractions may not act on them or may understand, define, and label their experiences differently than those with similar desires, because of the unique cultural and historical constructs regarding ethnicity, gender, and sexuality (Harper et al., 2004; Mays & Cochran, 1998; Walters, Simoni, & Horwath, 2001; Weinrich & Williams, 1991).

Further, a subset of individuals who engage in same-sex sexual behaviors or have same-sex sexual attractions do not self-identify as LGB or may remain unlabeled, and some self-identified lesbian and gay individuals may engage in other-sex sexual behaviors without self-identifying as bisexual or heterosexual (Beckstead, 2003; Carrillo, 2002; Diamond, 2003, 2008; Diamond & Savin-Williams, 2000; Dunne et al., 2000; Fox, 2004; Gonsiorek, Sell, & Weinrich, 1995; Hoberg, Konik, Williams, & Crawford, 2004; Kinsey et al., 1948, 1953; Klein et al., 1985; Masters & Johnson, 1979; McConaghy, 1987, 1999; McConaghy, Buhrich, & Silove, 1994; Storms, 1980; Thompson & Morgan, 2008). Thus, for some individuals, personal and social identities differ from sexual attraction, and sexual orientation

identities may vary due to personal concerns, culture, contexts, ethnicity, nationality, and relationships.

As a result, a number of scholars have argued that the construct of sexual orientation would be more easily and reliably assessed and defined if it were disentangled from sexual orientation identity (e.g., Chang & Katayama, 1996; Drescher, 1998a, 1998b; Drescher, Stein, & Byne, 2005; Rust, 2003; Stein, 1999; R. L. Worthington, Savoy, Dillon, & Vernaglia, 2002). Recent research has found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability inherent in reports of these two variables (R. L. Worthington et al., 2002; R. L. Worthington & Reynolds, 2009).

We adopted this current understanding of sexuality to clarify issues in the research literature. For instance, *sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings, such as "falling in love." Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women, social affiliations with LGB or heterosexual individuals and communities, emotional attachment preferences for men or women, gender role and identity, lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct.

Sexual orientation identity refers to acknowledgment and internalization of sexual orientation and reflects self-exploration, self-awareness, self-recognition, group membership and affiliation, culture, and self-stigma. Sexual orientation identity involves private and public ways of self-identifying and is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997; Ponticelli, 1999; Wolkomir, 2001).

Given this new understanding of sexual orientation and sexual orientation identity, a great deal of debate surrounds the question of how best to assess sexual orientation in research (Gonsiorek et al., 1995; Kinsey et al., 1948, 1953; Masters & Johnson, 1979; Sell, 1997). For example, some authors have criticized the Kinsey scale for dichotomizing sexual orientation—with heterosexuality and homosexuality as opposites along a single dimension and bisexuality in between—

thus implying that in increasing desire for one sex represents reduced desire for the other sex (Gonsiorek et al., 1995; Sell, 1997; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). An alternative that has been proposed suggests that same-sex and other-sex attractions and desires may coexist relatively independently and may not be mutually exclusive (Diamond, 2003, 2006; 2008; Fox, 2004; Klein et al., 1985,³³ Sell, 1997; Shively & DeCecco, 1977; Storms, 1980; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). Models with multiple dimensions that permit the rating of the intensity of an individual's sexual desire or arousal for other-sex individuals separately from the intensity of that individual's sexual desire or arousal for same-sex individuals allow individuals to have simultaneous levels of attractions. Some commentators believe such models allow for greater understanding of sexual diversity and its interactions with other aspects of identity and culture (Mays & Cochran, 1998; R. L. Worthington et al. 2002).

Considered in the context of the conceptual complexities of and debates over the assessment of sexual orientation, much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals. Early research that focuses on sexual arousal may be more precise than that which relies on self-report of behavior. Overall, recent research may actually measure sexual orientation identity (i.e., beliefs about sexual orientation, self-report of identity or group affiliation, self-report of behavior, and self-labeling) rather than sexual orientation.

Study treatments

In general, what constitutes SOCE in empirical research is quite varied. As we show in Appendix B, early studies tested a variety of interventions that

include aversive conditioning techniques (e.g., electric shock, deprivation of food and liquids, smelling salts, chemically induced nausea), biofeedback, hypnosis, masturbation reconditioning, psychotherapy, systematic desensitization, and combinations of these approaches. A small number of early studies compare approaches alone or in combination. The more recent research includes an even wider variety of interventions (e.g., gender role reconditioning, support groups, prayer, psychotherapy) and providers (e.g., licensed and unlicensed LMHP in varied disciplines, pastoral counselors, laypersons). The recent studies were conducted in such a way that it is not possible to attribute results to any particular intervention component, approach, or provider. For instance, these interventions were provided simultaneously or sequentially, without specific separate evaluations of each intervention. The recent research and much of the early research cannot provide clarity regarding which specific efforts are associated with which specific outcomes.

Outcome measures

Regarding assessment mode, outcomes in early studies were assessed by one or more of the following: gauging an individual's physiological responses when presented with sexual stimuli, obtaining the person's self-report of recent sexual behavior and attractions, and using clinical opinion regarding improvement. In men especially, physiological measures are considered more dependable than self-report of sexual arousal or attraction (Freund, 1976; McConaghy, 1999). However, these measures have important limitations when studying sexual orientation. Some men are incapable of sexual arousal to any stimuli in the laboratory and must be excluded from research investigations in which the measure is the sole outcome measure. More recent research indicates that some penile circumference gauges are less consistent than penile volume gauges (Kuban, Barbaree, & Blanchard, 1999; McConaghy, 1999; Quinsey & Lalumiere, 2001; Seto, 2004) and that some men can intentionally produce false readings on the penile circumference gauges by suppressing their standard sexual arousal responses (Castonguay, Proulx, Aubut, McKibben, & Campbell, 1993; Lalumiere & Harris, 1998) or consciously making themselves aroused when presented with female erotic stimuli (Freund, 1971, 1976; Freund, Watson, & Rienzo, 1988; Lalumiere & Earls, 1992; McConaghy, 1999, 2003). The physiological measure used in all the SOCE experiments was the penile circumference gauge.

³³ Although Klein advanced the notion of sexual orientation as a multidimensional variable, his Sexual Orientation Grid confounds constructs of sexual orientation and sexual orientation identity, as it includes attraction; behavior; identification; and emotional, political, and social preferences.

McConaghy (1999) has questioned the validity of the results of SOCE research using this gauge and believes that data illustrating a reduction in same-sex sexual attraction should be viewed skeptically.

In recent research on SOCE, overreliance on self-report measures and/or on measures of unknown validity and reliability is common. Reliance on self-reports is especially vulnerable to a variety of reactivity biases such that shifts in an individual's score will reflect factors other than true change. Some of these biases are related to individual motivations, which have already been discussed, and others are due to features of the experimental situation. Knowing that one is being studied and what the experimenter hopes to find can heighten people's tendency to self-report in socially desirable ways and in ways that please the experimenter.

Measures used in early studies vary tremendously in their psychometric acceptability, particularly for attitudinal and mental health measures, with a limited number of studies using well-validated measures. Recent research has not advanced significantly in using psychometrically sound measures of important study variables such as depression, despite the widespread use of measures that permit accurate assessment of these variables in other studies. Measures in these studies are also sources of bias due to problems such as item wording and response anchors from which participants may have inferred that other-sex attraction is a normative standard, as well as from the exclusion of items related to healthy homosexual functioning to parallel items that ask for reports on healthy heterosexual functioning.

Study operations

Regarding the adequacy of study operations, few of the early studies attempted to overcome the demand characteristics associated with the interventionists' obtaining measures of change themselves. In other words, few studies sought to minimize the possibility that people receiving treatment would be motivated to please their treatment providers by providing them with reports that were consistent with what the providers were perceived to desire and expect. Issues in recruitment of participants may also contribute to this effect; subjects were aware of the goals of the study, were recruited by individuals with that knowledge, or were participating in treatment to avoid legal and/or religious sanction. Novelty effects associated with exposure to an experimental laboratory situation

may also have influenced study results. People may become excited and energized by participating in a research investigation, and these reactions to being in the research environment may contribute to change in scores. Recent research is also vulnerable to demand characteristics as a function of how individuals are recruited into samples, which is discussed in more detail in the section on sampling concerns.

CONCLUSION VALIDITY CONCERNS

Conclusion validity concerns the validity of the inferences about the presence or absence of a relationship among variables that are drawn from statistical tests. Small sample sizes, sample heterogeneity, weak measures, and violations to the assumptions of statistical tests (e.g., non-normally distributed data) are central threats to drawing valid conclusions. In this body of research, conclusion validity is often severely compromised. Many of the studies from the early period are characterized by samples that are very small, containing on the average about 9 subjects (see Appendix B; see also H. E. Adams & Sturgis, 1977). Combined with high rates of attrition, skewed distributions, unreliable measures, and infrequent use of statistical tests designed for small and skewed samples, confidence in the statistical results of many of these studies may be misplaced. The recent research involved unreliable measures and inappropriate selection and performance of statistical tests, which are threats to their statistical conclusion validity,³⁴ even though these studies involved larger samples than the early research.

³⁴ For instance, to assess whether sexual orientation had changed, Nicolosi et al. (2000) performed a chi-square test of association on individuals' prior and current self-rated sexual orientation. Several features of the analysis are problematic. Specifically, the nature of the data and research question are inappropriate to a chi-square test of association, and it does not appear that the tests were properly performed. Chi-square tests of association assume that data are independent, yet these data are not independent because the row and column scores represent an individual's rating of his or her past and present self. Chi-square tests ought not to be performed if a cell in the contingency table includes fewer than five cases. Other tests, such as the nonparametric McNemar's test for dichotomous variables (McNemar, 1969) or the sign (Conover, 1980) or Wilcoxon signed-rank tests (Wilcoxon, 1945) for nominal and ordinal data, respectively, are used to assess whether there are significant differences between an individual's before and after score and are appropriate when data fail to meet the assumptions of independence and normality, as these data do and would have been more appropriate choices. Paired *t* tests for mean differences could also have been performed on these data. There are procedural problems in how Nicolosi et al. conducted the chi-square test, such as missing data, and the analyses were conducted without adjustment for chance, with different numbers of subjects responding to each item, and without corrections to the gain scores to address regression artifacts. Taken together, the problems associated with running so many tests without adjusting for chance associations

Problems in Generalizing Findings

A significant challenge to interpreting the research on SOCE is establishing external validity—that is, judging to whom and to what circumstances the results of any particular study might reasonably be generalized.

SAMPLE COMPOSITION

Concerns regarding the sample composition in these studies are common in critiques (e.g., Cramer et al., 2008). The studies from the early period are characterized by samples that are narrow in their demographic characteristics, composed almost exclusively of Caucasian males over the age of 18. No investigations are of children and adolescents exclusively, although adolescents are included in a very few study samples. Few SOCE studies in the early period include women. Although more recent research

The research findings from early and recent studies may have limited applicability to non-Whites, youth, or women.

includes women and respondents of diverse ethnic and racial backgrounds (e.g., Moran, 2007; Nicolosi et al., 2000;

Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001), White men continue to dominate recent study samples. Thus, the research findings from early and recent studies may have limited applicability to non-Whites, youth, or women. The samples in the recent research have been narrowly defined in other respects, focusing on well-educated, middle-class individuals to whom religion is extremely important (e.g., Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001). Same-sex sexual attraction and treatments are confounded with these particular demographic characteristics across the recent literature. These research findings may be most applicable to educated White men who consider themselves highly religious.

The early research sometimes included men who were receiving intervention involuntarily (e.g., Barlow, Agras, Abel, Blanchard, & Young, 1975; Callahan & Leitenberg, 1973; S. James, 1978; MacCulloch & Feldman, 1967; MacCulloch et al., 1965; McConaghy, 1969, 1976; McConaghy et al., 1972), usually men who were court referred as a result of convictions on charges

or correcting for regression artifacts and having different respondents in nearly every test make it difficult to assess what changes in scores across these items actually reflect.

related to criminalized acts of homosexual sex.³⁵ The samples also include men who were not receiving intervention because of same-sex sexual attractions; rather, some of the men receiving intervention are described as pedophiles, exhibitionists, transvestites, and fetishists (Callahan & Leitenberg, 1973; Conrad & Wincze, 1976; Fookes, 1960; Hallam & Rachman, 1972; Marquis, 1970; Thorpe, Schmidt, Brown, & Castell, 1964; Thorpe, Schmidt, & Castell, 1963). Thus, the early samples are notable for including men who may not be same-sex attracted at all or have been distressed by their attractions but who had to undergo intervention by court order or out of fear of being caught by law enforcement in the future.

Moreover, in the early research—to the extent that it was assessed—the samples contained individuals who varied widely along the spectrum of same-sex sexual orientation prior to intervention, so that the studies included men who were other-sex sexually attracted to varying degrees alongside men who were primarily or exclusively same-sex sexually attracted (Bancroft, 1969; Barlow et al., 1975; Birk, 1974; Conrad & Wincze, 1976; Fookes, 1960; Hallman & Rachman, 1972; Kendrick & MacCulloch, 1972; LoPiccolo, Stewart, & Watkins, 1972; Marquis, 1970; McCrady, 1973). Additionally, study samples included men with and without histories of current and prior sexual contact with men and women (Bancroft, 1969; Colson, 1972; Curtis & Presly, 1972; Fookes, 1960; Freeman & Meyer, 1975; Gray, 1970; Hallman & Rachman, 1972; Herman, Barlow, & Agras, 1974; Larson, 1970; Levin, Hirsch, Shugar, & Kapche, 1968; LoPiccolo et al., 1972; MacCulloch & Feldman, 1967; McConaghy, 1969; McConaghy, Armstrong, & Blaszcynski, 1981; McConaghy & Barr, 1973; McConaghy et al., 1972; Segal & Sims, 1972; Thorpe et al., 1964), so that men who were or had been sexually active with women and men, only women, only men, or neither were combined. Some recent studies of SOCE have similar problems (e.g., Spitzer, 2003). Including participants with attractions, sexual arousal, and behaviors to both sexes in the research on SOCE makes evaluating change more difficult (Diamond, 2003; Rust, 2003; Vasey & Rendell, 2003; R. L. Worthington, 2003).

Data analyses rarely adjust for preintervention factors such as voluntary pursuit of intervention, initial degree of other-sex attraction, or past and current other-sex and same-sex behaviors; in very few studies did investigators perform and report subgroup analyses to clarify how

³⁵ Shidlo and Schroeder (2002) found that roughly 24% of their respondents perceived that SOCE was imposed on them rather than pursued voluntarily.

subpopulations fared as a result of intervention. The absence of these analyses obscures results for men who are primarily same-sex attracted and seeking intervention regarding these attractions versus any other group of men in these studies, such as men who could be characterized as bisexual in their attractions and behaviors or those on whom treatment was imposed. For these reasons, the external validity (generalizability) of the early studies is unclear, with selection–treatment interactions of particular concern. It is uncertain which effects observed in these studies would hold for which groups of same-sex attracted people.

SAMPLING AND RECRUITMENT PROCEDURES

Early and recent study samples are typically of convenience, so it is unclear precisely what populations these samples represent. Respondents in the recent studies were typically recruited through ex-gay ministries and advocates of SOCE rather than through population-based probability sampling strategies designed to obtain a representative sample of same-sex attracted people or the subset who experience their attractions as distressing and have sought and been exposed to SOCE. Additionally, study respondents are often invited to participate in these studies by LMHP who are proponents of SOCE, introducing unknown selection biases into the recruitment process (cf. Beckstead, 2003; Shidlo & Schroeder, 2002).

Qualitative studies have been more successful in applying a variety of purposive stratified sampling strategies (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and developing appropriate comparison samples. However, the qualitative studies were not undertaken with the purpose of determining if SOCE interventions are effective in changing sexual orientation. These studies focused on understanding aspects of the experience of participating in SOCE from the perspective of same-sex attracted people in distress.

As noted previously, recent research has used designs that are incapable of making attributions of intervention effects. In many of the recent studies, the nature of the procedures for recruiting samples is likely to have accentuated response-shift biases rather than to have minimized them, because study recruiters were open proponents of the techniques under scrutiny; it cannot be assumed that the recruiters sought to encourage the participation of those individuals whose experiences ran counter to their own view of the value of these approaches. Proponents of these efforts may also have limited access to the research for

former clients who were perceived to have failed the intervention or who experienced it as harmful. Some of the recent research to assess harm resulting from these interventions (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002) suffers from sampling weaknesses and biases of a similar nature.

Treatment Environments

Clinically trained professionals using reasonably well-described change efforts generally conducted early research in clinical laboratory settings. By contrast, the recent research included a wide variety of change efforts, providers, and settings in which these efforts may take place. The recent research has not been performed in a manner that permits examination of the interactions among characteristics of change efforts, providers, settings, and individuals seeking to change, nor does the research associate these patterns with outcomes.

Summary

Our analysis of the methodology of SOCE reveals substantial deficiencies. These deficiencies include limitations in making causal claims due to threats to internal validity (such as sample attrition, use of retrospective pretests); lack of construct validity,

The recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation.

including definition and assessment of sexual orientation; and variability of study treatments and outcome measures.

Additional limitations with recent research include problems with conclusion validity (the ability to make inferences from the data) due to small or skewed samples, unreliable measures, and inappropriate selection and performance of statistical tests. Due to these limitations, the recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation. Any reading of the literature on SOCE outcomes must take into account the limited generalizability of the study samples to the population of people who experience same-sex sexual attraction and are distressed by it. Taking into account the weaknesses and limitations of the evidence base, we next summarize the results from research in which same-sex sexual attraction and behavior have been treated.

4. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SEXUAL ORIENTATION CHANGE EFFORTS: OUTCOMES

In Chapter 3, we provided an overview of our systematic review of research on sexual orientation change efforts (SOCE)³⁶ and the results of the review for methodological concerns. In this chapter, we describe the evidence on outcomes associated with SOCE, whether beneficial or harmful. No studies reported effect size estimates or confidence intervals, and many studies did not report all of the information that would be required to compute effect sizes. As a result, statistical significance and methodology are considered in interpreting the importance of the findings. As the report will show, the peer-refereed empirical research on the outcomes of efforts to alter sexual orientation provides little evidence of efficacy and some evidence of harm. We first summarize the evidence of efficacy and then the evidence of unintended harmful effects.

Reports of Benefit

Sexual orientation change efforts have aimed to address distress in individuals with same-sex sexual attractions by achieving a variety of outcomes:

- Decreased interest in, sexual attraction to, and sexual behavior with same-sex sexual partners.

- Increased interest in, sexual attraction to, and sexual behavior with other-sex sexual partners.
- Increased healthy relationships and marriages with other-sex partners.
- Improved quality of life and mental health.

Although not all of these aims are equally well studied, these are the outcomes that have been studied frequently enough to be reported in this systematic review. One general point that we wish to emphasize as we begin the discussion of the outcomes that have been reported in this literature is that nonexperimental studies often find positive effects that do not hold up under the rigor of experimentation. The literature on SOCE is generally consistent with this point. In other words, the least rigorous studies in this body of research generally provide a more positive assessment of efficacy than do studies that meet even the most minimal standards of scientific rigor.

Decreasing Same-Sex Sexual Attraction

EARLY STUDIES

A number of investigators have assessed aversion therapy interventions to reduce physiological and self-reported sexual arousal in response to same-sex stimuli and self-reports of same-sex sexual attraction (see Appendix B).

³⁶ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved

Experimental studies

Results from the experimental studies of aversive techniques provide some evidence that these treatments can reduce self-reported and physiological sexual arousal for some men. The experimental studies that we reviewed showed lower rates of change in sexual arousal toward the same sex than did the quasi-experimental and nonexperimental studies. This finding was consistent with H. E. Adams and Sturgis's (1977) review of studies published through 1976.

In their review, H. E. Adams and Sturgis (1977) found that across the seven studies that they classified as controlled studies, 34% of the 179 subjects that were retained in these studies decreased their same-sex sexual arousal. McConaghy (1976) found that roughly half of the men who received one of four treatment regimens reported less intense sexual interest in men at 6 months. McConaghy et al. (1972) found reductions in penile response in the laboratory following treatment. Penile response to female nudes also declined for those men who initially responded to female stimuli. McConaghy (1969) similarly reported a decline in sexual arousal to all stimuli as a result of treatment for some men and that treatment also increased same-sex sexual arousal for some men. Overall, however, a majority of participants showed decreases in same-sex sexual arousal immediately following treatment. McConaghy and Barr (1973) found that about half of men reported that their same-sex sexual attractions were reduced. Tanner (1975) found that aversive shock could lessen erectile response to male stimuli.

An important caveat in considering the results of these experiments is that none compared treatment outcomes to an untreated control group. That is, these studies compared treatments to one another. The fact that four of these studies also involved men who were being treated by court referral should also be considered in interpreting the findings. These experiments cannot address whether men would have changed their sexual arousal pattern in the absence of treatment. Only one of the experiments that we identified compared treatment outcomes against the outcomes for an untreated control group. Tanner (1974) examined change in sexual arousal among 8 men receiving electric shock therapy. Tanner found that physiological arousal to male stimuli in the laboratory had declined at the 8-week follow-up, when scores among the 8 men in the treatment were compared with those of the 8 men in a control group. Changes were not achieved for all of the men, and there were no

differences between the experimental and control groups in the frequency of same-sex sexual behavior.

The results of the experimental studies suggest that some men who participate in clinical treatment studies may be conditioned to control their sexual arousal response to sexual stimuli, although McConaghy's (cf. McConaghy, 1999) studies suggest that aversive treatments may affect sexual arousal indiscriminately. These studies found that not all men reduce their sexual arousal to these treatments and that changes in sexual arousal in the lab are not necessarily associated with changes in sexual behavior.

Quasi-experimental studies

The three quasi-experiments listed in Appendix B all compare treatment alternatives for nonequivalent groups of men. Birk et al. (1971) found that 5 (62%) of the 8 men in the aversive treatment condition reported decreased sexual feelings following treatment; one man out of the 8 (12%) demonstrated reduced sexual arousal at long-term follow-up. In comparing groups, the researchers found that reports of same-sex "cruising," same-sex sexual "petting," and orgasm declined significantly for men receiving shocks when compared with men receiving associative conditioning. McConaghy and colleagues (1981) found that 50% of respondents reported decreased sexual feelings at 1 year. S. James (1978) reported that anticipatory avoidance learning was relatively ineffective when compared with desensitization. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they termed uncontrolled studies reported reduced sexual arousal.

Nonexperimental studies

Nonexperimental studies, which lack sufficient rigor to assess efficacy but which may be useful in identifying potential treatment approaches, offer a similar view of the impact of aversive treatment on reductions in sexual arousal. For instance, Bancroft (1969), in a within-subject study without a comparison group, delivered electric shocks based on males' penile volume responses to photographs of nude men as they were fantasizing about homosexual sexual encounters. Research subjects underwent a minimum of 30 treatment sessions. Bancroft reported that of the men who were initially sexually attracted to both sexes, 30% ($n = 3$) of these men lessened their same-sex sexual interest over the long-term. Among those with no initial other-sex sexual attraction, no lasting changes were observed in sexual

arousal and attraction. Several other uncontrolled studies found reductions in participants' self-reported sexual attraction and physiological response under laboratory conditions (range = 7%–100%; average = 58%) (Callahan & Leitenberg, 1973; Feldman & MacCulloch, 1965; Fookes, 1960; Hallam & Rachman, 1972; MacCulloch & Feldman, 1967; Sandford, Tustin, & Priest, 1975).

As is typically found in intervention research, the average proportion of men who are reported to change in uncontrolled studies is roughly double the average proportion of men who are reported to change in controlled studies. For instance, as noted previously, results from controlled studies show that far less change can be produced in same-sex sexual arousal by aversion techniques. H.E. Adams and Sturgis (1977) reported that in the nonexperimental studies in their review, 68% of 47 participants reduced their same-sex sexual arousal, compared with 34% of participants in experimental studies.

The studies of nonaversive techniques as the primary treatment, such as biofeedback and hypnosis, were only assessed in the nonexperimental within-subject and patient case studies. For example, Blicht and Haynes (1972) treated a single female who was heterosexually experienced and whom they described as strongly committed to reducing her same-sex sexual attractions. Using relaxation, rehearsal, and masturbation reconditioning, she was reported to be able to masturbate without female fantasies 2 months after intervention. Curtis and Presly (1972) used covert sensitization to treat a married man who experienced guilt about his attraction to and extramarital engagement with men. After intervention, he showed reduced other-sex and same-sex sexual interest, as measured by questionnaire items. Huff (1970) treated a single male who was interested in becoming sexually attracted to women. Following desensitization, his journal entries showed that his same-sex sexual fantasies continued, though the ratio of other-sex to same-sex sexual fantasies changed by the 6-month follow-up to favor other-sex sexual fantasies. His MMPI scores showed improvement in his self-concept and reductions in his distress.

By contrast, among the 4 men exposed to orgasmic reconditioning by Conrad and Wincze (1976), all reported decreased same-sex sexual attractions immediately following intervention, but only one demonstrated a short-term measurable alteration in physiological responses to male stimuli. Indeed, one subject's sexual arousal to same-sex sexual stimuli

increased rather than decreased, a result that was obtained for some men in the experimental studies. In a study by Barlow and colleagues (1975), among 3 men who were each exposed to unique biofeedback treatment regimens, all maintained same-sex sexual arousal patterns at follow-up, as measured by penile circumference change in response to photos of male stimuli.

Mintz (1966) found that 8 years after initiating group and individual therapy, 5 of his 10 research participants (50%) had dropped out of therapy. Mintz perceived that among those who remained, 20% ($n = 1$) were distressed, 40% ($n = 2$) accepted their same-sex sexual

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

attractions, and 40% ($n = 2$) were free from conflict regarding same-sex sexual attractions. Birk (1974) assessed the impact of behavioral therapy on 66 men, of whom 60% ($n = 40$) had dropped out of intervention by 7 months. Among those

who remained in the study, a majority shifted toward heterosexual scores on the Kinsey scale by 18 months.

Overall, the low degree of scientific rigor in these studies is likely to lead to overestimates of the benefits of these treatments on reductions in same-sex sexual arousal and attraction and may also explain the contradictory results obtained in nonexperimental studies.

RECENT STUDIES

Recent studies have investigated whether people who have participated in efforts to change their sexual orientation report decreased same-sex sexual attractions (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003) or how people evaluate their overall experiences of SOCE (Beckstead & Morrow 2004; Pattison & Pattison, 1980; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Wolkomir, 2001). These studies all use designs that do not permit cause-and-effect attributions to be made. We conclude that although these studies may be useful in describing people who pursue SOCE and their experiences of SOCE, none of the recent studies can address the efficacy of SOCE or its promise as an intervention. These studies are therefore described elsewhere in the

report in places where they contribute to understanding respondents' motivations for and experiences of SOCE.

SUMMARY

Overall, early studies suggest that modest short-term effects on reducing same-sex sexual arousal in the laboratory may be obtained for a minority of study participants through some forms of SOCE, principally interventions involving aversion procedures such as electric shock. Short-term reductions in sexual arousal to other-sex stimuli were also reported for some treatments. When outcomes were described for individual participants or subgroups of participants, short-term reductions in same-sex sexual arousal patterns were more commonly reported for people described as having other-sex sexual attractions prior to intervention and high levels of motivation to change. Initial and sustained reductions in sexual arousal were reported less commonly for people who were described as having no other-sex sexual attraction prior to intervention. The results from the uncontrolled studies are more positive than those from the controlled studies, as would be expected. Yet these studies also found that reduction in sexual arousal may not occur for study participants. Recent studies provide no sound scientific basis for determining the impact of SOCE on decreasing same-sex sexual attraction.

Decreasing Same-Sex Sexual Behavior

EARLY STUDIES

Early studies show that SOCE have limited impact on same-sex sexual behavior, even in cases in which lab results show some reduction in same-sex sexual arousal.³⁷

Experimental studies

In their review, H. E. Adams and Sturgis (1977) found that across the seven controlled studies published between 1960 and 1976, 18% of 179 subjects in these studies were reported to have decreased same-sex sexual behavior; the percentage reporting reductions in sexual arousal was nearly double that percentage, at 34%. In our review, we found that the results of

³⁷ In considering the results of early studies on this outcome, readers are advised that data on this outcome are not always reported. In some cases, not all research participants in these studies had engaged in sexual activity with same-sex partners prior to treatment, though they may have fantasized about doing so. In other studies, reducing sexual arousal under lab conditions was examined and not behavior in daily life.

the experimental studies that we reviewed provided a picture of the effects of aversive forms of SOCE similar to that painted by H. E. Adams & Sturgis.

For instance, in his study comparing aversion and aversion relief therapies,³⁸ McConaghy (1969) reported that about 20% of men had engaged in same-sex sexual behavior within 2 weeks following treatment. No longer-term follow-up data were reported. McConaghy (1976) found that 50% of men had reduced the frequency of their same-sex behavior, 25% had not changed their same-sex behavior, and 25% reported no same-sex behavior at 1 year. McConaghy and Barr (1973) reported that 25% of men had reduced their same-sex sexual behavior at 1-year. Tanner (1975) reported a significant decline in same-sex behavior across treatments. In the only untreated control group study that we identified, Tanner (1974) found that intervention had no effect on rates of same-sex behavior, even though the intervention did reduce changes in penile circumference in response to male stimuli in the lab.

Quasi-experimental studies

Birk and colleagues (1971) found that 2 of 18 men (11%) had avoided same-sex behavior at 36 months. McConaghy et al. (1981) reported that among the 11 men who were sexually active with same-sex partners, about 25% reduced their same-sex behavior. S. James (1978) did not report on behavior. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they called uncontrolled group studies reported reduced sexual arousal, and 42% reported less frequent same-sex sexual behavior. Among the quasi-experiments that we reviewed, the reported reductions in sexual behavior were lower (i.e., 11% and 25%) than what was reported by H. E. Adams and Sturgis. These differences may be due to our more rigorous criteria of what constitutes a quasi-experiment than the criteria employed by Adams and Sturgis.

Nonexperimental studies

Among the case and single-group within-subject studies, the results are mixed. Some studies found that people reported having abstained from same-sex behavior in the months immediately following intervention or having decreased its frequency. Bancroft (1969) found that 4 of the 10 men in his study had reduced their behavior at follow-up. Freeman and Meyer (1975) found that 7 of the 9 men in their study were abstinent at 18

³⁸ Aversion therapy involves the application of a painful stimulus; aversion relief therapy involves the cessation of an aversive stimulus.

months. Other single-subject and case study subjects reported declines in or no same-sex behavior (Gray, 1970; Huff, 1970; B. James, 1962, 1963; Kendrick & McCullough, 1972; Larson, 1970; LoPiccolo, 1971; Segal & Sims, 1972).

Not all individuals, however, successfully abstained on every occasion of sexual opportunity (Colson, 1972; Rehm & Rozensky, 1974), and some relapse occurred within months following treatment (Bancroft, 1969; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Levin et al., 1968; MacCulloch et al., 1965; Marquis, 1970). In other studies, the proportion reporting that they changed their sexual behavior was a minority. For instance, among Barlow et al.'s (1975) research participants, 2 of the 3 men demonstrated no change in their same-sex behavior. In the case studies, clients who were described as exclusively attracted to the same sex prior to treatment were most commonly reported to have failed to avoid same-sex sexual behavior following treatment.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current behavior to SOCE. No results are reported for these studies.

SUMMARY

In the early studies with the greatest rigor, it appears that SOCE may have decreased short-term same-sex sexual behavior for a minority of men. However, in the only randomized control group trial, the intervention had no effect on same-sex sexual behavior. Quasi-experimental results found that a minority of men reported reductions in same-sex sexual behavior following SOCE. The nonexperimental studies found that study participants often reported reduced behavior but also found that reductions in same-sex sexual behavior, when reported, were not always sustained.

Increasing Other-Sex Sexual Attraction

Early studies provide limited evidence for reductions in sexual arousal to same-sex stimuli and for reductions in same-sex sexual behavior following aversive treatments. The impact of the use of aversive treatments for increasing other-sex sexual arousal is negligible.

EARLY STUDIES

Experimental studies

In many of the early experiments on aversive treatments, sexual arousal to female sexual stimuli was a desired outcome. McConaghy (1969) found that about 16% of 40 men increased their sexual arousal to female stimuli immediately following treatment and that 5% increased their sexual arousal to male stimuli. It is unclear how the 50% of men in this study who were aroused by females prior to the treatment were distributed among the men who increased their sexual arousal and among those who did not. In other words, it is possible that most of the men who changed were sexually aroused by women initially. In interviews following treatment, McConaghy (1976) reported that 25% of 157 men indicated that they felt more sexual arousal toward females than they did before treatment. McConaghy et al. (1972) found no change in rates of sexual arousal to female stimuli. McConaghy et al.'s (1972) research participants showed no change in penile volume in response to female stimuli after intervention.

In a randomized control trial, Tanner's (1974) 8 research participants reported increases in sexual fantasizing about other-sex partners after aversive conditioning. However, penile circumference data showed no increased sexual arousal to female stimuli. H. E. Adams and Sturgis (1977) found that 26% of 179 participants in the controlled studies that they reviewed increased their sexual arousal toward the other-sex.

Quasi-experimental studies

Birk and colleagues (1971) found no difference between their treatment groups in reported sexual arousal to women. Two men (11% of 18 participants) in the study reported sustained sexual interest in women following treatment. McConaghy and colleagues (1981) reported no significant improvement in attraction to females. S. James (1978) reported little impact of treatment on participants in anticipatory avoidance learning. He noted a general improvement among 80% of the 40 men undergoing desensitization to other-sex situations.

Nonexperimental studies

Among the nonexperimental studies, for men who were described as having some degree of other-sex sexual attraction and experience before the intervention, the balance of studies showed an increase in other-sex sexual attraction over time, although given the nonexperimental nature of these studies, this change

cannot be validly attributed to SOCE. For men with little or no preintervention other-sex sexual attraction, the research provides little evidence of increased other-sex sexual attraction.

As in some of the experimental studies, the results reported in the nonexperiments were not always in the desired direction. Studies occasionally showed that reductions in sexual arousal and interest may occur for same- and other-sex partners, suggesting the possibility that treatments may lower sexual arousal to sexual stimuli in general. For instance, Curtis and Presly's (1972) married male subject reported slightly lower rates of sexual arousal in response to women than before intervention, in addition to reduced same-sex sexual arousal.

Among early studies, many found little or no increases in other-sex sexual attraction among participants who showed limited or no other-sex sexual attraction to begin with. For instance, 2 of the 3 men in Barlow et al.'s (1975) within-subject biofeedback investigation reported little or no other-sex sexual interest prior to intervention. As measured by penile circumference, one of these men demonstrated negligible increases in other-sex sexual attraction; one other individual showed stable low other-sex sexual attraction, which contradicted his self-report.

In contrast, a handful of the early single-patient case studies found increases in other-sex attraction. For instance, Hanson and Adesso's (1972) research participant, who was reported to be primarily same-sex sexually attracted at the onset of intervention, increased his sexual arousal to women and ultimately reported that he enjoyed sex with women. Huff's (1970) male research participant also reported increased other-sex sexual attraction at 6 months following desensitization.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current other-sex sexual attraction to SOCE. No results are reported for these studies.

SUMMARY

Taken together, the research provides little support for the ability of interventions to develop other-sex sexual attraction where it did not previously exist, though it may be possible to accentuate other-sex sexual attraction among those who already experience it.

Increasing Other-Sex Sexual Behavior

Studies on whether interventions can lead to other-sex sexual activity show limited results. These studies show more success for those who had some other-sex sexual orientation (e.g., sexual arousal) and were sexually experienced with members of the other sex prior to intervention than for those who had no other-sex sexual orientation and no history of other-sex sexual behavior. The results for this outcome suggest that some people can initiate other-sex sexual behavior whether or not they have any observed other-sex sexual orientation.

As previously noted, in the early studies many people were described as heterosexually experienced. From the data provided by H.E. Adam and Sturgis in their 1977 review, 61%–80% of male research participants appeared to have histories of dating women, and 33%–63% had sexual intercourse with women prior to intervention. Additionally, some of the men were married at the time of intervention. Because so many of the research participants in these studies had other-sex sexual attractions or intimate relationships at the outset, it is unclear how to interpret changes in their levels of other-sex sexual activity.

EARLY STUDIES

Experimental studies

According to H. E. Adams and Sturgis (1977), only 8% of participants in controlled studies are reported to have engaged in other-sex sexual behavior following SOCE. Among those studies we reviewed, only 2 participants showed a significant increase in other-sex sexual activity (McConaghy & Barr, 1973; Tanner, 1974). In Tanner's randomized controlled trial, men increased the frequency of intercourse with females but maintained the frequency of intercourse with males.

Quasi-experimental studies

McConaghy et al. (1981) found no difference in the frequency of other-sex sexual behavior following SOCE.

Nonexperimental studies

Among within-subject patient studies in which aversion techniques were used, some studies reported that a subset of 12%–40% of people in the multiple-subject studies and all people in single-patient studies engaged in other-sex sexual behavior following intervention (e.g., Bancroft, 1969; Fookes, 1960; Hallam & Rachman, 1972; Hanson & Adesso, 1972; Kendrick & McCullough, 1972; Larson, 1970). Regarding other techniques

studied in early intervention research, Barlow et al. (1975) reported that 1 of 3 research participants began to date women after biofeedback. Huff's (1970) research participant also began to date women after desensitization training. LoPiccolo (1971) used orgasmic reconditioning to treat a male–female couple. The male could not achieve an erection with his female partner and found sex with women dissatisfying. At 6 months, he was able to develop and maintain an erection and ejaculate intravaginally.

RECENT STUDIES

As previously noted, recent studies provide no sound basis for attributing individual reports of their current sexual behavior to SOCE. No results are reported for these studies.

SUMMARY

In general, the results from studies indicate that while some people who undergo SOCE do engage in other-sex sexual behavior afterward, the balance of the evidence suggests that SOCE is unlikely to increase other-sex sexual behavior. Findings show that the likelihood of having sex with other-sex partners for those research participants who possess no other-sex sexual orientation prior to the intervention is low.

Marriage

One outcome that some proponents of efforts to change sexual orientation are reported to value is entry into heterosexual marriage. Few early studies reported on whether people became heterosexually married after intervention. In a quasi-experimental study, Birk et al. (1971) found that 2 of 18 respondents (11%) were married at 36 months. Two uncontrolled studies (Birk, 1974; Larson, 1970) indicated that a minority of research participants ultimately married, though it is not clear what role, if any, intervention played in this outcome. Recent research provides more information on marriage, though research designs do not permit any attribution of marital outcomes to SOCE.

Improving Mental Health

The relationship between mental health, psychological well-being, sexual orientation, sexual orientation identity, and sexual behavior is important. Few studies report health and mental health outcomes, and those that do report outcomes tend to use psychometrically

weak measures of these constructs and weak study designs. Among the early studies that report on mental health, three nonexperimental single-patient case studies report that clients were more self-assured (Blitch & Haynes, 1972) or less fearful and distressed (Hanson & Adesso, 1972; Huff, 1970).

Overall, the lack of high-quality data on mental health outcomes of efforts to change sexual orientation provide no sound basis for claims that people's mental health and quality of life improve. Indeed, these studies add little to understanding how SOCE affects people's long-term mental health.

Reports of Harm

Determining the efficacy of any intervention includes examination of its side effects and evidence of its harm (Flay et al., 2005; Lilienfeld, 2007). A central issue in the debates regarding efforts to change same-sex sexual attractions concerns the risk of harm to people that may result from attempts to change their sexual orientation. Here we consider evidence of harm in early and recent research.

EARLY STUDIES

Early research on efforts to change sexual orientation focused heavily on interventions that include aversion techniques. Many of these studies did not set out to investigate harm. Nonetheless, these studies provide some suggestion that harm can occur from aversive efforts to change sexual orientation.

EXPERIMENTAL STUDIES

In McConaghy and Barr's (1973) experiment, 1 respondent of 46 subjects is reported to have lost all sexual feeling and to have dropped out of the treatment as a result. Two participants reported experiencing severe depression, and 4 others experienced milder depression during treatment. No other experimental studies reported on iatrogenic effects.

QUASI-EXPERIMENTAL STUDIES

None reported on adverse events.

NONEXPERIMENTAL STUDIES

A majority of the reports on iatrogenic effects are provided in the nonexperimental studies. In the study conducted by Bancroft (1969), the negative outcomes reported include treatment-related anxiety (20% of 16

participants), suicidal ideation (10% of 16 participants), depression (40% of 16 participants), impotence (10% of 16 participants), and relationship dysfunction (10% of 16 participants). Overall, Bancroft reported the intervention had harmful effects on 50% of the 16 research subjects who were exposed to it. Quinn, Harbison, and McAllister (1970) and Thorpe et al. (1964) also reported cases of debilitating depression, gastric distress, nightmares, and anxiety. Herman and Prewett (1974) reported that following treatment, their research participant began to engage in abusive use of alcohol that required his rehospitalization. It is unclear to what extent and how his treatment failure may have contributed to his abusive drinking. B. James (1962) reported symptoms of severe dehydration (acetonuria), which forced treatment to be suspended.

Overall, although most early research provides little information on how research participants fared over the longer term and whether interventions were associated with long-term negative effects, negative effects of treatment are reported to have occurred for some people during and immediately following treatment.

High dropout rates characterize early treatment studies and may be an indicator that research participants experience these treatments as harmful. Lilienfeld's (2007) review of harm in psychotherapy identified dropout as not only an indicator of direct harm but also of treatment ineffectiveness.

RECENT STUDIES

Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; G. Smith et al., 2004), just as other recent studies document that there are people who perceive that they have benefited from it (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003). Among those studies reporting on the perceptions of harm, 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. These reports of perceptions of harm are countered by accounts of

perceptions of relief, happiness, improved relationships with God, and perceived improvement in mental health status, among other reported benefits. Many participants in studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described experiencing first the positive effects and then experiencing or acknowledging the negative effects later.

Overall, the recent studies do not give an indication of the client characteristics that would lead to perceptions of harm or benefit. Although the nature of these studies precludes causal attributions for harm or benefit to SOCE, these studies underscore the diversity of and range in participants' perceptions and evaluations of their SOCE experiences.

Summary

We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the

Studies from both periods indicate that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm.

prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. However, studies from both periods indicate

that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm (cf. Lilienfeld, 2007).

Conclusion

The limited number of rigorous early studies and complete lack of rigorous recent prospective research on SOCE limits claims for the efficacy and safety of SOCE. Within the early group of studies, there are a small number of rigorous studies of SOCE, and those focus on the use of aversive treatments. These studies show that

enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed any credible evidence of reduced

Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life.

same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased

attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective.

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies do document iatrogenic effects of aversive forms of SOCE. High dropout rates characterize early aversive treatment studies and may be an indicator that research participants experience these treatments as harmful. Recent research reports indicate that there are individuals who perceive they have been harmed and others who perceive they have benefited from nonaversive SOCE. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from nonaversive SOCE from those who will later perceive that they have failed or been harmed. In the next chapter, we explore the literature on individuals who seek to change their sexual orientation to better understand their concerns.

5. RESEARCH ON ADULTS WHO UNDERGO SEXUAL ORIENTATION CHANGE EFFORTS

In the preceding three chapters, we have focused on sexual orientation change efforts (SOCE),³⁹ because such interventions have been the primary focus of attention and contention in recent decades. Now we turn from the problem of sexual orientation change, as it has been defined by “expert” narratives of sin, crime, disorder, and dysfunction in previous chapters, to the problem of sexual orientation distress, as it exists in the lives of individuals who seek and participate in sexual orientation change. We try to present what the research literature reveals—and clarify what it does not—about the natural history of the phenomenon of people who present to LMHP seeking SOCE.

We do this for two major reasons. The first is to provide a scholarly basis for responding to the core task force charge: “the appropriate application of affirmative therapeutic interventions” for the population of those individuals who seek sexual orientation change. The second is our hope to step out of the polemic that has defined approaches to sexual orientation distress. As discussed in the introduction, some professional articles (e.g., Rosik, 2001, 2003; Yarhouse & Burkett, 2002), organizations, and accounts of debates (cf. Drescher, 2003) have argued that APA and mainstream psychology are ignoring the needs of those for whom same-sex sexual attractions are unwanted, especially

We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of the needs of this population so that an affirmative therapeutic approach may be developed.

the needs of this population so that an affirmative therapeutic approach may be developed.

We decided to expand our review beyond empirical literature to have a fuller view of the population in question. Because of the lack of empirical research in this area, the conclusions must be viewed as tentative. The studies that are included in this discussion are (a) surveys and studies of individuals who participated in SOCE and their perceptions of change, benefit, and harm (e.g., S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005)⁴⁰; (b) high-quality qualitative studies of the concerns of participants and the dynamics of SOCE (e.g., Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); (c) case reports, clinical articles, dissertations, and reviews in

for religious populations. We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of

³⁹ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

⁴⁰ As previously noted, these studies, due to their significant methodological issues, cannot assess whether actual sexual orientation change occurred.

which sexual orientation or sexual orientation identity change were considered or attempted (e.g., Borowich, 2008; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Horlacher, 2006; Karten, 2006; Mark, 2008; Tan, 2008, Yarhouse et al., 2005; Yarhouse, 2008); and (d) scholarly articles, case reports, dissertations, and reviews on the concerns of religious individuals who are conflicted by their same-sex sexual attractions, some of whom accept their same-sex sexual orientation (e.g., Coyle & Rafalin, 2000, Horlacher, 2006; Kerr, 1997; Mahaffy, 1996; Mark, 2008, Moran, 2007; O'Neill & Ritter, 1992; Shallenberger, 1998; Tan, 2008; Thumma, 1991; Yarhouse, 2008; Yarhouse et al., 2005; Yip, 2000, 2002, 2003, 2005). We also reviewed a variety of additional scholarly articles on subtopics such as individuals in other-sex marriages and general literature on sexual orientation concerns.

Demographics

The majority of participants in research studies on SOCE have been Caucasian men. Early studies included some men who were court-referred and whose participation was not voluntary (S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972), but more recent research primarily included men who indicated that their religion is of central importance (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Wolkomir, 2001). Some studies included small numbers of women (22%–29%; Nicolosi et al., 2000; S. L. Jones & Yarhouse, 2007; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003), and two studies focused exclusively on women (Moran, 2007; Ponticelli, 1999). However, these studies do not examine if there are potential differences between the concerns of men and women.

To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

sample in other studies (S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003). In the recent studies, no comparisons were reported between the

Members of racial-ethnic groups are not included in some samples (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and are a small percentage (5%–14%) of the

ethnic minorities in the sample and others. Thus, there is no evidence that can elucidate concerns of ethnic minority individuals who have sought SOCE. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

Samples in recent SOCE studies have been composed predominantly of individuals from conservative Christian denominations (Beckstead & Morrow, 2004; Erzen, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001). These studies included very few nonreligious individuals, and the concerns of religious individuals of faiths other than Christian are not described. Thus, the existing literature limits information to the concerns of a particular group of religious individuals. Finally, most individuals in studies of SOCE have tried multiple ways to change their sexual orientation, ranging from individual psychotherapy to religiously oriented groups, over long periods of time and with varying degrees of satisfaction and varying perceptions of success (Beckstead & Morrow, 2004; Comstock, 1996; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Mark, 2008; Nicolosi et al., 2000; Shidlo & Schroeder, 2002).

Why Individuals Undergo Sexual Orientation Change Efforts

Because no research provides prevalence estimates of those participating in SOCE, we cannot determine how prevalent the wish to change sexual orientation is among the conservative Christian men who have predominated in the recent research, or among any other population. Clients' motivations to seek out and participate in SOCE seem to be complex and varied and may include mental health and personality issues, cultural concerns, religious faith, internalized stigma, as well as sexual orientation concerns (Beckstead & Morrow, 2004; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000). Some of the factors influencing a client's request for SOCE that have been identified in the literature include the following:

- Confusion or questions about one's sexuality and sexual orientation (Beckstead & Morrow, 2004; G. Smith et al., 2004)
- Religious beliefs that consider homosexuality sinful or unacceptable (Erzen, 2006; Haldeman, 2004; S. L. Jones & Yarhouse, 2007; Mark, 2008; Ponticelli, 1999; Tan, 2008; Tozer & Hayes, 2004; Wolkomir, 2001, 2006; Yarhouse, 2008)
- Fear, stress, and anxiety surrounding the implications of an LGB identity (especially the illegitimacy of such an identity within the client's religious faith or community) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002)
- Family pressure to be heterosexual and community rejection of those who are LGB (Haldeman, 2004; Glassgold, 2008; Mark, 2008; Shidlo & Schroeder, 2002; G. Smith et al., 2004)

Some individuals who have pursued SOCE report having had only unsuccessful or unfulfilling same-sex sexual experiences in venues such as bars or sexual "cruising" areas (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). These experiences reflected and re-created restricted views that the "gay lifestyle" is nonspiritual, sexually desperate, or addicted, depressive, diseased, and lonely (Drescher, 1998b; Green, 2003; Rosik, 2003; Scasta, 1998). Many sexual minority individuals who do not seek SOCE are also affected by these factors. Thus, these findings do not explain why some people seek SOCE and others do not.

There are some initial findings that suggest differences between those who seek SOCE and those who resolve their sexual minority stress through other means. For example, Ponticelli (1999) and S. L. Jones and Yarhouse (2007) reported higher levels of self-reported family violence and sexual abuse in their samples than were reported by Laumann et al. (1994) in a population-based sample. Beckstead and Morrow (2004) and S. L. Jones and Yarhouse reported high levels of parental rejection or authoritarianism among their religious samples (see also G. Smith et al., 2004). Wolkomir (2001) found that distress surrounding nonconformity to traditional gender roles distinguished the men in her sample who did not accept their sexual orientation from those who did. Similarly, Beckstead and Morrow found that distress and questions about masculinity were an important appeal of SOCE; some men who sought SOCE described feeling distress about

not acting more traditionally masculine. In reviewing the SOCE literature, Miville and Ferguson (2004) proposed that White, conservatively religious men might not feel adept at managing a minority status and thus seek out SOCE as a resolution.

The views of LMHP concerning SOCE and homosexuality appear to influence clients' decision making in choosing SOCE; some clients reported being urged by their provider to participate in SOCE (M. King et al. 2004; Schroeder & Shidlo, 2001; G. Smith et al., 2004). For example, G. Smith et al. (2004) found that some who had received SOCE had not requested it. These individuals stated they had presented with confusion and distress about their orientation due to cultural and relational conflicts and were offered SOCE as the solution.

Specific Concerns of Religious Individuals

In general, the participants in research on SOCE have come from faiths that believe heterosexuality and other-sex relationships are part of the natural order and are morally superior to homosexuality (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001, 2006). The literature on SOCE suggests that individuals reject or fear their same-sex sexual attractions because of the internalization of the values and attitudes of their religion that characterize homosexuality negatively and as something to avoid (Beckstead & Morrow, 2004; Erzen, 2006; Glassgold, 2008; Mark, 2008; Nicolosi et al., 2000; Ponticelli, 1999; Wolkomir, 2001, 2006).

The experiences of some conservative religious individuals with same-sex sexual attractions who undergo SOCE appear to involve significant stress due to the struggle to live life congruently with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse & Tan, 2004). These individuals perceive homosexuality to be irreconcilable with their faith and do not wish to surrender or change their faith (Wolkomir, 2006). Some report fearing considerable shifts or losses in their core identity, role, purpose, and sense of order if they were to pursue an outward LGB identity (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Wolkomir, 2006). Some report difficulty coping with intense guilt over the failure to live a virtuous life and inability to stop committing unforgivable sins, as defined by their

religion (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008). Some struggled with their belief in God, perceiving that God was punishing or abandoning them—or would if they acted on their attractions; some expressed feelings of anger at the situation in which their God had placed them (Beckstead & Morrow, 2004; Glassgold, 2008; cf. Exline, 2002; Pargament, Smith, Koenig, & Perez, 1998; Pargament et al., 2005).

Some individuals' distress took the form of a crisis of faith in which their religious beliefs that a same-sex sexual orientation and religious goodness are

The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation.

diametrically opposed led them to question their faith and themselves (Glassgold, 2008; Moran, 2007; Tozer & Hayes, 2004). Spiritual struggles also occurred for religious sexual

minorities due to struggling with conservatively religious family, friends, and communities who thought differently than they did. The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation (Beckstead & Morrow, 2004).

These spiritual struggles had mental health consequences. Clinical publications and studies of religious clients (both male and female) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008) have described individuals who felt culpable, unacceptable, unforgiven, disillusioned, and distressed due to the conflict between their same-sex sexual attractions and religion. The inability to integrate religion and sexual orientation into a religiously sanctioned life (i.e., one that provides an option for positive self-esteem and religiously sanctioned sexuality and family life) has been described as causing great emotional distress (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003). These spiritual struggles were sometimes associated with anxiety, panic disorders, depression, and suicidality, regardless of the level of religiosity or the perception of religion as a source of comfort and coping (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Horlacher, 2006). The emotional

reactions reported in the literature on SOCE among religious individuals are consistent with those reported in the psychology of religion literature that describes both the impact of an inability to live up to religious motivations and the effects of religion and positive and negative religious coping (Ano & Vasconcelles, 2005; Exline, 2002; Pargament & Mahoney, 2002; Pargament et al., 2005; Trenholm, Trent, & Compton, 1998).

Some individuals coped by trying to compartmentalize their sexual orientation and religious identities and behaviors or to suppress one identity in favor of another (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008). Relief came as some sought repentance from their "sins," but others continued to feel isolated and unacceptable in both religious and sexual minority communities (Shidlo & Schroeder, 2002; Yarhouse & Beckstead, 2007). As an alternative, some with strong religious motivations and purpose were willing to make sexual abstinence a goal and to limit sexual and romantic needs in order to achieve congruence with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse, 2008). These choices are consistent with the psychology of religion that emphasizes religious motivations and purpose (cf. Emmons, 1999; Emmons & Paloutzian, 2003; Hayduk, Stratkotter, & Rovers, 1997; Roccas, 2005). Success with this choice varied greatly and appeared successful in a minority of participants of studies, although not always in the long term, and both positive and negative mental health effects have been reported (Beckstead & Morrow, 2004; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Shidlo & Schroeder, 2002).

Some conservatively religious individuals felt a need to change their sexual orientation because of the positive benefits that some individuals found from religion (e.g., community, mode of life, values, sense of purpose) (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Nicolosi et al., 2000; Yarhouse, 2008). Others hoped that being heterosexual would permit them to avoid further negative emotions (e.g., self-hatred, unacceptability, isolation, confusion, rejection, and suicidality) and expulsion from their religious community (Beckstead & Morrow, 2004; Borowich, 2008; Glassgold, 2008; Haldeman, 2004; Mark, 2008).

The literature on non-Christian religious denominations is very limited, and no detailed literature was found on most faiths that differed from the descriptions cited previously. There is limited information on the specific concerns of observant

and Orthodox Jews⁴¹ (e.g., Blechner, 2008; Borowich, 2008; Glassgold, 2008; Mark, 2008; Wolowelsky & Weinstein, 1995). This work stresses the conflicts that emerge within a communal and insular culture that values obedience to religious law and separates itself from mainstream society and other faiths, including mainstream LGB communities, thus isolating those in conflict and distress (Glassgold, 2008; Mark, 2008). As marriage, family, and community are the central units of life within such a religious context, LGB individuals do not have a place in Orthodox Judaism and traditional Jewish society and may fear losing contact with family and society or bringing shame and negative consequences to their family if their sexual orientation is disclosed.⁴² Many of the responses and concerns of the conservative Christian population appear relevant to those who are Orthodox Jews, especially those that arise from the conflicts of faith and sexual orientation, such as feelings of guilt, doubt, crisis of faith, unworthiness, and despair (Glassgold, 2008; Mark, 2008).

We found no scholarly psychological literature on sexual minority Muslims who seek SOCE. There is some

It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress in other ways than SOCE.

literature on debates about homosexuality within Islam and cultural conflicts for those Muslims who live in Western societies with more progressive attitudes

toward homosexuality (Halstead & Lewicka, 1998; Hekma, 2002; de Jong & Jivraj, 2002; Massad, 2002; Nahas, 2004). Additionally, there is some literature on ways in which individuals integrate LGBT identities with their Muslim faith (Minwalla, Rosser, Feldman, & Varga, 2005; Yip, 2005). We did not find scholarly articles about individuals from other faiths who sought SOCE, except for one article (Nicolosi et al., 2000) that did not report any separate results for individuals from non-Christian faiths.

It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress

⁴¹ Among Jewish traditions, Orthodox Judaism is the most conservative and does not have a role for same-sex relationships or sexual orientation identities within its faith (Mark, 2008). Individuals in other denominations (e.g., Conservative, Reform, Reconstructionist) may not face this type of conflict or this degree of conflict.

⁴² These conflicts may also be relevant to those whose religion and community are similarly intertwined and separate from larger society; see Cates (2007), for instance, regarding an individual from an Old Amish community.

in other ways than SOCE (Coyle & Rafalin, 2000; Mahaffy, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2005). For instance, some individuals are adherents of more accepting faiths and thus experience less distress. Some end their relationship with all religious institutions, although they may retain the religious and spiritual aspects of their original faiths that are essential to them. Others choose another form of religion or spirituality that is affirming of sexual minorities (Lease, Horne, & Noffsinger-Frazier, 2005; Ritter & O'Neill, 1989, 1995; Ritter & Terndrup, 2002; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2004).

Conflicts of Individuals in Other-Sex Marriages or Relationships

There is indication that some individuals with same-sex sexual attractions in other-sex marriages or relationships may request SOCE. Many subjects in the early studies were married (H. E. Adams & Sturgis, 1977). In the more recent research, some individuals were married (e.g., Horlacher, 2006; Spitzer, 2003), and there are clinical reports of experiences of SOCE among other-sex married people (e.g., Glassgold, 2008; Isay, 1998). For some, the marriage to an other-sex person was described as based on socialization, religious views that deny same-sex sexual attractions, lack of awareness of alternatives, and hopes that marriage would change them (Gramick, 1984; Higgins, 2006; Isay, 1998; Malcolm, 2000; Ortiz & Scott, 1994; M. W. Ross, 1989). Others did not recognize or become aware of their sexuality, including same-sex sexual attractions, until after marriage, when they became sexually active (Bozett, 1982; Carlsson, 2007; Schneider et al., 2002). Others had attractions to both men and women (Brownfain, 1985; Coleman, 1989; Wyers, 1987).

For those who experienced distress with their other-sex relationship, some were at a loss as to how to decide what to do with their conflicting needs, roles, and responsibilities and experienced considerable guilt, shame, and confusion (Beckstead & Morrow, 2004; Bozett, 1982; Buxton, 1994, 2004, 2007; Gochros, 1989; Hays & Samuels, 1989; Isay, 1998; Shidlo & Schroeder, 2002; Yarhouse & Seymore, 2006). Love for their spouse conflicted with desires to explore or act on same-sex romantic and sexual feelings and relationships or to connect with similar others (Bridges & Croteau, 1994; Coleman, 1981/1982; Yarhouse & Seymore, 2006).

However, many individuals wished to maintain their marriage and work at making that relationship last (Buxton, 2007; Glassgold, 2008; Yarhouse, Pawlowski, & Tan, 2003; Yarhouse & Seymore, 2006). Thus, the sexual minority individual sometimes felt frustrated and hopeless in facing feelings of loss and guilt that result from trying to decide whether to separate from or remain in the marriage as he or she balanced hopes and ambiguities (e.g., the chances of finding a same-sex romantic or sexual partner or the possibilities of experiencing further intimacy with one's heterosexual spouse) (Hernandez & Wilson, 2007).

Reported Impacts of Sexual Orientation Change Efforts

Perceived Positives of SOCE

In this section we review the perceptions of individuals who underwent SOCE in order to examine what may be perceived as being helpful or detrimental by such individuals, distinct from a scientific evaluation of the efficacy or harm associated with sexual orientation change efforts, as reported in Chapter 4.

Individuals have reported that SOCE provided several benefits: (a) a place to discuss their conflicts (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001); (b) cognitive frameworks that permitted them to reevaluate their sexual orientation identity, attractions, and selves in ways that lessened shame and distress and increased self-esteem (Erzen, 2006; Karten, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton, 2002); (c) social support and role models (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); and (d) strategies for living consistently with their religious faith and community (Beckstead & Morrow, 2004; Erzen, 2006; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Throckmorton & Welton, 2005; Wolkomir, 2001, 2006).

For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation, gender identity, sexual behavior, sexual orientation identity (Beckstead, 2001; Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton & Welton, 2005), or improving nonsexual relationships with men (Karten, 2006). These changes in sexual self-views were described in a variety of ways (e.g., ex-

gay, heterosexual, heterosexual with same-sex sexual attractions, heterosexual with a homosexual past) and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). McConaghy (1999) reported that some men felt they had more control in their sexual behavior and struggled less with their attractions after interventions, although same-sex sexual attractions still existed (cf. Beckstead & Morrow, 2004). Additionally, some SOCE consumers noted that trying and failing to change their same-sex sexual orientation actually allowed them to accept their same-sex attractions (Beckstead & Morrow, 2004; G. Smith et al., 2004).

Participants described the social support aspects of SOCE positively. Individuals reported as positive that their LMHP accepted their goals and objections and had similar values (i.e., believing that a gay or lesbian identity is bad, sick, or inferior and not supporting same-sex relationships) (Nicolosi et al., 2000; Throckmorton & Welton, 2005). Erzen (2006), Ponticelli (1999), and Wolkomir (2001) described these religiously oriented ex-gay groups as a refuge for those who were excluded from conservative churches and from their

... such groups built hope, recovery, and relapse into an ex-gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

families because of their same-sex sexual attractions, as well as from gay organizations and social networks because of their conservative religious beliefs. In Erzen's

experiences with these men, these organizations seemed to provide options for individuals to remain connected to others who shared their religious beliefs, despite ongoing same-sex sexual feelings and behaviors. Wolkomir (2006) found that ex-gay groups recast homosexuality as an ordinary sin, and thus salvation was still achievable. Erzen observed that such groups built hope, recovery, and relapse into an ex-gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

Some participants of SOCE reported what they perceived as other positive values and beliefs underlying SOCE treatments and theories, such as supporting celibacy, validating other-sex marriage, and encouraging and supporting other-sex sexual behaviors (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Throckmorton & Welton, 2005). For instance, many SOCE theories

and communities focus on supporting clients' values and views, often linked to religious beliefs and values (Nicolosi et al., 2000; Schaeffer et al., 2000; Throckmorton & Welton, 2005). According to Ponticelli (1999), ex-gay support groups provide alternate ways of viewing same-sex attractions that permit individuals to see themselves as heterosexual, which provided individuals a sense of possibility.

Participants' interpretations of their SOCE experiences and the outcomes of their experiences appeared to be shaped by their religious beliefs and by their motivations to be heterosexual. In Schaeffer

These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

et al. (2000), people whose motivation to change was strongly influenced by their Christian beliefs and convictions were more likely to perceive themselves as having a heterosexual sexual orientation after

their efforts. Schaeffer et al. also found that those who were less religious were more likely to perceive themselves as having an LGB sexual orientation after the intervention. Some of the respondents in Spitzer's (2003) study concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions. These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

A number of authors (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001; Yarhouse et al., 2005; Yarhouse & Tan, 2004) have found that identity exploration and reinterpretation were important parts of SOCE. Beckstead and Morrow (2004) described the identity development of their research participants who were or had been members of the Church of Jesus Christ of Latter-Day Saints and had undergone therapy to change their sexual orientation to heterosexual. In this research, those who experienced the most satisfaction with their lives seemed to undergo a developmental process that included the following aspects: (a) becoming disillusioned, questioning authorities, and reevaluating outside norms; (b) wavering between ex-gay, "out" gay, heterosexual, or celibate identities that depended on cultural norms and fears rather than on internally self-informed choices; and (c) resolving their conflicts through developing self-acceptance, creating

a positive self-concept, and making decisions about their relationships, religion, and community affiliations based on expanded information, self-evaluations, and priorities. The participants had multiple endpoints, including LGB identity, "ex-gay" identity, no sexual orientation identity, and a unique self-identity. Some individuals chose actively to *disidentify* with a sexual minority identity so the individual's sexual orientation identity and sexual orientation could be incongruent (Wolkomir, 2001, 2006; Yarhouse, 2001; Yarhouse & Tan, 2004; Yarhouse et al., 2005).

Further, the findings suggest that some participants may have reconceptualized their *sexual orientation identity* as heterosexual but *not* achieved sexual orientation change, as they still experienced same-sex sexual attractions and desires (for a discussion of the distinction between sexual orientation and sexual orientation identity, see Chapter 3; see also R. L. Worthington, 2003; R. L. Worthington et al., 2002). For these individuals, sexual orientation identity may not reflect underlying attractions and desires (Beckstead, 2003; Beckstead & Morrow, 2004; McConaghy, 1999; Rust, 2003; Shidlo & Schroeder, 2002).

Perceived Negatives of SOCE

Participants in the studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described the harm they experienced as (a) decreased self-esteem and authenticity to others; (b) increased self-hatred and negative perceptions of homosexuality; (c) confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, and suicidality; (d) anger at and a sense of betrayal by SOCE providers; (e) an increase in substance abuse and high-risk sexual behaviors; (f) a feeling of being dehumanized and untrue to self; (g) a loss of faith; and (h) a sense of having wasted time and resources. Interpreting SOCE failures as individual failures was also reported in this research, in that individuals blamed themselves for the failure (i.e., weakness, and lack of effort, commitment, faith, or worthiness in God's eyes). Intrusive images and sexual dysfunction were also reported, particularly among those who had experienced aversion techniques.

Participants in these studies related that their relationships with others were also harmed in the following ways: (a) hostility toward and blame of parents, believing their parents "caused" their homosexuality; (b) anger at and a sense of betrayal by SOCE providers; (c) loss of LGB friends and potential romantic partners because of the belief that they should

avoid sexual minority people; (d) problems in sexual and emotional intimacy with other-sex partners; (e) stress due to the negative emotions of spouses and family members because of expectations that SOCE would work (e.g., disappointment, self-blame for failure of change, perception of betrayal by partner) (see also J. G. Ford, 2001); and (f) guilt and confusion when they were sexually intimate with other same-sex members of the ex-gay groups to which they had turned for help in avoiding their attractions.

LMHP working with former participants in SOCE noted that when clients who formerly engaged in SOCE consider adopting an LGB identity or experience same-sex romantic and sexual relationships later in life, they have more difficulty with identity development due to delayed developmental tasks and dealing with any harm associated with SOCE (Haldeman, 2001; Isay, 2001). Such treatments can harm some men's understanding of their masculine identity (Haldeman, 2001; Schwartzberg & Rosenberg, 1998) and obscure other psychological issues that contribute to distress (Drescher, 1998b).

Schroeder and Shidlo (2001) identified aspects of SOCE that their participants perceived as negative, which included (a) receiving pejorative or false information regarding sexual orientation and the lives of LGB individuals; (b) encountering overly directive treatment (told not to be LGB) or to repress sexuality; (c) encountering treatments based on unsubstantiated theories or methods; (d) being misinformed about the likelihood of treatment outcomes (i.e., sexual orientation change); (e) receiving inadequate information about alternative options; and (f) being blamed for lack of progress of therapy. Some participants in Schroeder and Shidlo's (2001) study reported feeling coerced by their psychotherapist or religious institution to remain in treatment and pressured to represent to others that they had achieved a "successful reorientation" to heterosexuality.

Religiously Oriented Mutual Support Groups

Much of the literature discusses the specific dynamics and processes of religiously oriented mutual self-help groups. A reduction of distress through sexual orientation identity reconstruction or development is described in the literature of self-help or religious groups, both for individuals who reject (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006) and for

individuals who accept a minority sexual orientation identity (Kerr, 1997; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Thumma, 1991; Wolkomir, 2006).

Ponticelli (1999) and Wolkomir (2001, 2006) found several emotional and cognitive processes that seemed central to the sexual orientation "identity reconstruction" (i.e., recasting oneself as ex-gay, heterosexual, disidentifying as LGB) (Ponticelli, 1999, p. 157) that appeared to relieve the distress caused by conflicts between religious values and sexual orientation (Ponticelli, 1999). Ponticelli identified certain conditions necessary for resolving identity conflicts, including (a) adopting a new discourse or worldview, (b) engaging in a biographical reconstruction, (c) embracing a new explanatory model, and (d) forming strong interpersonal ties. For those rejecting a sexual minority identity, these changes occurred by participants taking on "ex-gay" cultural norms and language and finding a community that enabled and reinforced their primary religious beliefs, values, and concerns. For instance, participants were encouraged to rely on literal interpretations of the Bible, Christian psychoanalytic theories about the causes of homosexuality, and "ex-gay" social relationships to guide and redefine their lives.

Interesting counterpoints to the SOCE support groups are LGB-affirming religious support groups. These groups employ similar emotional and cognitive strategies to provide emotional support, affirming ideologies, and identity reconstruction. Further, they appear to facilitate integration of same-sex sexual attractions and religious identities into LGB-affirming identities (Kerr, 1997; Thumma, 1991; Wolkomir, 2001, 2006).

Both sexual-minority-affirming and ex-gay mutual help groups potentially appear to offer benefits to their participants that are similar to those claimed for self-help groups, such as social support, fellowship, role models, and new ways to view a problem through unique philosophies or ideologies (cf. Levine, Perkins, & Perkins, 2004).

The philosophy of mutual help groups often gives a normalizing meaning to the individual's situation and may act as an "antidote" to a sense of deficiency (Antze, 1976). New scripts can shape how a member views and shares her or his life story by replacing existing personal or cultural scripts with the group ideology (Humphreys, 2004; Mankowski, 1997, 2000; Maton, 2000). For instance, individuals who are involved in SOCE or LGB-affirming groups may adopt a new explanation for their homosexuality that permits reconceptualizing themselves as heterosexual or acceptable as LGB people (Ponticelli, 1999; Wolkomir, 2001, 2006).

Remaining Issues

Ponticelli (1999) ended her article with the following questions: “What leads a person to choose Exodus and a frame that defined them as sinful and in need of change?” (p. 170). Why do some individuals choose SOCE over sexual-minority-affirming groups, and why are some individuals attracted to and able to find relief in a particular ideology or group over other alternatives?

There are some indications that the nature and type of religious motivation and faith play a role. In comparing individuals with intrinsic⁴³ and quest religious motivations, Tozer and Hayes (2004) proposed that those with a greater intrinsic religiosity may be motivated to seek out SOCE more than those with the quest motivation. However, within both groups (intrinsic and quest motivation), internalized stigma influenced who sought SOCE; those who sought SOCE had higher levels of internalized stigma. Tozer and Hayes (2004) and Mahaffy (1996) found that individuals in earlier stages of sexual minority identity development (see, e.g., Cass, 1979; Troiden, 1993) were more likely to pursue SOCE.

Wolkomir (2001, 2006) found some evidence that biographical factors may be central to these choices. Wolkomir (2006) found that motivations for participation in faith distinguished individuals who joined ex-gay groups from sexual-minority-affirming groups. For instance, men who joined conservative Christian communities as a solution to lives that had been lonely and disconnected and those who turned to faith when they felt overwhelmed by circumstance were more likely to join ex-gay groups. Wolkomir hypothesized that these men perceived homosexuality as a threat to the refuge that conservative faith provided (cf. Glassgold, 2008).

The other common path to an ex-gay (as well as, to some degree, to a sexual-minority-affirming) group was remaining in the community of faith in which one was raised and meeting the expectations of that faith, such as heterosexuality. The loss of a personal relationship or a betrayal by a loved one might influence an individual's choice of a group, and the stress of loss and the self-blame that accompany such a loss may constitute factors that lead someone to seek SOCE (Wolkomir, 2001, 2006).

Additionally, Wolkomir found that a sense of gender inadequacy (see also “gender role strain”; Levant, 1992;

⁴³ Internal motivation refers to a motivation that focuses on belief and values as ends in themselves, and quest sees religion as a process of exploration.

Pleck, 1995) made groups that embraced traditional gender roles and gender-based models of homosexuality appealing to some men. Gender-based internalized stigma and self-stigma increased distress in these men.

Finally, “contractual promises” to God (Wolkomir, 2001, p. 332) regarding other concerns (e.g., drug/alcohol abuse) increased the likelihood that men would choose ex-gay groups. However, these issues are as yet underresearched and remain unresolved.

Very little is known about the concerns of other religious faiths and diverse ethnicities and cultures (Harper et al., 2004; Miville & Ferguson, 2004). There are some studies in the empirical and theoretical literature, clinical cases, and material from other fields (e.g., anthropology, sociology) on sexual orientation among ethnic minorities and in different cultures and countries. Sexual orientation identity may be constructed differently in ethnic minority communities and internationally (Boykin, 1996; Carillo, 2002; Crawford et al., 2002; Harper et al., 2004; Mays, Cochran, & Zamudio, 2004; Miville & Ferguson, 2004; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006; B. D. Wilson & Miller, 2002; Zea, Diaz, & Reisen, 2003). There is some information that such populations experience distress or conflicts due to legal discrimination, cultural stigma, and other factors (McCormick, 2006), and in some other countries, homosexuality is still seen as a mental disorder or is illegal (Forstein, 2001; see also the publications of the International Gay & Lesbian Human Rights Commission: <http://www.iglhrc.org>). We did not identify empirical research on members of these populations who had sought or participated in SOCE other than as part of the research already cited.

Summary and Conclusion

The recent literature on those who participate in SOCE identifies a population of predominantly White men who are strongly religious and participate in conservative faiths. This contrasts with the early research that included primarily nonreligious individuals. There is a lack of research on non-Christian individuals and limited information on ethnic minority populations, women, and nonreligious populations.

The religious individuals in the recent literature report experiencing serious distress, including depression, identity confusion, and fear due to the strong prohibitions of their faith regarding same-sex sexual orientation, behaviors, and relationships.

These individuals struggle to combine their faiths and their sexualities in meaningful personal and social identities. These struggles cause them significant distress, including frequent feelings of isolation from both religious organizations and sexual minority communities. The ensuing struggles with faith, sexuality, and identity lead many individuals to attempt sexual orientation change through professional interventions and faith-based efforts.

These individuals report a range of effects from their efforts to change their sexual orientation, including both benefits and harm. The benefits include social and

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means to resolve the distress caused by conflicts between religious values and sexual orientation.

mental health effects (depression and suicidality), decreased self-esteem and authenticity to others, increased self-hatred and negative perceptions of homosexuality, a loss of faith, and a sense of having wasted time and resources.

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means of resolving the distress caused by conflicts between religious values and sexual orientation (Erzen, 2006; Kerr, 1997; Ponticelli, 1999; Thumma, 1991; Wolkomir, 2001, 2006). Sexual orientation identity reconstruction found in such groups (Ponticelli, 1999; Thumma, 1991) and identity work in general may provide reduction in individual distress (Beckstead & Morrow, 2004). Individuals may seek out sexual-minority-affirming religious groups or SOCE in the form of ex-gay religious support groups due to (a) a lack of other sources of social support; (b) a desire for active coping, including both cognitive and emotional coping (Folkman & Lazarus, 1980); and (c) access to methods of sexual orientation identity exploration and reconstruction (Ponticelli, 1999; Wolkomir, 2001).

The limited information provided by the literature on individuals who experience distress with their sexual attractions and seek SOCE provides some direction to LMHP in formulating affirmative interventions for this population. The following appear to be helpful to clients:

- Finding social support and interacting with others in similar circumstances
- Experiencing understanding and recognition of the importance of religious beliefs and concerns
- Receiving empathy for their very difficult dilemmas and conflicts
- Being provided with affective and cognitive tools for identity exploration and development

Reports of clients' perceptions of harm also provide information about aspects of interventions to avoid:

- Overly directive treatment that insists on a particular outcome
- Inaccurate, stereotypic, or unscientific information or lack of positive information about sexual minorities and sexual orientation
- The use of unsound or unproven interventions
- Misinformation on treatment outcomes

It is important to note that the factors that are identified as benefits are not unique to SOCE. An affirmative and multiculturally competent framework can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs. An approach that integrates the information identified in this chapter as helpful is described in an affirmative model of psychotherapy in Chapter 6.

6. THE APPROPRIATE APPLICATION OF AFFIRMATIVE THERAPEUTIC INTERVENTIONS FOR ADULTS WHO SEEK SEXUAL ORIENTATION CHANGE EFFORTS

 Our charge was to “generate a report that includes discussion of “the appropriate application of affirmative therapeutic interventions for children, adolescents, and adults who present [themselves for treatment expressing] a desire to change either their sexual orientation or their behavioral expression of their sexual orientation.” In this chapter, we report on affirmative interventions for adults. Affirmative interventions for children and adolescents are reported separately in Chapter 8.

The appropriate application of affirmative psychotherapy is based on the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality; in other words, they are not indicators of mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences (e.g., minority stress) throughout the life span (D’Augelli & Patterson, 1995; DiPlacido, 1998; Herek & Garnets, 2007; Meyer, 1995, 2003).
- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities (Diamond, 2006; Hoberg et al., 2004; Rust, 1996; Savin-Williams, 2005).
- Gay men, lesbians, and bisexual individuals can live satisfying lives as well as form stable, committed relationships and families that are equivalent to heterosexual relationships in essential respects

(APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).

- There are no empirical studies or peer-reviewed research that support theories attributing same-sex sexual orientation to family dysfunction or trauma (Bell et al., 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord et al., 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes et al., 1976).

A Framework for the Appropriate Application of Affirmative Therapeutic Interventions

The task force findings that are relevant to the appropriate application of affirmative therapeutic interventions for adults are the following:

1. Our systematic review of the research on sexual orientation change efforts (SOCE)⁴⁴ found that enduring change to an individual’s sexual orientation as a result of SOCE was unlikely. Further, some participants were harmed by the interventions.

⁴⁴ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

2. What appears to shift and evolve in some individuals' lives is sexual orientation identity, not sexual orientation (Beckstead, 2003; Beckstead & Morrow, 2004; Buchanan, et al., 2001; Cass, 1983/1984; Diamond, 1998, 2006; McConaghy, 1999; Ponticelli, 1999; Rust, 2003; Tan, 2008; Throckmorton & Yarhouse, 2006; Troiden, 1988; Wolkomir, 2001, 2006; R. L. Worthington, 2003, 2004).
3. Some participants in SOCE reported benefits, but the benefits were not specific to SOCE. Rather, clients perceived a benefit when offered interventions that emphasized acceptance, social support, and recognition of important values and concerns.

On the basis of the above three findings and our comprehensive review of the research and clinical literature, we developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements: (a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development.

Acceptance and Support

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation has been grounded in a client-centered approach⁴⁵ (e.g., Astrapovich, 2003; Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Buchanan et al., 2001; Drescher, 1998b; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; Mark, 2008; Ritter & O'Neill, 1989, 1995; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse & Tan, 2005a). The client-centered approach (Rogers, 1957; cf. Brown, 2006) stresses (a) the LMHP's unconditional positive regard for and congruence and empathy with the client, (b) openness to the client's perspective as a means of understanding their concerns, and (c) encouragement of the client's positive self-concept. This approach incorporates aspects of the therapeutic relationship that have been shown in the research literature to have a positive benefit, such as empathy, positive regard, and honesty (APA, 2005a, 2005b; Lambert & Barley, 2001; Norcross, 2002; Norcross & Hill, 2004).

⁴⁵ We consider the client-centered approach not as the ultimate theoretical basis of our model but as a foundation that is consistent with a variety of theoretical approaches, as most psychotherapy focuses on acceptance and support as a foundation of interventions.

This approach consists of empathic attunement to concerns regarding sexual orientation identity that acknowledges the role of cultural context and diversity and allows the different aspects of the evolving self to be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Brown, 2006; Buchanan et al., 2001; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Miville & Ferguson, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008). The empathic therapeutic environment aspires to be a place of compassionate caring and respect that facilitates development (Bronfenbrenner, 1979; Winnicott, 1965) by exploring issues without criticism or condemnation (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; McMinn, 2005; Throckmorton & Welton, 2005) and by reducing distress caused by isolation, stigma, and shame (Drescher, 1998b; Glassgold, 2008; Haldeman, 2004; Isay, 2001).

This approach involves empathizing with the client's desire to change his or her sexual orientation while understanding that this outcome is unlikely (Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004). Haldeman (2004) cautioned that LMHP who turn down a client's request for SOCE at the onset of treatment without exploring and understanding the many reasons why the client may wish to change may instill hopelessness in the client, who already may feel at a loss about viable options. Haldeman emphasized that before coming to a conclusion regarding treatment goals, LMHP should seek to validate the client's wish to reduce suffering and normalize the conflicts at the root of distress, as well as create a therapeutic alliance that recognizes the issues important to the client (cf. Beckstead & Israel, 2007; Glassgold, 2008; Liddle, 1996; Yarhouse, 2008).

Affirmative client-centered approaches consider sexual orientation to be uniquely individual and inseparable from an individual's personality and sense of self (Glassgold, 1995, 2008). This includes (a) being aware of the client's unique personal, social, and historical context; (b) exploring and countering the harmful impact of stigma and stereotypes on the

client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity,

LMHP who work with religious clients who are distressed by their sexual orientation may wish to consult the literature from the psychology of religion. This literature reminds us that religion is a complex way of making meaning that includes not only beliefs and values but also community, relationships, traditions, family ties, coping, and social identity.

the psychology of religion. This literature reminds us that religion is a complex way of making meaning that includes not only beliefs and values but also community, relationships, traditions, family ties, coping, and social identity (Mark, 2008; Pargament & Mahoney, 2002, 2005; Pargament et al., 2005; Park, 2005).

A Comprehensive Assessment

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation included providing a comprehensive assessment in order to obtain a fuller understanding of the multiple issues that influence that client's presentation. Such an assessment allows the LMHP and client to see the client's sexual orientation as part of the whole person and to develop interventions based on all significant variables (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004). This comprehensive assessment includes understanding how a client's distress may involve (a) psychological disequilibrium from trying to manage the stressors (e.g., anxiety, depression, substance abuse and dependence, sexual compulsivity, posttraumatic stress disorder) and (b) negative effects from developmental experiences and traumas and the impact of cultural and family norms. Assessing the influence of factors such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status on the experience and expression of sexual orientation and sexual orientation identity may aid the LMHP in understanding the complexity of the client's distress.

The literature indicated that most of the individuals who are extremely distressed about their same-sex sexual orientation and who are interested in SOCE have conservative religious beliefs. A first step to addressing the conflicts regarding faith and sexual orientation is a thorough assessment of clients' spiritual and religious beliefs, religious identity and motivations, and spiritual functioning (Exline, 2002; Hathaway, Scott, & Garver, 2004; Pargament et al., 2005). This helps the LMHP understand how the current dilemmas impact clients' spiritual functioning (and vice versa) and assess resources for growth and renewal.

This assessment could include (a) understanding the specific religious beliefs of the client; (b) assessing the religious and spiritual conflicts and distress experienced by the client (Hathaway et al., 2004); (c) assessing the client's religious goals (Emons & Paloutzian, 2003) and motivations (e.g., internal, external, quest, fundamentalism) and positive and negative ways of coping within his or her religion (Pargament, Koenig, Tasakeshwas, & Hahn, 2001; Pargament & Mahoney, 2005; Pargament et al., 1998); (d) seeking to understand the impact of religious beliefs and religious communities on the experience of the client's self-stigma, sexual prejudice, and sexual orientation identity (Beckstead & Morrow, 2004; Buchanan et al., 2001; Fulton et al., 1999; Herek, 1987; Hunsberger & Jackson, 2005; J. P. Schwartz & Lindley, 2005; Schulte & Battle, 2004); (e) developing an understanding of the client's faith identity development (Fowler, 1981, 1991; Oser, 1991; Reich, 1991; Streib, 2005) and its intersection with his or her sexual orientation identity development (Harris, Cook, & Kashubeck-West, 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Mahaffy, 1996; Yarhouse & Tan, 2005a; Yarhouse et al., 2005); and (f) enhancing with the client, when applicable, the search for meaning, significance, and a relationship with the definitions of the sacred in his or her life (Fowler, 2001; Goldstein, 2007; Pargament & Mahoney, 2005; Shafranske, 2000). Finally, an awareness of the varieties of religious faith, issues for religious minorities, and the unique role of religion in ethnic minority communities is important (Trujillo, 2000; Zea, Mason, & Muruia, 2000).

Some individuals who present with requests for SOCE may have clinical concerns that go beyond their sexual orientation conflicts. These may include mental health disorders, personality disorders, or trauma-related conditions that influence the presentation of sexual orientation conflicts and distress (cf. Brown, 2006; Drescher, 1998b; Glassgold, 2008; Haldeman,

2001; Iwasaki & Ristock, 2007; Lasser & Gottlieb, 2004; Mohr & Fassinger, 2003; S. L. Morrow, 2000; Pachankis et al., 2008; Schneider et al., 2002; Sherry, 2007; Szymanski & Kashubeck-West, 2008). Such conditions may require intervention separate from or in conjunction with the intervention directed at the sexual orientation distress. For instance, some clients who seek SOCE may have histories of trauma (Ponticelli, 1999), and in some individuals sexual abuse can cause sexual orientation identity confusion and other sexuality-related concerns (Gartner, 1999). Some heterosexual individuals may obsess over the fear of being gay and require a unique treatment model to help them accept their fear (M. Williams, 2008). Other individuals seeking SOCE may make homosexuality the explanation for all they feel is wrong with their lives (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Shidlo & Schroeder, 2002). This displacement of self-hatred onto homosexuality can be an attempt to resolve a sense of badness and shame (cf. Brandchaft, 2007; Drescher, 1998b), and clients may thus need effective interventions to deal with this self-hatred and shame (Brandchaft, 2007; Linehan, Dimeff, & Koerner, 2007; Zaslav, 1998).

Sexual stigma impacts a client's appraisal of sexuality, and since definitions and norms of healthy sexuality vary among individuals, LMHP, and religious and societal institutions, potential conflicts can arise for clients about what a person should do to be sexually acceptable and healthy. O'Sullivan, McCrudden, and Tolman (2006) emphasized that sexuality is an integral component of psychological health, involving mental and emotional health, physical health, and relational health.⁴⁶ Initiating sensitive but open and educated discussions with clients about their views of and experiences with sexuality may be helpful, especially for those who have never had the opportunity or the permission to talk about such issues (Schneider et al., 2002).

Active Coping

In our review of the research and clinical literature, we found that the appropriate application of affirmative

⁴⁶ The Pan American Health Organization and the World Health Organization (2000) defined sexual health in the following manner: "Sexual health is the ongoing process of physical, psychological, and sociocultural well-being in relationship to sexuality. Sexual health can be identified through the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching life within an ethical framework. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that sexual rights be recognized and exercised" (p. 9).

therapeutic interventions for adults presenting with a desire to change their sexual orientation seeks to

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it.

increase clients' capacity for active coping to mitigate distress. Coping strategies refer to the efforts that individuals use to resolve, endure, or diminish stressful

life experiences, and active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it (Folkman & Lazarus, 1980). Research has indicated that active coping is superior to other efforts, such as passive coping, and that individuals use both cognitive and emotional strategies to address stressful events (Folkman & Lazarus, 1980). These strategies are described in more depth in the following sections.

COGNITIVE STRATEGIES

Research on those individuals who resolve their sexual orientation conflicts indicate that cognitive strategies helped to reduce cognitive dissonance (Coyle & Rafalin, 2000; Mahaffy, 1996). One of the dilemmas for many clients who seek sexual orientation change is that they see their situation as a dichotomy. For instance, their same-sex sexual attractions make them unworthy or bad, and only if they are heterosexual can they be worthy (Beckstead & Morrow, 2004; Haldeman, 2001, 2004; Lasser & Gottlieb, 2004; D. F. Morrow, 2003; Wolkomir, 2001, 2006). Cognitive strategies can reduce the all-or-nothing thinking, mitigate self-stigma, and alter negative self-appraisals (Beckstead & Israel, 2007; Johnson, 2001, 2004; Lasser & Gottlieb, 2004; Martell et al., 2004). For example, Buchanan et al. (2001), using a narrative therapy approach, described a process of uncovering and deconstructing dominant worldviews and assumptions with conflicted clients that enabled them to redefine their attitudes toward their spirituality and sexuality (cf. Bright, 2004; Comstock, 1996; Graham, 1997; Yarhouse, 2008). Similarly, rejection of stereotypes about LGB individuals was found to be extremely important for increased psychological well-being in a mixed sample of LGB individuals (Luhtanen, 2003).

Recent developments in cognitive-behavior therapy, such as mindfulness-based cognitive therapy, dialectical

behavior therapy, and acceptance and commitment therapy techniques are relevant (e.g., Hayes, Strosahl,

Acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead.

& Wilson, 2003; Linehan et al., 2007). Acceptance of the presence of same-sex sexual attractions and sexual orientation paired with

exploring narratives or reframing cognitions, meanings, or assumptions about sexual attractions have been reported to be helpful (cf. Beckstead & Morrow, 2004; Buchanan et al., 2001; Moran, 2007; Rodriguez, 2006; Tan, 2008; Yarhouse, 2005a, 2005c; Yarhouse & Beckstead, 2007). For instance, using these techniques, Beckstead and Morrow (2004) and Tan (2008) found that clients were able to cope with their sexual arousal experiences and live with them rather than negatively judge or fight against them. Male participants in Beckstead and Morrow's (2004) investigation, regardless of their ultimate sexual orientation identity, described their ability to accept, reframe, or "surrender" to their attractions as reducing their distress by decreasing their self-judgments and reducing their fear, anxiety, and shame. However, acceptance of same-sex sexual attractions and sexual orientation may not mean the formation of an LGB sexual orientation identity; alternate identities may develop instead (Beckstead & Morrow, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008; Yarhouse et al., 2005).

For clients with strong values (religious or secular), an LMHP may wish to incorporate techniques that promote positive meaning-making, an active process through which people revise or reappraise an event or series of events (Baumeister & Vohs, 2002; cf. Taylor, 1983) to resolve issues that arise out of crises, loss, and suffering (cf. Frankl, 1992; Nolen-Hoeksema & Davis, 2002; O'Neill & Ritter, 1992; Pargament et al., 2005; Ritter & O'Neill, 1989, 1995). Such new meanings involve creating a new purpose in life, rebuilding a sense of mastery, and increasing self-worth (Nolen-Hoeksema & Davis, 2002; Pargament & Mahoney, 2002).

EMOTION-FOCUSED STRATEGIES

For those who seek SOCE, the process of addressing one's sexual orientation can be very emotionally challenging, as the desired identity does not fit the individual's psychological, emotional, or sexual predispositions and needs. The experience of

irreconcilability of one's sexual orientation to one's deeply felt values, life situation, and life goals may disrupt one's core sense of meaning, purpose, efficacy, and self-worth (Beckstead & Morrow, 2004; Yarhouse, 2008; cf. Baumeister & Vohs, 2002; L. A. King & Smith, 2004) and result in emotional conflict, loss, and suffering (Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Thus, emotion-focused strategies that facilitate mourning losses have reportedly been helpful to some (Beckstead & Israel, 2007; Glassgold, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Yarhouse, 2008; cf. Wolkomir, 2001, 2006).

Therapeutic outcomes that have been reported include (a) coming to terms with the disappointments and losses and with the dissonances between psychological and emotional needs and possible and impossible selves (Bartoli & Gillem, 2008; Drescher, 1998b; L.A. King & Hicks, 2007; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995); (b) clarifying and prioritizing values and needs (Glassgold, 2008; Yarhouse, 2008); and (c) learning to tolerate and adapt to the ambiguity, conflict, uncertainty, and multiplicity with a positive attitude (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004; Buchanan et al., 2001; Corbett, 2001; Drescher, 1998b; Glassgold, 2008; Halbertal & Koren, 2006; Haldeman, 2002; Miville & Ferguson, 2004).

RELIGIOUS STRATEGIES

Although many individuals desire to live their lives consistently with their values, primarily their religious values, we concluded that telic congruence grounded

Connecting clients to core and overarching values and virtues such as charity, hope, forgiveness, gratitude, kindness, and compassion may shift the focus from their religion's rejection of homosexuality to the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace.

in self-stigma and shame was unlikely to result in psychological well-being (Beckstead & Morrow, 2004; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002). Psychotherapeutic interventions can focus the client on positive religious coping (e.g., Ano &

Vasconcelles, 2005; Pargament et al., 2005; Park, 2005; Silberman, 2005; T. B. Smith, McCullough, & Poll,

2003) that may present the client with alternatives to the concreteness of the conflict between sexual orientation and religious values. For instance, several publications indicate that active engagement with religious texts can reduce identity conflicts by reducing the salience of negative messages about homosexuality and increasing self-authority or understanding (Brzezinski, 2000; Comstock, 1996; Coyle & Rafalin, 2000; Glassgold, 2008; Gross, 2008; Mahaffy, 1996; Ritter & O'Neill, 1989, 1995; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Schnoor, 2006; Schuck & Liddle, 2001; Thumma, 1991; Wilcox, 2001, 2002; Yip, 2002, 2003, 2005). Additionally, connecting clients to core and overarching values and virtues such as charity, hope, forgiveness, gratitude, kindness, and compassion may shift the focus from their religion's rejection of homosexuality to the more accepting elements of their religion, which may provide more self-acceptance, direction, and peace (Lease et al., 2005; McMinn, 2005). Exploration of how to integrate religious values and virtues into their sexuality may further development (cf. Helminiak, 2004).

Reframing the meaning of suffering and the burden of being conflicted as spiritual challenges rather than as divine condemnation (Glassgold, 2008; Hall & Johnson, 2001) and believing that God continues to love and accept them, because of or despite their sexual orientation, may be helpful in resolving distress (Graham, 1997; Ritter & O'Neill, 1989, 1995). For some, reframing spiritual struggles not only as a crisis of faith but also as an opportunity to increase faith or delve more deeply into it may be productive (Bartoli & Gillem, 2008; de la Huerta, 1999; Glassgold, 2008; Horne & Noffisnger-Frazier, 2003; Ritter & Terndrup, 2002).

Examining the intersection between mental health concerns and the presentation of religious beliefs can be helpful in understanding the client (Johnson, 2001, 2004; Nielsen, 2001; Pargament et al., 2005; Robb, 2001; Shrafranske, 2004). For instance, Johnson (2004) described a rational emotive behavior therapy case study that focused on reducing excessive self-criticism, which lessened the self-stigma surrounding same-sex sexual attractions. This approach seeks to understand the core depressive cognitive structures and other problematic schemata that can become associated with the clients' religious values or distort their religious values (Johnson, 2001, 2004; Nielsen, 2001; Robb, 2001).

In our review of the research and clinical literature, we found that the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation seeks to increase clients' access to social support. As Coyle (1993) and others have noted (e.g., Wright & Perry, 2006), struggling with a devalued identity without adequate social support has the potential to erode psychological well-being. Increasing social support through psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) may relieve some distress. For instance, participants reported benefits from mutual support groups, both sexual-minority-affirming and ex-gay groups (Kerr, 1997; Ponticelli, 1999; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Rodriguez, 2006; Thumma, 1991; Wolkomir, 2001). These groups counteracted and buffered minority stress, marginalization, and isolation. Religious denominations that provide cognitive and affective strategies that aid in the resolution of cognitive dissonance and increase religious coping were helpful to religious individuals as well (Kerr, 1997; Maton, 2000; Ponticelli, 1999; Rodriguez & Ouellette, 2000; Wolkomir, 2001, 2006).

LMHP can provide clients with information about a wide range of diverse sexual minority communities and religious and faith organizations available locally, nationally, or internationally in person or over the Internet.⁴⁷ These settings can provide contexts in which clients may explore and integrate identities, find role models, and reduce self-stigma (Heinz, Gu, Inuzuka, & Zender, 2002; Johnson & Buhrke, 2006; Schneider et al., 2002). However, some groups may reinforce prejudice and stigma by providing inaccurate or stereotyped information about homosexuality, and LMHP may wish to weigh with clients alternative options in these circumstances (Schneider et al., 2002).

For those clients who cannot express all aspects of themselves in the community settings currently available to them, LMHP can help the client to consider more flexible and strategic ways of expressing the multiple aspects of self that include managing self-disclosure and multiple identities (Bing, 2004; Glassgold, 2008; Halbertal & Koran, 2006; LaFromboise, Coleman, & Gerton, 1993). Social support may be difficult to find

⁴⁷ There are growing numbers of communities available that address unique concerns and identities (see, e.g., www.safraproject.org/ for Muslim women or <http://www.al-fatiha.org/> for LGB Muslims; for Orthodox Jews, see <http://tirtzah.wordpress.com/>).

for clients whose communities stigmatize their sexual orientation identity and other identities (e.g., ethnic, racial, religious), and these clients may benefit from considering the alternate frame that the problem does not lie with the client but with the community that is not able to affirm their sexual orientation or particular identity or meet their developmental needs (Blechner, 2008; Buchanan et al., 2001; Lasser & Gottlieb, 2004; Mark, 2008; Tremble, 1989).

Individuals with same-sex attractions in other-sex marriages may struggle with the loss (or fear of the loss) of social support and important relationships. Several authors (e.g., Alessi, 2008; Auerback & Moser, 1987; Bridges & Croteau, 1994; Brownfain, 1985; Buxton, 1994, 2001, 2004, 2007; Carlsson, 2007; Coleman, 1989; Corley & Kort, 2006; Gochros, 1989; Hernandez & Wilson, 2007; Isay, 1998; Klein & Schwartz, 2001; Malcolm, 2000; Schneider et al. 2002; Treyger, Ehlers, Zajicek, & Trepper, 2008; Yarhouse et al., 2003) have laid out counseling strategies for individuals in marriages with the other sex who consider SOCE. These strategies for individual, couples, and group counseling do not focus solely on one outcome (e.g., divorce, marriage) but on exploring the underlying personal and contextual problems, motivations, realities, and hopes for being in, leaving, or restructuring the relationship.

Identity Exploration and Development

In our review of the research and clinical literature, we found that identity issues, particularly the ability to explore and integrate aspects of the self, are central to the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation. As described in earlier sections of this report, conflicts among disparate elements of identity appear to play a major role in the distress of those seeking SOCE, and identity exploration and development appear to be ways in which individuals resolve or avoid distress (e.g., Balsam & Mohr, 2007; Beckstead & Morrow, 2004; Coyle & Rafakin, 2000; Drescher, 1998b; Glassgold, 2008; Herek & Garnets, 2007; Mahaffy, 1996; Yarhouse et al., 2005; Yip, 2002, 2003, 2005).

Ideally, identity comprises a coherent sense of one's needs, beliefs, values, and roles, including those aspects of oneself that are the bases of social stigma, such as age, gender, race, ethnicity, disability, national origin, socioeconomic status, religion, spirituality, and sexuality (G. R. Adams & Marshall, 1996; Bartoli & Gillem, 2008; Baumeister & Vohs, 2002; LaFramboise

et al., 1993; Marcia, 1966; Meyers et al., 1991; R. L. Worthington et al., 2002). Marcia (1966) generated a model in which identity development is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. R. L. Worthington et al. (2002) hypothesized that sexual orientation identity could be conceptualized along these same lines and advanced a model of heterosexual identity development based on the assumption that congruence among the dimensions of individual identity is the most adaptive status, which is achieved by active exploration. There is some empirical research supporting this model (R. L. Worthington, Navarro,

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation.

Savoy, & Hampton, 2008). Additionally, research has found that the formation of a collective identity has important mental health benefits for sexual minorities by buffering individuals from sexual stigma and increasing self-esteem (Balsam & Mohr, 2007; Crawford et al., 2002; Herek & Garnets, 2007).

An affirmative approach is supportive of clients' identity development without an a priori treatment goal for how clients identify or live out their sexual orientation. Sexual orientation identity exploration can be helpful for those who eventually accept or reject their same-sex sexual attractions; the treatment does not differ, although the outcome does. For instance, the existing research indicates that possible outcomes of sexual orientation identity exploration for those distressed by their sexual orientation may be:

- LGB identities (Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Yarhouse, 2008)
- Heterosexual sexual orientation identity (Beckstead & Morrow, 2004)
- Disidentifying from LGB identities (e.g., ex-gay) (Yarhouse, 2008; Yarhouse & Tan, 2004; Yarhouse et al., 2005)
- Not specifying an identity (Beckstead & Morrow, 2004; Haldeman, 2004; Tan, 2008)

The research literature indicates that there are variations in how individuals express their sexual orientation and label their identities based on ethnicity,

culture, age and generation, gender, nationality, acculturation, and religion (Boykin, 1996; Carrillo, 2002; Chan, 1997; Crawford et al., 2002; Denizet-Lewis, 2003; Kimmel & Yi, 2004; Martinez & Hosek, 2005; Miville & Ferguson, 2004; Millett, Malebranche, Mason, & Spikes, 2005; Stokes, Miller, & Mundhenk, 1998; Toro-Alfonso, 2007; Weeks, 1995; Yarhouse, 2008; Yarhouse et al., 2005; Zea et al., 2003). Some authors have provided analyses of identity that take into account diversity in sexual identity development and ethnic identity formation (Helms, 1995; LaFramboise et al., 1993; Myers et al., 1991; Yi & Shorter-Gooden, 1999), religious identity (Fowler, 1981, 1991; Oser, 1991; Strieb, 2001), as well as combinations of religious and sexual orientation identities (Coyle & Rafalin, 2000; Hoffman et al., 2007; Kerr, 1997; Knight & Hoffman, 2007; Ritter & O'Neill, 1989, 1995; Thumma, 1991; Throckmorton & Yarhouse, 2006; Yarhouse & Tan 2004).

In some of the literature on SOCE, religious beliefs and identity are presented as fixed, whereas sexual orientation is considered changeable (cf. Rosik, 2003). Given that there is a likelihood that some individuals will change religious affiliations during their lifetime (Pew Forum on Religion and Public Life, 2008) and that many scholars have found that both religious identity and sexual orientation identity evolve (Beckstead & Morrow, 2004; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Mahaffy, 1996; Ritter & Terndrup, 2002; Yarhouse & Tan, 2005b), it is important for LMHP to explore the development of religious identity and sexual orientation identity (Bartoli & Gillem, 2008). Some authors hypothesize that developmental awareness or stage of religious or sexual orientation identity may play a role in identity outcomes (Knight & Hoffman, 2007; Mahaffy, 1996; cf. Yarhouse & Tan, 2005a). Other authors have described a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth (Comstock, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995). Others have found that individuals disidentify or reject LGB identities (Ponticelli, 1999; Wolkomir, 2001, 2006; Yarhouse et al., 2005). Thus, LMHP seeking to take an affirmative attitude recognize that individuals will define sexual orientation identities in a variety of ways (Beckstead, as cited in Shidlo, Schroeder, & Drescher, 2002; Diamond, 2003; 2006; 2008; Savin-Williams, 2005; Yarhouse et al., 2005).

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 (Olson, 2007).

We found limited empirical research on the mental health consequences of that course of action.⁴⁸ Some clinical articles and surveys of individuals indicate that some may find such a life fulfilling (S. L. Jones & Yarhouse, 2007); however, there are others who cannot achieve such a goal and might struggle with depression and loneliness (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2001; Horlacher, 2006; Rodriguez, 2006; Shidlo & Schroeder, 2002). In a similar way, acting on same-sex sexual attractions may not be fulfilling solutions for others (Beckstead & Morrow, 2004; Yarhouse, 2008).

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 (cf. L. A. King & Hicks, 2007; Ritter & O'Neill, 1989, 1995).

On the basis of the aforementioned analyses, we adopted a perspective that recognizes the following:

- The important functional aspects of identity (G. R. Adams & Marshall, 1996).
- The multiplicity inherent in experience and identity, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (Bartoli & Gillem, 2008; Miville & Ferguson, 2004; Myers et al., 1991).
- The influence of social context and the environment on identity (Baumeister & Muraven, 1996; Bronfenbrenner, 1979; Meeus, Iedema, Helsen, & Vollebergh, 1999; Myers et al., 1991; Steenbarger, 1991).
- That aspects of multiple identities are dynamic and can be in conflict (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003; Tan, 2008; Yarhouse, 2008).

⁴⁸ However, Sipe (1990, 2003) has surveyed clergy and found difficulty in maintaining behavior consistent with aspirations. Other studies indicate that this goal is only achieved for a minority of participants who choose it (Brzezinski, 2000; S. L. Jones & Yarhouse, 2007).

- Identities can be explored, experienced, or integrated without privileging or surrendering one or another at any age (Bartoli & Gillem, 2008; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Myers et al., 1991; Phillips, 2004; Shallenberger, 1996).

Approaches based on models of biculturalism (LaFromboise et al., 1993) and pluralistic models of identity, including combining models of ethnic, sexual orientation, and religious identity that help individuals develop all aspects of self simultaneously or some sequentially, can encourage identity development and synthesis rather than identity conflict, foreclosure, or compartmentalization (Dworkin, 1997; Harris et al., 2008; Hoffman et al., 2007; Knight & Hoffman, 2007; Myers et al., 1991; Omer & Strenger, 1992; Ritter & O'Neill, 1989, 1995; Rosario, Schrimshaw, & Hunter, 2004; Rosario, Yali, Hunter, & Gwadz, 2006; Sophie, 1987; Troiden, 1988, 1993).

Sexual orientation identity exploration can help clients create a valued personal and social identity that provides self-esteem, belonging, meaning, direction, and future purpose, including the redefining of religious beliefs, identity, and motivations and the redefining of sexual values, norms, and behaviors (Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Tan, 2008; Yarhouse, 2008). We encourage LMHP to support clients in determining their own (a) goals for their identity process; (b) behavioral expression of sexual orientation; (c) public and private social roles; (d) gender role, identity, and expression; (e) sex and gender of partner; and (f) form of relationship(s).

Understanding gender roles and gender expression and developing a positive gender identity⁴⁹ continue to be concerns for many individuals who seek SOCE, especially as nonconformity with social expectations regarding gender can be a source of distress and stigma (APA, 2008e; Beckstead & Morrow, 2004; Corbett, 1996, 1998; Wolkomir, 2001). Some SOCE teach men how to adopt traditional masculine behaviors as a means of altering their sexual orientation (e.g., Nicolosi, 1991, 1993) despite the absence of evidence that such interventions affect sexual orientation. Such theoretical positions have been characterized as products of stigma and bias that are without an evidentiary basis

and may increase distress (American Psychoanalytic Association, 2000; Isay, 1987, 1999; Drescher, 1998b; Haldeman, 1994, 2001). For instance, Haldeman (2001) emphasized in his clinical work with men who had participated in SOCE that some men were taught that their homosexuality made them less masculine—a belief that was ultimately damaging to their self-esteem. Research on the impact of heterosexism and traditional gender roles indicates that an individual's adoption of traditional masculine norms increases sexual self-stigma and decreases self-esteem and emotional connection with others, thus negatively affecting mental health (Szymanski & Carr, 2008).

Advances in the psychology of men and masculinity provide more appropriate conceptual models for considering gender concerns—for instance, in such concepts as gender role strain or gender role stress (cf. Butler, 2004; Enns, 2008; Fischer & Good, 1997; Heppner & Heppner, 2008; Levant, 1992; Levant & Silverstein, 2006; O'Neil, 2008; Pleck, 1995; Wester, 2008). This literature suggests exploring with clients the role of traditional gender norms in distress and reconceptualizing gender in ways that feel more authentic to the client. Such approaches could also

Most literature in this area suggests that for clients who experience distress with their gender-role nonconformity, LMHP provide them with a more complex theory of gender that affirms a wider range of gender diversity and expands definitions and expressions of masculinity and femininity.

reduce the gender stereotypes associated with same-sex sexual orientation (Corbett, 1998; Haldeman, 2001; Schwartzberg & Rosenberg, 1998). Most literature in this area suggests that for clients who experience distress with their gender-role nonconformity, LMHP provide them with a

more complex theory of gender that affirms a wider range of gender diversity and expands definitions and expressions of masculinity and femininity (Butler, 2004; Corbett, 1996, 1998, 2001; Haldeman, 2001; Levant & Silverstein, 2006).

Some women find current categories for conceptualizing their sexual orientation and sexual orientation identity limiting, as concepts in popular culture and professional literature do not mirror their experiences of fluidity and variation in sexuality and relationships (Chivers et al., 2007; Diamond, 2006, 2008; Peplau & Garnets, 2000). Some women, for example, may experience relationships with others as

⁴⁹ *Gender* refers to the roles, behaviors, activities, and attributes that a particular society considers appropriate for men and women. *Gender identity* is a person's own psychological sense of identification as male or female, another gender, or identifying with no gender. *Gender expression* is the activities and behaviors that purposely or inadvertently communicate our gender identity to others, such as clothing, hairstyles, mannerisms, way of speaking, and social roles.

important parts of sexuality and may place sexuality, sexual orientation, and sexual orientation identity in the context of interpersonal bonds and contexts (Diamond, 2003, 2006, 2008; Diamond & Savin-Williams, 2000; Garnets & Peplau, 2000; Kinnish, Strassberg, & Turner 2005; Kitlinger, & Wilkinson, 1994; Miller, 1991; Morgan & Thompson, 2006; Peplau & Garnets, 2000; Surrey, 1991). Specific psychotherapy approaches that focus on an understanding of emotional and erotic interpersonal connections in sexuality rather than simply on sexual arousal can aide LMHP in providing a positive framework and goals for therapy with women (Garnets & Peplau, 2000; Glassgold, 2008; Miller, 1991; Surrey, 1991).

For many women, religious or cultural influences discourage exploration of sexuality and do not portray female sexuality as positive or self-directed (Brown, 2006; Espin, 2005; Fassinger & Arseneau, 2006; Mahoney & Espin, 2008; Moran, 2007; Stone, 2008). Treatment might involve deconstructing cultural scripts in order to explore possibilities for religion, sexuality, sexual orientation, identity, and relationships (Avishai, 2008; Biaggio, Coan, & Adams, 2002; Morgan & Thompson, 2006; Rose & Zand, 2000).

Conclusion

The appropriate application of affirmative therapeutic interventions to adults is built on three key findings in the research: (a) An enduring change to an individual's sexual orientation as a result of SOCE was unlikely, and some participants were harmed by the interventions; (b) sexual orientation identity—not sexual orientation—appears to change via psychotherapy, support groups, and life events; and (c) clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns.

On the basis of these findings and the clinical literature on this population, we suggest client-centered approaches grounded on the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders.
- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities.

- Gay men, lesbians, and bisexual individuals can live satisfying lives as well as form stable, committed relationships and families that are equivalent to heterosexual relationships in essential respects.
- No empirical studies or peer-reviewed research support theories attributing same-sex sexual orientation to family dysfunction or trauma.

Affirmative client-centered approaches consider sexual orientation uniquely individual and inseparable from an individual's personality and sense of self (Glassgold, 1995, 2008). This includes (a) being aware of the client's

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can mitigate distress caused by isolation, rejection, and lack of role models.

unique personal, social, and historical context; (b) exploring and countering the harmful impact of stigma and stereotypes on the client's self-concept (including the prejudice related to age, gender, gender identity, race,

ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status); and (c) maintaining a broad view of acceptable life choices.

We developed a framework for the appropriate application of affirmative therapeutic interventions for adults that has the following central elements: (a) acceptance and support, (b) comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development.

Acceptance and support include (a) unconditional positive regard for and empathy with the client, (b) an openness to the client's perspective as a means of understanding their concerns, and (c) encouragement of the client's positive self-concept.

Comprehensive assessment includes an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation.

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it and includes both cognitive and emotional strategies.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can

mitigate distress caused by isolation, rejection, and lack of role models.

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 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. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth.

LMHP 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.

7. ETHICAL CONCERNS AND DECISION MAKING IN PSYCHOTHERAPY WITH ADULTS⁵⁰

Ethical concerns relevant to sexual orientation change efforts (SOCE)⁵¹ have been a major theme in the literature and a central aspect of the debate around SOCE (e.g., Benoit, 2005; Cramer et al., 2008; Davison, 1976, 1978, 1991; Drescher, 1999, 2001, 2002; Gonsiorek, 2004; Haldeman, 1994, 2002, 2004; Herek, 2003; Lasser & Gottlieb, 2004; Rosik, 2003; Schreier, 1998; Schroeder & Shidlo, 2001; Sobocinski, 1990; Tozer & McClanahan, 1999; Wakefield, 2003; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). The major concerns raised in these publications have been (a) the potential for harm, (b) the client's right to choose SOCE and other issues generally related to the ethical issue of client autonomy, and (c) questions of how to appropriately balance respect for two aspects of diversity—religion and sexual orientation. SOCE presents an ethical dilemma to practitioners because these publications have urged LMHP to pursue multiple and incompatible courses of action (cf. Kitchener, 1984).

In 1997 APA adopted the Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998). This resolution highlighted the provisions of the then-current *Ethical Principles for Psychologists*

and *Code of Conduct* (APA, 1992) that APA believed to be relevant to situations in which clients request treatments to alter sexual orientation and psychologists provide such treatments, including the provisions regarding bias and discrimination, false or deceptive information, competence, and informed consent to treatment. For a discussion of the resolution's application to clinical situations, readers are referred to Schneider et al. (2002). In the resolution, APA also reaffirmed (a) its position that homosexuality is not a mental disorder; (b) its opposition to stigma, prejudice, and discrimination based on sexual orientation; and (c) its concern about the contribution of the promotion of SOCE to the continuation of sexual stigma in U.S. culture.

The APA's charge to the task force included "to review and update the APA Resolution on Appropriate Therapeutic Responses to Sexual Orientation." In the process of fulfilling this aspect of our charge, we considered the possibility of recommending revisions to the 1997 resolution to update it with the specific principles and standards of the 2002 APA Ethics Code. Ultimately, we decided against a revision,⁵² because the relevant concepts in the two versions of the principles and code are similar. Instead, this chapter examines the relevant sections of the 2002 APA *Ethical Principles for Psychologists and Code of Conduct* [hereafter referred to as the Ethics Code] in light of current debates regarding

⁵⁰ Ethical concerns for children and adolescents are considered in Chapter 8.

⁵¹ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

⁵² We developed a new resolution that APA adopted in August 2009 (see Appendix A)..

ethical decision making in this area.⁵³ We build our discussion on the concepts outlined in the 1997 resolution and discuss some of the ethical controversies in light of the newer APA Ethics Code (2002b) and of the systematic research review presented in Chapters 3 and 4 of this report. Although many of the principles and standards in the Ethics Code are potentially pertinent,⁵⁴ the principles and standards most relevant to this discussion are (in alphabetical order):

1. Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (e.g., 2.01a, 2.01b)⁵⁵
2. Principle A: Beneficence and Nonmaleficence
3. Principle D: Justice
4. Principle E: Respect for People's Rights and Dignity

Bases for Scientific and Professional Judgments and Competence

Many of the standards of the Ethics Code are derived from the ethical and valuative foundations found in the principles (Knapp & VandeCreek, 2004). Two of the more important standards are competence and the bases for scientific and professional judgments. These standards are linked, as competence is based on knowledge of the scientific evidence relevant to a case (Glassgold & Knapp, 2008). When practicing with those who seek sexual orientation change for themselves or for others, commentators on ethical practice have

⁵³ This section is for descriptive and educational purposes. It is not designed to interpret the APA (2002b) Ethics Code. The APA Ethics Committee alone has the authority to interpret the APA (2002b) Ethics Code and render decisions about whether a course of treatment is ethical. Furthermore, this section is not intended to provide guidelines or standards for practice. Guidelines and standards for practice are created through a specific process that is outside the purview of the task force.

⁵⁴ The following are some of the pertinent standards: 2. Competence, 2.01 Boundaries of Competence, 2.03 Maintaining Competence, 2.04 Bases for Scientific and Professional Judgments; 3. Human Relations, 3.01 Unfair Discrimination, 3.03 Other Harassment, 3.04 Avoiding Harm, 3.10 Informed Consent; 5.01 Avoidance of False or Deceptive Statements, 5.04 Media Presentations; 7.01 Design of Education and Training Programs; 8.02 Informed Consent to Research; 10.01 Informed Consent to Therapy, 10.02 Therapy Involving Couples or Families.

⁵⁵ Knapp and VandeCreek (2004) proposed that Ethical Standard 2 (Competence) is derived from Principle A: Beneficence & Nonmaleficence, as it is more likely that an LMHP can provide benefit if he or she is competent; however, for our purposes, this chapter will discuss these issues sequentially.

recommended that the practitioner understand the scientific research on sexual orientation and SOCE (Glassgold & Knapp, 2008; Schneider et al., 2002). It is obviously beyond the task force's scope to provide a systematic review of the whole body of research on sexual orientation, but we have tried to provide a systematic review of the research on SOCE in Chapters 3 and 4. From this review, we have drawn two key conclusions.

The first finding from our review is that there is insufficient evidence that SOCE are efficacious for changing sexual orientation. Furthermore, there is some evidence that such efforts cause harm. On the

On the basis of this evidence, we consider it inappropriate for psychologists and other LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate in SOCE.

basis of this evidence, we consider it inappropriate for psychologists and other LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate

in SOCE. We believe that among the various types of SOCE, the greatest level of ethical concern is raised by SOCE that presuppose that same-sex sexual orientation is a disorder or a symptom of a disorder.⁵⁶ Treatments based on such assumptions raise the greatest level of ethical scrutiny by LMHP because they are inconsistent with the scientific and professional consensus that homosexuality per se is not a mental disorder. Instead, we counsel LMHP to consider other treatment options when clients present with requests for sexual orientation change.

The second key finding from our review is that those who participate in SOCE, regardless of the intentions of these treatments, and those who resolve their distress through other means, may evolve during the course of their treatment in such areas as self-awareness, self-concept, and identity. These changes may include (a) sexual orientation identity, including changes in private and public identification, behavior, group membership, and affiliation; (b) emotional adjustment, including reducing self-stigma and shame; and (c) personal beliefs, values, and norms, including changes in religious and moral beliefs and behaviors and motivations (Buchanon et al., 2001; Diamond, 1998, 2006; Rust, 2003; Savin-Williams, 2004; R. L.

⁵⁶ See, e.g., Socarides (1968), Hallman (2008), and Nicolosi (1991); these theories assume homosexuality is always a sign of developmental defect or mental disorder.

Worthington, 2002, 2004, 2005; Yarhouse, 2008). These areas become targets of LMHP interventions in order to reduce identity conflicts and distress and to explore and enhance the client's identity integration.

Because a large number of individuals who seek SOCE are from conservative faiths and indicate that religion is very important to them, integrating research on the psychology of religion into treatment may be helpful. For instance, individual religious motivations can be examined, positive religious coping increased, and religious identity and sexual orientation identity explored and integrated (Beckstead & Israel, 2007; Fowler, 1981; Glassgold, 2008; Haldeman, 2004; Knight & Hoffman, 2007; O'Neill & Ritter, 1992; Yarhouse & Tan, 2005a, 2005b). This is consistent with advances in the understanding of human diversity that place LGB-affirmative approaches within current multicultural perspectives that include age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (e.g., Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006), consistent with Principle D (Justice) and Principle E (Respect for People's Rights and Dignity).

However, in some of the debates on these issues, there are tensions between conservative religious perspectives and affirmative and scientific perspectives (Haldeman, 2002; Rosik, 2003; Throckmorton & Welton, 2005; Yarhouse, 1998a; Yarhouse & Burkett, 2002; Yarhouse & Throckmorton, 2002). Although there are tensions

APA (2008a) delineates a perspective that affirms the importance of science in exploring and understanding human behavior while respecting religion as an important aspect of human diversity.

between religious and scientific perspectives, the task force and other scholars do not view these perspectives as mutually exclusive (Bartoli & Gillem, 2008; Haldeman, 2004; S. L. Morrow & Beckstead, 2004; Yarhouse, 2005b).

As we noted in the introduction, in its Resolution on Religious, Religion-Related, and/or Religion-Derived Prejudice, APA (2008a) delineates a perspective that affirms the importance of science in exploring and understanding human behavior while respecting religion as an important aspect of human diversity. Scientific findings from the psychology of religion can be incorporated into treatment, thus respecting all aspects of diversity while providing therapy that is consistent with scientific research.

Most important, respecting religious values does not require using techniques that are unlikely to have an effect. We proposed an approach that respects religious values and welcomes all of the client's actual and potential identities by exploring conflicts and identities without preconceived outcomes. This approach does not prioritize one identity over another and may aide a client in creating a sexual orientation identity consistent with religious values (see Chapter 6) (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Tan, 2008; Yarhouse, 2008).

Benefit and Harm

Principle A of the APA Ethics Code, Beneficence and Nonmaleficence, establishes that psychologists aspire to provide services that maximize benefit and minimize harm (APA, 2002b). Many ethicists and scholars consider the avoidance of harm to be the priority of modern health care and medical ethics (Beauchamp & Childress, 2008; Herek, 2003; S. L. Morrow, 2000). The literature on effective treatments and interventions stresses that to be considered effective, interventions must not have serious negative side effects (Beutler, 2000; Flay et al., 2005). When applying this principle in the context of providing interventions, LMHP assess the risk of harm, weigh that risk with the potential benefits, and communicate this to clients through informed consent procedures that aspire to provide the client with an understanding of potential risks and benefits that are accurate and unbiased. Some of the published considerations of ethical issues related to SOCE have focused on the limited evidence for its efficacy, the potential for client harm, and the potential for misrepresentation of these issues by proponents of SOCE (Cramer et al., 2008; Haldeman, 1994, 2002, 2004; Herek, 2003; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). Other discussions focus on other harms of SOCE, such as reinforcing bias, discrimination, and stigma against LGB individuals (Davison, 1976, 1978, 1991; Drescher, 1999, 2001, 2002; Gonsiorek, 2004).

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

interventions did cause inadvertent and harmful mental health effects such as increased anxiety, depression, suicidality, and loss of sexual functioning in some participants. Additionally, client dropout rate is sometimes an indication of harmful effects (Lilienfeld, 2007). Early studies with aversive procedures are characterized by very high dropout rates, perhaps indicating harmful effects, and substantial numbers of clients unwilling to participate further. Other perceptions of harm mentioned by recipients of SOCE include increased guilt and hopelessness due to the failure of the intervention, loss of spiritual faith, and a sense of personal failure and unworthiness (Beckstead & Morrow, 2004; Haldeman, 2001, 2004; Shidlo & Schroeder, 2002). Other indirect harms from SOCE include the time, energy, and cost of interventions that were not beneficial (Beckstead & Morrow, 2004; Lilienfeld, 2007; G. Smith et al., 2004).

We found limited research evidence of benefits from SOCE. There is qualitative research that describes clients' positive perceptions of such efforts, such as

... the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.

experiencing empathy and a supportive environment to discuss problems and share similar values, which seemed to reduce their stress about their same-sex sexual attractions

(Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001). The literature on SOCE support groups, for instance, illustrates results similar to those found for LGB-affirming groups and mutual help groups in general (e.g., Kerr, 1997; Levine et al., 2004; Thumma, 1991). The positive experiences clients report in SOCE are not unique. Rather, they are benefits that have been found in studies of therapeutic relationships and support groups in a number of different contexts (Levine et al., 2004; Norcross, 2002; Norcross & Hill, 2004). Thus, the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.

Perceptions of risks and rewards of certain courses of action influence the individual's decisions, distress, and process of exploration in psychotherapy. The client and LMHP may define these risks and rewards differently, leading to different perceptions of benefit and harm. Recognizing, understanding, and clarifying these different perceptions of risks and rewards are crucial for a thorough ethical analysis of each client's unique situation and are aspects of client-centered

approaches. For instance, an LMHP may attempt to provide information to the client to reduce sexual stigma and increase life options by informing the client about the research literature on same-sex couples. Such relationships may be threatening to the client when such a life course is perceived as being inconsistent with existing religious beliefs and motivations and potentially having negative repercussions on existing relationships with religious communities. Thus, the client and LMHP may perceive the benefits and harms of the same course of action differently. Yet, discussing positive coping resources with clients regarding how to manage such inconsistencies, stigma, and negative repercussions may provide the client with more informed and empowered solutions from which to choose, thus increasing benefit and autonomy and reducing harm.

Justice and Respect for Rights and Dignity

In this section, we focus on two concepts, Justice (Principle D) and Self-Determination (Principle E, Respect for People's Rights and Dignity). The first considers justice, both distributive and procedural justice (Knapp & VandeCreek, 2004), and the second focuses on recognizing diversity and maximizing a client's ability to choose. The APA Ethics Code uses the term *self-determination* to encompass the meanings for which many ethicists have used the term autonomy; we define self-determination as the process by which a person controls or determines the course of her or his own life (*Oxford American Dictionary*, 2007). Client self-determination encompasses the ability to seek treatment, consent to treatment, and refuse treatment. The informed consent process is one of the ways by which self-determination is maximized in psychotherapy.

Informed consent and self-determination cannot be considered without an understanding of the individual, community, and social contexts that shape the lives of sexual minorities. By understanding self-determination as context-specific and by working to increase clients' awareness of the influences of context on their decision making, the LMHP can increase clients' self-determination and thereby increase their ability to make informed life choices (Beckstead & Israel, 2007; Glassgold, 1995; 2008; Haldeman, 2004). For instance, some have suggested that social stigma and prejudice are fundamental reasons for sexual minorities' desire

to change their sexual orientation (Davison, 1976; 1978, 1982, 1991; Haldeman, 1994; Silverstein, 1991; G. Smith et al., 2004; Tozer & Hayes, 2004). As stigma, prejudice, and discrimination continue to be prevalent,⁵⁷ we recommend that LMHP strive to understand their clients' request for SOCE in the context of sexual stigma and minority stress (e.g., DiPlacido, 1998; Meyer, 2001). We further recommend that providers explore with their clients the impact of these factors on their clients' decision making in order to assess the extent to which self-determination is compromised (cf. G. Smith et al., 2004).

For instance, repressive, coercive, or invalidating cultural, social, political, and religious influences can limit autonomous expression of sexual orientation, including the awareness and exploration of options for expression of sexual orientation within an individual life (e.g., Glassgold, 2008; Mark, 2008; McCormick, 2006; G. Smith et al., 2004; Wax, 2008). We recommend that LMHP consider the impact of discrimination and stigma on the client and themselves (e.g., Beckstead & Israel, 2007; Haldeman, 2001, 2002). This consideration can become quite complex when the client or the community of the client or the LMHP believes that homosexuality is sinful and immoral (see Beckstead & Israel, 2007). Further exploration of religious beliefs and the cognitive assumptions underlying those beliefs may be helpful in understanding the client's beliefs and perception of choices (Buchanan et al., 2001; Fischer & DeBord, 2007; Johnson, 2004; Yarhouse, 2008; Yip, 2000, 2002, 2005).

The issue of self-determination has become controversial, and some have suggested that SOCE be offered in the spirit of maximizing client autonomy so that clients have access to a treatment they request (e.g., Rosik, 2003; Yarhouse & Throckmorton, 2002). Others have cautioned against providing interventions that have very limited evidence of effectiveness, run counter to current scientific knowledge, and have the potential for harm, despite client requests (Drescher,

1999, 2002; Forstein, 2001; Gonsiorek, 2004; Haldeman, 2002; Herek, 2003). With regard to claims that client autonomy is the defining concern in treatment decision making, elevating one aspect of ethical reasoning, such as autonomy, above all others is not consistent with the current framework of the APA Ethics Code or medical ethics that focus on the interrelatedness of ethical principles (Beauchamp & Childress, 2008; Knapp & VandeCreek, 2004).

For instance, current ethics guidance focuses on the interrelatedness of ethical principles and understanding a clinical situation fully so as to appropriately balance the various pertinent principles (e.g., Knapp & VandeCreek, 2004). Self-determination and autonomy can vary in degree due to interpersonal and intrapersonal concerns and can be considered in relation to other ethical principles, such as providing services that (a) are likely to provide benefit, (b) are not effective, or (c) have the potential for harm.

We believe that simply providing SOCE to clients who request it does not necessarily increase self-

We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation.

determination but rather abdicates the responsibility of LMHP to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm. We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand,

acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation (Bartoli & Gillem, 2008; Beckstead & Israel, 2007; S. L. Morrow & Beckstead, 2004; Haldeman, 2004; Tan, 2008; Throckmorton & Yarhouse, 2006; Yarhouse, 2008).

Relational Issues in Treatment

Ideal or desired outcomes may not always be possible, and at times the client may face difficult decisions that

⁵⁷ For instance, the criminalization of certain forms of same-sex sexual behavior between consenting adults in private was constitutional in the United States until 2003 (see *Lawrence v. Texas*, 2003). The federal government and most U.S. states do not provide civil rights protections to LGB individuals and their families (National Gay and Lesbian Task Force: <http://www.thetaskforce.org>). In some other countries, homosexual behavior is still illegal and subject to extreme consequences, even death (e.g., Human Rights Watch, 2008; Wax, 2008; see also International Gay & Lesbian Human Rights Commission (IGLHRC): <http://www.iglhrc.org>). In extremely repressive environments, sexual orientation conversion efforts are provided in a coercive manner and have been the subject of human rights complaints (e.g., IGLHRC, 2001).

require different types and degrees of disappointment, distress, and sacrifice, as well as benefits, fulfillment, and rewards (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Yarhouse, 2008). LMHP may face strong emotions regarding the limits of their ability to provide relief from such difficult decisions or their consequences. Such emotions are understandable in this complex area, yet acting on such emotions within treatment has the potential to be harmful to the client (Knapp & VandeCreek, 2004; Pope & Vasquez, 2007). In these situations, in order to aid the client, the LMHP may have to address his or her own emotional reactions to the client's dilemmas. As the client must address regrets, losses (such as impossible and possible selves; see L. A. King & Hicks, 2007), and definitions of what is a fulfilling and worthwhile life, the LMHP must address his or her own values and beliefs about such issues. The LMHP's self-awareness, self-care, and judicious use of consultation can be helpful in these circumstances (Pope & Vasquez, 2007; Porter, 1995).

Moreover, LMHP may have their own internalized assumptions about sexual orientation, sexual orientation identity, sexuality, religion, race, ethnicity, and cultural issues (APA, 2000, 2002b; Garnets et al., 1991; McIntosh, 1990; Pharr, 1988; Richards & Bergin, 2005). The ethical principles of justice and respect for people's rights and dignity encourage LMHP to be aware of discrimination and prejudice so as to avoid condoning or colluding with the prejudices of others, including societal prejudices. As a way to increase awareness of their assumptions and promote the resolution of their own conflicts, R. L. Worthington, Dillon, and Becker-Schutte (2005) advised LMHP to develop their own competence surrounding sexual orientation, sexual minorities, and heterosexual privilege. Such competence requires self-reflection, contact with diverse sexual minority communities, and self-management of biases and sexual prejudice (cf. Israel, Ketz, Detrie, Burke, & Shulman, 2003).

Several authors (e.g., Faiver & Ingersoll, 2005; Lomax, Karff, & McKenny, 2002; Richards & Bergin, 2005; Yarhouse & Tan, 2005a; Yarhouse & VanOrman, 1999) have described potential ethical concerns related to working with religious clients. LMHP can strive to be aware of how their own religious values affect treatment and can aspire to focus on the client's perspective and aspire to become informed about the importance and content of specific religious beliefs and the psychology of religion (Bartoli, 2007; Yarhouse & Fisher, 2002; Yarhouse & VanOrman, 1999). Yet, for LMHP, the goal of treatment is determined by mental health concerns

Although LMHP strive to respect religious diversity and to be aware of the importance of religion to clients' worldviews, LMHP focus on scientific evidence and professional judgment in determining mental health interventions.

rather than directed by religious values (Gonsiorek, 2004). Although LMHP strive to respect religious diversity and to be aware of the importance of religion to clients' worldviews, LMHP

focus on scientific evidence and professional judgment in determining mental health interventions (APA, 2008a; Beckstead, 2001; Glassgold, 2008; Haldeman, 2004; Yarhouse & Burkett, 2002).

Summary

The principles and standards of the 2002 *Ethical Principles for Psychologists and Code of Conduct* most relevant to working with sexual minorities who seek to alter their sexual orientation are (a) Bases for Scientific and Professional Judgments (Standard 2.04) and Competence (2.01); (b) Beneficence and Nonmaleficence (Principle A); (c) Justice (Principle D); and (d) Respect for People's Rights and Dignity (Principle E). The key scientific findings relevant to the ethical concerns that are important in the area of SOCE are the limited evidence of efficacy or benefit and the potential for harm. LMHP are cautioned against promising sexual orientation change to clients. LMHP are encouraged to consider affirmative treatment options when clients present with requests for sexual orientation change. Such options include the therapeutic approaches included in Chapter 6. Self-determination is increased by approaches that support a client's exploration and development of sexual orientation identity. These approaches balance an understanding of the role of sexual stigma and respect other aspects of diversity in a client's exploration and maximize client self-determination.

8. ISSUES FOR CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

Task Force Charge and Its Social Context

The task force was asked to report on three issues for children and adolescents:

- The appropriate application of affirmative therapeutic interventions for children and adolescents⁵⁸ who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
- The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.⁵⁹
- Recommendations regarding treatment protocols that promote stereotyped gender-

⁵⁸ In this report, we define *adolescents* as individuals between the ages of 12 and 18 and children as individuals under age 12. The age of 18 was chosen because many jurisdictions in the United States use this age as the legal age of majority, which determines issues such as consent to treatment and other relevant issues.

⁵⁹ We define *coercive treatments* as practices that compel or manipulate a child or adolescent to submit to treatment through the use of threats, intimidation, trickery, or some other form of pressure or force. The threat of future harm leads to the cooperation or obedience. Threats of negative consequences can be physical or emotional, such as threats of rejection or abandonment from or disapproval by family, community, or peer-group; engendering feelings of guilt/obligation or loss of love; exploiting physical, emotional, or spiritual dependence.

normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

These issues reflected recent events in the current social context. Advocacy groups (Sanchez, 2007), law journals (Goishi, 1997; Morey, 2006; Weithorn, 1987), and the news media (A. Williams, 2005) have reported on involuntary⁶⁰ sexual orientation change efforts (SOCE)⁶¹ among adolescents. Publications by LMHP directed at parents and outreach from religious organizations advocate SOCE for children and youth as interventions to prevent adult same-sex sexual orientation (e.g., Nicolosi & Nicolosi, 2002; Rekers, 1982; see also Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006; Sanchez, 2007).

Reports by LGB advocacy groups (e.g., Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006) have claimed that there has been an increase in attention to youths by religious organizations that believe homosexuality is a mental illness or an adverse developmental outcome. These reports further suggested that there has

⁶⁰ We define *involuntary treatment* as that which is performed without the individual's consent or assent and which may be contrary to his or her expressed wishes. Unlike coercive treatment, no threats or intimidation are involved.

⁶¹ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals,

been an increase in outreach to youths that portrays homosexuality in an extremely negative light and uses fear and shame to fuel this message. These reports expressed concern that such efforts have a negative impact on adolescents' and their parents' perceptions of their sexual orientation or potential sexual orientation, increase the perception that homosexuality and religion are incompatible, and increase the likelihood that some adolescents will be exposed to SOCE without information about evidence-based treatments.

One aspect of these concerns expressed by LGB advocacy groups has been the presence of residential programs in which adolescents have been placed by their parents, in some cases with reported lack of assent from the adolescent (e.g., Cianciotto & Cahill, 2006; Kennedy & Cianciotto, 2006). In addition, a longstanding concern raised by advocacy groups for both LGB people and transgender people has been the alleged use of residential psychiatric commitment and gender-normative behavioral treatments for children and adolescents whose expression of gender or sexuality violates gender norms (Goishi, 1997; Morey, 2006; Weithorn, 1988).

To fulfill our charge, we reviewed the literature on SOCE in children and adolescents and affirmative psychotherapy for children, adolescents, and their families. We considered the literature on best practices in child and adolescent treatment, inpatient treatment, and legal issues regarding involuntary or coercive treatments and consent to and refusal of treatment. We also reviewed the literature on the development of sexual orientation in children and adolescents.

Literature Review

Literature on Children

There is a lack of published research on SOCE among children. Research on sexuality in childhood is limited and seldom includes sexual orientation or sexual orientation identity (Perrin, 2002). Although LGB adults and others with same-sex sexual attractions often report emotional and sexual feelings and attractions from their childhood or early adolescence and recall a sense of being different even earlier in childhood (Beckstead & Morrow, 2004; Bell et al., 1981; D'Augelli & Hershberger, 1993; Diamond & Savin-Williams, 2000; Troiden, 1989), such concerns have not been studied directly in young children (cf. Bailey & Zucker, 1995; Cohen & Savin-Williams, 2004).

There is no published research suggesting that children are distressed about their sexual orientation per se. Parental concern or distress about a child's behavior, mental health, and possible sexual orientation plays a central role in referrals for psychotherapy (Perrin, 2002; C. Ryan & Futterman, 1997). Parents may be concerned about behaviors in the child that are stereotypically associated with a same-sex sexual orientation (e.g., affection directed at another child of the same sex, lack of interest in the other sex, or behaviors that do not conform to traditional gender norms) (American Academy of Pediatrics [AAP], 1999; Haldeman, 2000). This situation contrasts with the condition of gender dysphoria in childhood and adolescence, for which there is clear evidence that some children and adolescents experience distress regarding their assigned sex, and some experience distress with the consequences of their gender and biological sex (i.e., youth struggling with social discrimination and stigma surrounding gender nonconformity) (APA, 2008e; R. Green, 1986, 1987; J. D. Menville, 1998; E. J. Menville & Tuerk, 2002; Zucker & Bradley, 1995).

Childhood interventions to prevent homosexuality have been presented in non-peer-reviewed literature (see Nicolosi & Nicolosi, 2002; Rekers, 1982).⁶² These interventions are based on theories of gender and sexual orientation that conflate stereotypic gender roles or interests with heterosexuality and homosexuality or that assume that certain patterns of family relationships cause same-sex sexual orientation. These treatments focus on proxy symptoms (such as nonconforming gender behaviors), since sexual orientation as it is usually conceptualized does not emerge until puberty, with the onset of sexual desires and drives (see APA, 2002a; Perrin, 2002). These interventions assume a same-sex sexual orientation is caused by certain family relationships that form gender identity and assume that encouraging gender stereotypic behaviors and certain family relationships will alter sexual orientation (Burack & Josephson, 2005; see, e.g., Nicolosi & Nicolosi, 2002; Rekers, 1979, 1982).

⁶² The only peer-reviewed literature did not focus on sexual orientation but rather on children with gender identity disorder or who exhibited nonconformity with gender roles (e.g., Rekers, 1979, 1981; Rekers, Bentler, Rosen, & Lovaas, 1977; Rekers, Kilgus, & Rosen, 1990; Rekers & Lovaas, 1974). However, the relevance of such work to this topic is limited, as none of these children reported experiencing same-sex sexual attractions or were followed into adulthood. Gender nonconformity differs from gender identity disorder, and children with gender identity disorder are not necessarily representative of the larger population of those children who will experience same-sex sexual attractions in adulthood (Bailey & Zucker, 1995; Bradley & Zucker, 1998; Zucker, 2008).

The theories on which these interventions are based have not been confirmed by empirical study (Perrin, 2002; Zucker, 2008; Zucker & Bradley, 1995). Although retrospective research indicates that some gay men and lesbians recall gender nonconformity in childhood (Bailey & Zucker, 1995; Bem, 1996; Mathy & Drescher, 2008), there is no research evidence that childhood gender nonconformity and adult homosexuality are identical or are necessarily sequential developmental phenomena (Bradley & Zucker, 1998; Zucker, 2008). Theories that certain patterns of family relationships cause same-sex sexual orientation have been discredited (Bell et al., 1981; Freund & Blanchard, 1983; R. R. Green, 1987; D. K. Peters & Cantrell, 1991).

The research that has been attempted to determine whether interventions in childhood affect adult sexual orientation exists only within the specific population of children with gender identity disorder (GID). R. Green (1986, 1987) and Zucker and Bradley (1995) (to a limited degree) examined prospectively whether psychotherapy in children with GID influenced adult or adolescent sexual orientation and concluded that it did not (for a review of the issues for children with GID, see APA, 2009, *Report of the Task Force on Gender Identity and Gender Variance*). Thus, we concluded that there is no existing research to support the hypothesis that psychotherapy in children alters adult sexual orientation.

Literature on Adolescents

We found no empirical research on adolescents who request SOCE, but there were a few clinical articles reporting cases of psychotherapy with religious

The general body of research on adolescents who identify themselves as same-sex oriented does not suggest that the normal development of a same-sex sexual orientation in adolescence is typically characterized by distress that results in requests for sexual orientation change.

of these cases, the adolescents or their families sought SOCE or considered SOCE (Cates, 2007; Yarhouse & Tan, 2005a; Yarhouse et al., 2005). The general body of research on adolescents who identify themselves as same-sex oriented does not suggest that the normal

adolescents who expressed confusion regarding their sexual orientation and conflicts between religious values and sexual orientation (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005). In some

development of a same-sex sexual orientation in adolescence is typically characterized by distress that results in requests for sexual orientation change (e.g., D'Augelli, 2002; Garofalo & Harper, 2003; Savin-Williams & Cohen, 2004).

The absence of evidence for adolescent sexual orientation distress that results in requests for SOCE and the few studies in the literature on religious adolescents seeking psychotherapy related to sexual orientation suggest that sexual orientation distress is most likely to occur among adolescents in families for whom religious views that homosexuality is sinful and undesirable are important. Yarhouse and colleagues (Yarhouse, 1998b; Yarhouse, Brooke, Pisano, & Tan, 2005; Yarhouse & Tan, 2005a) discussed clinical examples of distress caused by conflicts between faith and sexual orientation identity. For instance, a female adolescent client struggled with guilt and shame and fears that God would not love her, and a male adolescent experienced a conflict between believing God created him with same-sex feelings and believing that God prohibited their expression (Yarhouse & Tan, 2005a). Cates (2007) described three cases of Caucasian males who were referred by schools, courts, or parents for concerns that included their sexual orientation. All three youths perceived that within their faith community and family, an LGB identity was unacceptable and would probably result in exclusion and rejection (Cates, 2007). Because of the primacy of religious beliefs, the adolescents or their families requested religiously based therapy or SOCE. For instance, Cates described the treatment of an adolescent who belonged to the Old Amish Community and who requested SOCE. The young man perceived that there was no place for him in his faith community as a gay man and did not want to leave that community.

Research on Parents' Concerns About Their Children's Sexual Orientation

We did not find specific research on the characteristics of parents who bring their children to SOCE. Thus, we do not know whether this population is similar to or different from the more general population of parents who may have concerns or questions regarding their children's sexual orientation or future sexual orientation. We cannot conclude that parents who present to LMHP with a request for SOCE are motivated by factors that cause distress in other parents of adolescents with emerging LGB identities.

As reported in case studies and clinical papers, parents' religious beliefs appear to be factors in their request for SOCE for their children. These articles identified a population of parents who have strong conservative religious beliefs that reject LGB identities and perceive homosexuality as sinful (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a; Yarhouse et al., 2005).

Other reports suggest that parents of adolescents with emerging same-sex sexual orientation and conservative religious beliefs that perceive homosexuality negatively appear to be influenced by religious authorities and LMHP who promote SOCE. For instance, Burack and Josephson (2005) and Cianciotto and Cahill (2006) reported that fear and stereotypes appeared to be contributing factors in parents who resort to residential SOCE or other related coercive treatment on youth. Cianciotto and Cahill found that some advocacy groups do outreach to parents that encourages commitment to SOCE residential programs even if the children do not assent. These programs also appear to provide information to parents that stresses that sexual orientation can be changed (Burack & Josephson, 2005; Cianciotto & Cahill, 2006), despite the very limited empirical evidence for that assertion.

Residential and Inpatient Services

We were asked to report on "the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation." We performed a thorough review of the literature on these programs. Upon completion of this review, we decided that the best way to address this task was to evaluate issues of the appropriateness of these programs for adolescents in light of issues of harm and benefit based on the literature on adolescent development, standards for inpatient and residential treatment, and ethical issues such as informed consent.

There are several accounts of inpatient and residential treatment, sometimes involuntary or coerced, for adolescents who were LGB-identified, confused or questioning their sexual orientation, gender nonconforming, or transgender (Arriola, 1998; Burack & Josephson, 2005; Goishi, 1997; Molnar, 1997; Weithorn, 1988). These incidents mostly occurred because the parent or guardian was distressed regarding the child's actual sexual orientation or potential and perceived sexual orientation. An account of an adolescent boy who was placed in a program sponsored by Love in Action,

a religious-based program, was reported widely in the press (A. Williams, 2005). This program was reported to focus on religious approaches to SOCE as well as approaches that stress conformity to traditional gender roles and behaviors.

Concerns have arisen over the conduct of some private psychiatric hospitals that use alternative diagnoses—such as GID, conduct disorders, oppositional defiant disorders, or behaviors identified as self-defeating or self-destructive—to justify hospitalization of LGB and questioning youth and expose adolescents to SOCE (Arriola, 1998; Morey, 2006). Data on these issues are incomplete, as each state has different reporting requirements for public and private hospitals, and laws regarding confidentiality understandably protect client information.

ADOLESCENTS' RIGHTS TO CONSENT TO TREATMENT

In researching involuntary treatment, we reviewed the recent literature on the growing movement to increase adolescents' rights to consent to outpatient and inpatient mental health treatment so as to reduce involuntary hospitalization (Mutcherson, 2006;

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(Hartman, 2000, 2002; Mutcherson, 2006; Redding, 1993). The APA *Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients* (2000) and the APA Ethics Code (2002b) encourage professionals to seek the assent of minor clients for treatment. Within the field of adolescent mental health and psychiatry, there are developmental assessment models to determine an adolescent's competence to assent or consent to and potentially refuse treatment (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b). Some states now permit adolescents some rights regarding choosing or refusing inpatient treatment, participating in certain interventions, and control over disclosure of records (Koocher, 2003).

INPATIENT TREATMENT

The use of inpatient and residential treatments for SOCE is inconsistent with the recommendations of the

field. For instance, the American Academy of Child and Adolescent Psychiatry (1989) recommended that inpatient treatment, when it does occur, be of the shortest possible duration and reserved for the most serious psychiatric illnesses, such as those of a psychotic nature or where there is an acute danger to self or others. For less serious mental health conditions, the Academy recommended that inpatient hospitalization occur only after less restrictive alternatives (i.e., outpatient and community resources) are shown to be ineffective. In *Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care* (Wilber, Ryan, & Marksamer, 2006), the Child Welfare League of America recommended that, if necessary, hospitalization or residential substance abuse treatment for adolescents be in a setting that provides mental health treatments that are affirmative of LGB people and for which the staff is competent to provide such services. Further, in a review of the psychiatric literature, Weithorn (1988) concluded that the deprivation of normal social contacts and prevention of attendance at school and other normal social settings can be harmful as well as punitive.

PROGRAMS WITH RELIGIOUS AFFILIATIONS

Programs such as Love in Action's Refuge⁶³ provided religiously based interventions that claimed to change sexual orientation, control sexual behavior, or prevent the development of same-sex sexual orientation (Burack & Josephson, 2005; Sanchez, 2007; A. Williams, 2005). Because such programs are religious in nature and are not explicitly mental health facilities,⁶⁴ they are not licensed or regulated by state authorities. Burack and Josephson reported that there was effort by religious organizations and sponsors of these programs to communicate to parents that homosexuality is abnormal and sinful and could be changed.⁶⁵ Such religious organizations, according to the authors of the report, encouraged parents to seek treatment for their children. Based on anecdotal accounts of current and past residents, these programs, to influence adolescents' life decisions, allegedly used fear and even threats about negative spiritual, health, and life consequences and

thus are viewed as coercive (Burack & Josephson, 2005; Sanchez, 2007).

To provide an overview of the issues with residential programs for youth, we reviewed information gathered by the APA (2002a) Committee on Children, Youth, and Families in collaboration with the APA State Advocacy Office and the testimony and subsequent published report by members of the U.S. General Accounting Office before the Committee on Education and Labor of the U.S. House of Representatives (Kutz & O'Connell, 2007). These reports and testimony evaluated some current problems in adolescent residential mental health care. There are a large number of unlicensed and unregulated programs marketed to parents struggling to find behavioral or mental health programs for their

Although religious doctrines themselves are not the purview of psychologists, how religious doctrine is inculcated through educational and socialization practices is a psychological issue and an appropriate subject of psychological examination, especially if there are concerns regarding substantiation of benefit or harm, unlicensed and unregulated facilities, and coercive and involuntary treatment.

adolescent children.

Although many of these programs avoid regulation by not identifying themselves as mental health programs, they do advertise mental health, behavioral, and/or educational goals, especially for those youth perceived as troubled by their parents. Many of these programs

are involuntary and coercive and use seclusion or isolation and escort services to transport unwilling youth to program locations (Kutz & O'Connell, 2007). The testimony and report described the negative mental health impacts of these programs and expressed grave concerns about them, including questions about quality of care and harm caused by coercive or involuntary measures (Kutz & O'Connell, 2007).

Thus, residential and outpatient programs that are involuntary and coercive and provide inaccurate scientific information about sexual orientation or are excessively fear-based pose both clinical and ethical concerns, whether or not they are based on religious doctrine. Although religious doctrines themselves are not the purview of psychologists, how religious doctrine is inculcated through educational and socialization practices is a psychological issue and an appropriate subject of psychological examination, especially if there are concerns regarding substantiation of benefit

⁶³ The program "Refuge," directed at adolescents, was closed in 2007 and is no longer advertised. However, Love in Action still sponsors residential programs for adults.

⁶⁴ These programs advertise helping with addiction, "negative self-talk and irrational belief systems," and behavior change (see www.loveinaction.org).

⁶⁵ See www.loveinaction.org.

or harm, unlicensed and unregulated facilities, and coercive and involuntary treatment.

As noted earlier, we define coercive treatments as practices that compel or manipulate an individual to submit to treatment through the use of threats, intimidation, manipulation, trickery, or some other form of pressure, including threats of future harm. Harm can be physical or psychological. Harmful psychological consequences include disapproval; loss of love; rejection or abandonment by family, community, or peer group; feelings of guilt/obligation; and exploitation of physical, emotional, or spiritual dependence. Working with a variety of client populations presents ethical dilemmas for providers (APA, 2002b; Beauchamp & Childress, 2008; Davis, 2002); however, with children and adolescents, such concerns are heightened (Molnar, 1997; Weithorn, 1988). Children and adolescents are more vulnerable to such treatments because of the lack of legal rights and cognitive and emotional maturity and emotional and physical dependence on parents, guardians, and LMHP (Molnar, 1997; Weithorn, 1988). The involuntary nature of particular programs raises issues similar to those of other involuntary mental health settings; however, because they are religious programs, not mental health programs, they pose complex issues for licensure and regulation (A. Williams, 2005). On the basis of ethical principles (APA, 2002b; Beauchamp & Childress, 2008), LMHP should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments.

Appropriate Application of Affirmative Interventions With Children and Adolescents

Multicultural and Client-Centered Approaches for Adolescents

A number of researchers and practitioners have advised LMHP that when working with children or adolescents and their families, they should address concerns regarding sexual orientation and base their interventions on the current developmental literature on children and adolescents and the scholarly literature on parents' responses to their child's sexual orientation (e.g., Ben-Ari, 1995; Bernstein, 1990; Holtzen & Agriesti, 1990; Mattison & McWhirter, 1995; Perrin, 2002; C. Ryan, Huebner, Diaz, & Sanchez, 2009;

Salzburg, 2004, 2007; Yarhouse & Tan, 2005a).⁶⁶ This literature recommends that LMHP learn about the law and scholarship on developmental factors in informed consent and take steps to ensure that minor clients have a developmentally appropriate understanding of treatment, are afforded complete information about their rights, and are provided treatment in the least restrictive environment. LMHP can review the recommendations for assent to treatment recommended in the *Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients* (APA, 2000) and can seek an adolescent's consent consistent with evolving considerations of developmental factors (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b).

APA policies (APA, 1993, 2000) and the vast majority of current publications on therapy for LGB and questioning adolescents who are concerned about their sexual orientation recommend that LMHP support adolescents' exploration of identity by

- accepting homosexuality and bisexuality as normal and positive variants of human sexual orientation,
- accepting and supporting youths as they address the stigma and isolation of being a sexual minority,
- using person-centered approaches as youths explore their identities and experience important developmental milestones (e.g., exploring sexual values, dating, and socializing openly),
- reducing family and peer rejection and increasing family and peer support (e.g., APA, 2000, 2002a; D'Augelli & Patterson, 2001; Floyd & Stein, 2002; Fontaine & Hammond, 1996; Hart & Heimberg, 2001; Hetrick & Martin, 1987; Lemoire & Chen, 2005; Mallon, 2001; A. D. Martin, 1982; Perrin, 2002; Radkowski & Siegel, 1997; C. Ryan, 2001; C. Ryan et al., 2009; C. Ryan & Diaz, 2005; C. Ryan & Futterman, 1997; Schneider, 1991; Slater, 1988; Wilber, Ryan & Marksamer, 2006; Savin-Williams & Cohen, 2004; Yarhouse & Tan, 2005a).

When sexual minority and questioning youth require residential or inpatient treatment for mental health, behavioral, or family issues, it has been recommended that such treatment be safe from discrimination and

⁶⁶ Due to the limited research on children, adolescents, and families who seek SOCE, our recommendations for affirmative therapy for children, youth, and their families distressed about sexual orientation are based on general research and clinical articles addressing these and other issues, not on research specific to those who specifically request SOCE. We acknowledge that limitation in our recommendations.

prejudice and affirming of sexual orientation diversity by staff who are knowledgeable about LGB identities and life choices (Mallon, 2001; Wilber et al., 2006).

Other aspects of human diversity, such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status, may be relevant to an adolescent's identity development, and these differences may intersect with sexual orientation identity (Diamond & Savin-Williams, 2000; Rosario, Rotheram-Borus, & Reid, 1996; Rosario, Schrimshaw, & Hunter, 2004; Rosario, Schrimshaw, Hunter, & Braun, 2006). Some adolescents are more comfortable with fluid or flexible identities due to gender differences and generational or developmental concerns, and their sexual orientation identities may not be exclusive or dichotomous (Diamond, 2006; Morgan & Thompson, 2006; Savin-Williams, 2005).

Only a few articles addressed the specific conflicts between religious identities and sexual orientation identities among youth (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a). For instance, Yarhouse and Tan proposed solutions that respect religious beliefs and emphasized nondirective exploration of religious and sexual orientation identity that does not advocate a particular sexual orientation identity outcome. As adolescents may experience a crisis of faith and distress linked to religious and spiritual beliefs, the authors explored interventions that integrate the psychology of religion into interventions that stress improving the client's positive religious coping and relationship with the sacred (e.g., Exline, 2002; Pargament & Mahoney, 2005; Pargament et al., 1998, 2005). Cates (2007), from a more secular frame, emphasized a client-centered approach that stresses the LMHP's unconditional acceptance of the client and client choices even if the client cannot accept his or her own sexual orientation.

The ethical issues outlined in Chapter 7 are also relevant to children and adolescents; however, working with adolescents presents unique ethical dilemmas to LMHP (Koocher, 2003). Children and adolescents are often unable to anticipate the future consequences of a course of action and are emotionally and financially dependent on adults. Further, they are in the midst of developmental processes in which the ultimate outcome is unknown. Efforts to alter that developmental path may have unanticipated consequences (Perrin, 2002). LMHP should strive to be mindful of these issues, particularly as these concerns affect assent and consent to treatment and goals of treatment (Koocher, 2003; Rosner, 2004a, 2004b; Sobocinski, 1990). Possible

approaches include open-ended and scientifically based age-appropriate exploration with children, adolescents, and parents regarding these issues.

Multicultural and Client-Centered Approaches for Parents and Families

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment (Radkowski & Siegel, 1997; C. Ryan & Diaz, 2005; C. Ryan et al., 2009; Savin-Williams, 1989b, 1998; Wilber et al., 2006; Yarhouse, 1998b). One retrospective research study of adults indicated that LGB children are more likely to be abused by their families than by nonrelated individuals (Corliss, Cochran, & Mays, 2002). Another

<i>Reducing parental rejection, hostility, and violence (verbal or physical) may contribute to the mental health and safety of the adolescent.</i>	found that family rejection is a key predictor of negative health outcomes in White and Latino LGB young adults (C. Ryan et al., 2009).

Reducing parental rejection, hostility, and violence (verbal or physical) may contribute to the mental health and safety of the adolescent (Remafedi et al., 1991; C. Ryan et al., 2009; Savin-Williams, 1994; Wilber et al., 2006). Further, to improve parents' responses, LMHP can find ways to ameliorate parents' distress about their children's sexual orientation. Exploring parental attributions and values regarding same-sex sexual orientation is especially important in order to facilitate engagement in treatment, resolution of ethical dilemmas, and more beneficial psychotherapy (Morrissey-Kane & Prinz, 1999; Sobocinski, 1990).

Family therapy for families who are distressed by their child's sexual orientation may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate an adolescent's distress (Mattison & McWhirter, 1995; C. Ryan et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; C. Ryan & Diaz, 2005; Ryan & Futterman, 1997; C. Ryan et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998b). C. Ryan and Futterman (1997) termed this *anticipatory*

guidance: LMHP provide family members with accurate information regarding same-sex sexual orientation and dispel myths regarding the lives, health, and psychological well-being of LGB individuals.

Perrin (2002) recommended that providers, when working with families of preadolescent children, counsel parents who are concerned that their young children may grow up to be lesbian or gay to tolerate the ambiguity inherent in the limited knowledge of development. In addition, Perrin suggested a two-pronged approach: (a) provide information to reduce heterosexism within the family and increase the family's capacity to provide support and (b) introduce information about LGB issues into family discussions to aid the child's own self-awareness and self-acceptance and to counter stigma. For adolescents, C. Ryan et al. (2009) recommended that LMHP assess family reactions to LGB youth, specifically the presence of family rejection. Further, the authors advocated explaining to families the link between family rejection and negative health problems in children and adolescents, providing anticipatory guidance to families that includes recommendations for support on the part of the family, and helping families to modify highly rejecting behaviors.

Families with strong religious beliefs that condemn homosexuality may struggle with a child's same-sex sexual orientation (Cates, 2007; Yarhouse, 1998b; Yarhouse & Tan, 2005a). Yarhouse and Tan (2005a) suggested that family therapy reframe the religious beliefs to focus on aspects of faith that encourage love and acceptance of their child rather than on a religion's prohibitions. The authors stressed that these positive elements of faith can lay a constructive foundation for communication and problem solving and reduce family discord and rejection.

Providing anticipatory guidance to parents to address their unique personal concerns can be helpful (C. Ryan & Futterman, 1997). The LMHP can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual minority child. Parents must deal with their own unique choices and process of "coming out" and resolve fears of enacted stigma if they risk disclosure within their communities, at work, and to other family members (Bernstein, 1990). Further, the LMHP can address other stresses, such as managing life celebrations and transitions and coping with feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by LMHP might be helpful to counter the

isolation that many parents experience (J. D. Menveille & Tuerk, 2002).

Community Approaches for Children, Adolescents, and Families

Research has illuminated the potential that school-based and community interventions have for increasing safety and tolerance of sexual minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority youth (APA, 1993; D'Augelli & Patterson, 2001; Goodenow, Szalacha, & Westheimer, 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; A. J. Peters, 2003; Roffman, 2000; Safren & Heimberg, 1999; Schneider, 1991; Treadway & Yoakum, 1992). For instance, sexual minority adolescents in schools with support groups for LGB students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003). Kosciw and Diaz (2006) found that such support groups were related to improved academic performance and college attendance. The support groups that were examined in the research provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB youth (Goodenow et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority youth school achievement and mental health (Goodenow et al., 2006).

School and community interventions have the potential for introducing other sources of peer and adult support that may buffer children and adolescents from rejection that may occur in certain family, community, and religious contexts. These school and community interventions may provide alternative sources of information regarding LGB identities and lives. However, such school and community interventions are unlikely to directly affect the core attitudes and beliefs of the religious institutions and communities in which sexual orientation distress and family rejection might occur. These programs may have an indirect effect on communities and religious institutions because of their potential to change the general social context in which families deal with conflicts between their children's emerging sexual orientations and identities. We hope that such change will reduce the level of psychological

distress that such conflicts between religion and sexuality create and reduce the level of hostility and punitiveness to which some children and adolescents are exposed as a result of their sexual orientation.

For families, groups such as Parents, Families, and Friends of Lesbians and Gays (PFLAG) and the Straight Spouse Network may also provide a safe, nonjudgmental space in which to discuss their concerns, receive accurate information, reduce isolation, and reduce feelings of perceived stigma (Goldfried & Goldfried, 2001). PFLAG offers extensive literature for parents based on affirmative approaches to same-sex sexual attractions as well as a nationwide network of support groups. Such groups, by providing affirmative sources of information, could reduce the distress for parents that is and increase family support of their sexual minority children, thus positively affecting sexual minority youth and children whose families are concerned about their future sexual orientation.

Parents who are religious may benefit from finding support through religious organizations and groups. One concern is that some groups may provide parents with information that presents same-sex sexual orientation in a negative light (e.g., defective, “broken”), which could increase stigma and rejection of children and adolescents; thus, such groups should rarely be considered. Alternatively, some groups provide resources that are both LGB affirming and religious.⁶⁷

Conclusion

We were asked to report on three issues for children and adolescents. First, we were asked to provide recommendations regarding treatment protocols that attempt to prevent homosexuality in adulthood by promoting stereotyped gender-normative behavior in children to mitigate behaviors that are perceived to be

Some advocates of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years.

indicators that a child will develop a homosexual orientation in adolescence and adulthood. We found no empirical evidence that

providing any type of therapy in childhood can alter adult same-sex sexual orientation. Some advocates

of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years. Further, the theories that such efforts are based on have not been corroborated by scientific evidence or evaluated for harm. Thus, we recommend that LMHP avoid such efforts and provide instead multicultural, client-centered, and affirmative treatments that are developmentally appropriate (Perrin, 2002).

Second, we were asked to comment on the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. We found that serious questions are raised by involuntary and coercive interventions and residential centers for adolescents due to their advocacy of treatments that have no scientific basis and potential for harm due to coercion, stigmatization, inappropriateness of treatment level and type, and restriction of liberty. Although the prevalence of these treatment centers is unknown, we recommend that some form of oversight be established for such youth facilities, such as licensure and monitoring, especially as a means of reporting abuse or neglect.

States have different requirements and standards for obtaining informed consent to treatment for adolescents; however, it is recognized that adolescents are cognitively able to participate in some health care treatment decisions and that such participation is helpful. We recommend that when it comes to treatment that purports to have an impact on sexual orientation, LMHP assess the adolescent’s ability to understand treatment options, provide developmentally appropriate informed consent to treatment, and, at a minimum, obtain the youth’s assent to treatment. SOCE that focus on negative representations of homosexuality and lack a theoretical or evidence base provide no documented benefits and can pose harm through increasing sexual stigma and providing inaccurate information. We further concluded that involuntary or coercive residential or inpatient programs that provide SOCE to children and adolescents may pose serious risk of harm, are potentially in conflict with ethical imperatives to maximize autonomous decision making and client self-determination, and have no documented benefits. Thus, we recommend that parents, guardians, or youth not consider such treatments.

Finally, we were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change their sexual orientation or their behavioral

⁶⁷ See, e.g., “Family Fellowship” (www.ldsfamilyfellowship.org/) for parents who belong to the Church of Jesus Christ of Latter-Day Saints. The Institute of for Sexual Orientation and Judaism also lists resources: www.huc.edu/ijso/.

expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.

We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE.

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adolescents, and their families rather than SOCE.

Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) supporting children and youth in their developmental processes and milestones, (b) reducing internalized stigma in children and sexual stigma in parents, and (c) providing affirmative information and education on LGB identities and lives.

These approaches would support children and youth in identity exploration and development without seeking predetermined outcomes. Interventions that incorporate knowledge from the psychology of religion and that increase acceptance, love, and understanding among individuals, families, and communities are recommended for populations for whom religion is important. Family therapy that provides anticipatory guidance to parents to increase their support and reduce rejection of children and youth addressing these issues is essential. School and community interventions are also recommended to reduce societal-level stigma and provide information and social support to children and youth.

9. SUMMARY AND CONCLUSIONS

APA's charge to the task force included three major tasks that this report has addressed:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998).
2. Generate a report that includes discussion of the following:
 - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
 - The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
 - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
 - Education, training, and research issues as they pertain to such therapeutic interventions.
 - Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived

to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

The substance of the second task has been achieved in the preceding chapters of this report. In Chapters 3 and 4, we reviewed the body of research on the efficacy and safety of sexual orientation change efforts (SOCE).⁶⁸ In Chapter 5 we synthesized the literature on the nature of distress and identified conflicts in adults, which provided the basis for our recommendations for affirmative approaches to psychotherapy practice that are described in Chapter 6. Chapter 7 discussed ethical issues in SOCE for adults. In Chapter 8 we considered the more limited body of research on children and adolescents, including a review of SOCE with children and adolescents and affirmative approaches for psychotherapy.

In this final chapter, we summarize the report and focus on those two tasks—one and three—that have not been addressed in the report. With regard to the policy, we recommended that the 1997 policy be retained and

⁶⁸ In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

that a new policy be adopted to complement it. The new policy that we proposed (see Appendix A) was adopted by APA's Council of Representatives in August 2009. With regard to APA's response to groups that advocate for SOCE, we provide those recommendations at the end of this chapter in the section on policy.

To achieve the charge given by APA, we decided to conduct a systematic review of the empirical literature on SOCE. This review covered the peer-reviewed journal articles in English from 1960 to 2007.⁶⁹ The review is reported in Chapters 3 and 4: Chapter 3 addresses methodological issues in the research; and Chapter 4, the outcomes, such as safety, efficacy, benefit, and harm of SOCE.

We also reviewed the recent literature on the psychology of sexual orientation. There is a growing body of literature that concludes that social stigma, known specifically as sexual stigma, manifested as prejudice and discrimination directed at same-sex sexual orientations and identities, is a major source of stress for sexual minorities. This stress, known as minority stress, is a major cause of the mental health disparities of sexual minorities. On the basis of this literature, we recommend that all interventions and policy for these populations include efforts to mitigate minority stress and reduce stigma.

Further, we found that religious individuals with beliefs that homosexuality is sinful and morally unacceptable are prominent in the population that currently undergoes SOCE. These individuals seek SOCE because the disapproving stance of their faiths toward homosexuality produces conflicts between, on the one hand, their beliefs and values and, on the other, their sexual orientation. These conflicts result in significant distress due to clients' perceptions that they are unable to integrate their faith and sexual orientation. To respond as well as possible to this population, we included in our review some of the empirical and theoretical literature from the psychology of religion, recently adopted APA policies on religion and science, and specific interventions that have been proposed in the literature for religious populations.

SOCE has been quite controversial, and the controversy has at times become polemical because of clashes between differing political viewpoints about LGB individuals and communities and the differing

values between some faith-based organizations and scientific and professional organizations (Drescher, 2003; Zucker, 2008). Psychology, as a science, and various faith traditions, as theological systems, can

APA has affirmed that proven methods of scientific inquiry are the best methods to explore and understand human behavior and are the basis for the association's policies.

acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA has affirmed that proven

methods of scientific inquiry are the best methods to explore and understand human behavior and are the basis for the association's policies (APA, 2007a, 2008a). The APA affirms that discrimination directed at religions and their adherents or derived from religious beliefs is unacceptable and that religious faith should be respected as an aspect of human diversity (APA, 2008c).

Summary of the Systematic Review of the Literature

To fulfill the charge given by APA, we undertook a systematic review to address the key questions: What are the outcomes of SOCE and their potential benefits and harms? Is SOCE effective or safe? The first step was to evaluate the research to determine if such conclusions could be drawn from the research—in other words, was the research performed with the appropriate degree of methodological rigor to provide such answers? The next question was to determine, if such research existed, what answers it provided.

Efficacy and Safety

We found few scientifically rigorous studies that could be used to answer the questions regarding safety, efficacy, benefit, and harm (e.g., Birk et al., 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972; Tanner, 1974, 1975). Few studies could be considered true experiments or quasi-experiments that would isolate and control the factors that might effect change (see the list of studies in Appendix B). These studies were all conducted in the period from 1969 to 1978 and used aversive or other behavioral methods.

Recent SOCE differ from those interventions explored in the early research studies. The recent nonreligious interventions are based on the assumption that homosexuality and bisexuality are mental

⁶⁹ The articles in English include material on populations outside the United States, including Canada, Mexico, Western Europe, and some material on Middle Eastern, South Asian, and East Asian populations. No articles based on new research have been published since 2007. One article published in 2008 is a restatement of Schaeffer et al. (2000).

disorders or deficits and are based on older discredited psychoanalytic theories (e.g., Socarides, 1968; see American Psychoanalytic Association, 1991, 1992, 2000; Drescher, 1998b; Mitchell, 1978, 1981). Some focus on increasing behavioral consistency with gender norms and stereotypes (e.g., Nicolosi, 1991). None of these approaches is based on a credible scientific theory, as these ideas have been directly discredited through evidence or rendered obsolete. There is longstanding scientific evidence that homosexuality per se is not a mental disorder (American Psychiatric Association, 1973; Bell & Weinberg, 1978; Bell et al., 1981; Conger, 1975; Gonsiorek, 1991; Hooker, 1957), and there are a number of alternate theories of sexual orientation and gender consistent with this evidence (Bem, 1996; Butler, 2004; Chivers et al., 2007; Corbett, 1996, 1998, 2001; Diamond, 1998, 2006; Drescher, 1998b; Enns, 2008; Heppner & Heppner, 2008; Levant & Silverstein, 2006; Mustanski et al., 2002; O'Neil, 2008; Peplau & Garnets, 2000; Pleck, 1995; Rahman & Wilson, 2005; Wester, 2008).

Other forms of recent SOCE are religious, are not based on theories that can be scientifically evaluated, and have not been subjected to rigorous examination of efficacy and safety. These approaches are based on religious beliefs that homosexuality is sinful and immoral and, consequently, that identities and life paths based on same-sex sexual orientation are not religiously acceptable. The few high-quality studies of SOCE conducted from 1999 to 2004 are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkowicz, 2001) and these, due to the research questions explored, aid in understanding the population that seeks sexual orientation change but do not provide the kind of information needed for definitive answers to questions of the safety and efficacy of SOCE.

Thus, we concluded that the early evidence, though extremely limited, is the best basis for predicting what would be the outcome of psychological interventions. Scientifically rigorous older work in this area (e.g., Birk et al., 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972; Tanner, 1974, 1975) shows that enduring change to an individual's sexual orientation is uncommon and that only a very small number of people in these studies show any credible evidence of reduced same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased sexual attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence

that any changes produced in laboratory conditions translated to daily life. Many individuals continued to experience same-sex sexual attractions following SOCE and seldom reported significant change to other-sex sexual attractions. Thus, we concluded the following about SOCE: *The results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex sexual attractions or increase other-sex attractions through SOCE.*

The few early research investigations that were conducted with scientific rigor raise concerns about the safety of SOCE, as some participants suffered unintended harmful side effects from the interventions. These negative side effects included loss of sexual feeling, depression, suicidality, and anxiety. The high dropout rate in these studies may indicate that some research participants may have experienced these treatments as harmful and discontinued treatment (Lilienfeld, 2007). There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom.

Individuals Who Undergo SOCE and Their Experiences

Although scientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its participants, there is a population of consumers who participate in SOCE. To address the questions of appropriate application of affirmative interventions for this population, which was a major aspect of APA's charge to the task force, we returned to the research literature on SOCE, expanding beyond the scope of the systematic review to include other literature in order to develop an understanding of the current population that participates in SOCE. The research does reveal something about those individuals who undergo SOCE, how they evaluate their experiences, and why they may seek SOCE, even if the research does not indicate whether SOCE has anything to do with the changes some clients perceive themselves have experienced. We sought this information to be as comprehensive as possible and to develop an information base that would serve as a basis for considering affirmative interventions.

SOCE research identifies a population of individuals who experience conflicts and distress related to same-sex sexual attractions. The population of adults included in recent SOCE research is highly religious, participating

in faiths that many would consider traditional or conservative (e.g., the Church of Jesus Christ of Latter-Day Saints [Mormon], evangelical Christian, or Orthodox Jewish). Most of the participants in recent studies are White men who report that their religion is extremely important to them (Nicolosi et al., 2000; Schaeffer et al., 2000; Shidlo & Schroeder, 2002; Spitzer, 2003). These recent studies include a small number of participants who identify as members of ethnic minority groups. Recent studies include more women than in early studies, and one qualitative study focused exclusively on women (Ponticelli, 1999). Most of the individuals studied tried a variety of methods to change their sexual orientation, including psychotherapy, support groups, and religious efforts. Many of the individuals studied were recruited from groups endorsing SOCE. The body of literature overall is based on convenience samples; thus, the relationship between the characteristics of these individuals compared to the entire population of people who seek SOCE is unknown.

Comparisons of the early and recent research indicate changes in the demographics of those who seek SOCE. The individuals who participated in early research on SOCE were also predominantly White males, but those studies included men who were court-referred to treatment, men who were referred to treatment for a range of psychiatric and sexual concerns, and men who were fearful of criminal or legal sanctions, in addition to men who were distressed by their sexual attractions. There are no data on the religious beliefs of those in the early studies. As noted previously, the individuals in recent studies indicated that religion is very important to them.

We concluded that some of the controversy surrounding SOCE can be explained by different understandings of the nature of sexual orientation and sexual orientation identity. Recent research in the field of sexual orientation indicates a range of sexual attractions and desires, sexual orientations, and multiple ways of self-labeling and self-identifying (e.g., Carrillo, 2002; Diamond, 1998, 2006, 2008; Fox, 1995; Hoberg et al., 2004; Savin-Williams, 2005). Some researchers have found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability in reports of these two variables (R. L. Worthington & Reynolds, 2009). *Sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and

biological systems that are beyond conscious choice and involve profound emotional feelings such as "falling in love" and emotional attachment. Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women; sexual values, norms, and motivations; social affiliations with LGB or heterosexual individuals and communities; emotional attachment preferences for men or women; gender role and identity; lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct. *Sexual orientation identity* refers to recognition and internalization of sexual orientation and reflects self-awareness, self-recognition, self-labeling, group membership and affiliation, culture, and self-stigma. Sexual orientation identity is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997).

Recent studies of SOCE participants frequently do not distinguish between sexual orientation and sexual orientation identity. We concluded that the failure to distinguish these aspects of human sexuality in this recent SOCE research has obscured an understanding of what aspects of human sexuality might and might not change through intervention. The available evidence, from both early and recent studies, suggests that

The available evidence, from both early and recent studies, suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (i.e., values and behavior).

although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (i.e.,

values and behavior). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). For instance, in recent research, many individuals claim that through participating in SOCE, they became skilled in ignoring or tolerating their attractions or limiting the impact of their attractions on their sexual behavior (Beckstead & Morrow, 2004; McConaghy, 1976; Shidlo & Schroeder, 2002). Early nonexperimental case studies described

individuals who reported that they went on to lead outwardly heterosexual lives, including, for some, developing a sexual relationship with an other-sex partner and adopting a heterosexual identity (Birk, 1974; Larson, 1970). Some of these individuals reported heterosexual experience prior to treatment. People whose sexual attractions were initially limited to people of the same sex report much lower increases (if any) in other-sex attractions compared to those who report initial attractions to both men and women (Barlow et al., 1975). However, the low degree of scientific rigor in these studies makes any conclusion tentative.

Recent research indicates that former participants in SOCE report diverse evaluations of their experiences. Some individuals perceive that they have benefited from SOCE, while other individuals perceive that they have been harmed by SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from SOCE from those who will later perceive that they have failed or been harmed.

Some individuals who participated in the early research reported negative side effects such as loss of sexual arousal, impotence, depression, anxiety, and relationship dysfunction. Individuals who participated in recent research and who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Overall, those in this recent research who indicated that they were harmed reported feelings of distress, anxiety, depression, suicidal ideation, self-blame, guilt, and loss of hope among other negative feelings. Some who experienced religious interventions and perceived them negatively said that they felt disillusioned with religion; others felt they had failed their religion by having same-sex attraction (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Indirect harm from the associated costs (time, effort, money, disillusionment with psychotherapy) spent in ineffective treatment is significant. Both the early and recent research provide little clarity on the associations between claims to modify sexual orientation from same-sex to other-sex and subsequent improvements or harm to mental health.

Other individuals reported that they perceived SOCE to be helpful by providing a place to discuss

their conflicts, reduce isolation, and receive support (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001, 2006). Some reported that SOCE helped them view their sexual orientation in a different light that permitted them to live in a manner consistent with their faith, which they perceived as positive (Nicolosi et al., 2000). Some individuals described finding a sense of support and community through SOCE and valued having others with whom they could identify (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001). These effects mirror those provided by mutual support groups for a range of problems. And the positive benefits reported by participants in SOCE, such as reduction of isolation, change of meaning, and stress reduction, are consistent with the findings of social support literature (Levine et al., 2004). Given the findings of limited efficacy of change of sexual orientation, it is unlikely that SOCE provides any unique benefits other than those documented for the social support mechanisms of mutual help groups. For those who had received psychotherapy, the positive perceptions of SOCE seem inconsistent with the documented effects of the supportive function of psychotherapy relationships (e.g., Norcross, 2002).

Literature on Children and Adolescents

The task force was asked to report on the following: (a) the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change; (b) the presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation; and (c) recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.

We reviewed the limited research on child and adolescent issues and drew the following conclusions: There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation (R. Green, 1986,

1987; Zucker, 2008; Zucker & Bradley, 1995). There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation (Mathy & Drescher, 2008). We are concerned that such interventions may increase the self-stigma, minority stress, and ultimately the distress of children and adolescents. We have serious concerns that the coercive or involuntary treatment of children or adolescents has the potential to be harmful and may potentially violate current clinical and practice guidelines, standards for ethical practice, and human rights.

Recommendations and Future Directions

Affirmative Psychotherapy With Adults

The appropriate application of affirmative therapeutic interventions with adults is built on three key findings in the research: (a) an enduring change to an individual's sexual orientation as a result of SOCE was unlikely, and some participants were harmed by the interventions; (b) for some individuals, sexual orientation identity, not sexual orientation, shifted and evolved via psychotherapy, support groups, or life events; and (c) clients benefit from psychotherapeutic approaches that emphasize acceptance, support, and recognition of important values and concerns.

On the basis of these findings and the clinical literature on this population, we suggest client-centered, multiculturally competent approaches grounded in the following scientific facts: (a) same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders; (b) same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities; (c) gay men, lesbians, and bisexual individuals can live satisfying lives and form stable, committed relationships and families that are equivalent to those of heterosexual individuals in essential respects; and (d) no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma.

Based on these findings summarized above and our comprehensive review of the research and clinical literature, we developed a framework for the appropriate application of affirmative therapeutic

interventions for adults that has the following central elements:

- Acceptance and support
- A comprehensive assessment
- Active coping
- Social support
- Identity exploration and development

Acceptance and support include (a) unconditional positive regard for and empathy with the client, (b) openness to the client's perspective as a means of understanding his or her concerns, and (c) encouragement of the client's positive self-concept.

A comprehensive assessment considers sexual orientation uniquely individual and inseparable from an individual's personality and sense of self. This includes (a) being aware of the client's unique personal, social, and historical context and (b) exploring and countering the harmful impact of stigma and stereotypes on the client's self-concept (including the prejudice related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status).

Active coping strategies are efforts that include cognitive, behavioral, or emotional responses designed to change the nature of the stressor itself or how an individual perceives it and include both cognitive and emotional strategies. These may include cognitive strategies to reframe conflicts and emotional strategies to manage potential losses.

Psychotherapy, self-help groups, or welcoming communities (ethnic communities, social groups, religious denominations) provide social support that can mitigate distress caused by isolation, rejection, and lack of role models. Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE (Bartoli & Gillem, 2008; Beckstead & Morrow, 2004).

Identity exploration is an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity. LMHP facilitate this exploration by not having an a priori treatment goal for how clients identify or live out their sexual orientation. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction and reconstruction, and growth.

Treatments that are based on the assumption that homosexuality or same-sex sexual attractions are a mental disorder or based on inaccurate stereotypes regarding LGB people are to be avoided because they run counter to empirical data and because reports of harm suggest that such treatments can reinforce restricting stereotypes, increase internalized stigma, and limit a client's development (Beckstead & Morrow, 2004; Haldeman, 2001; Shidlo & Schroeder, 2002; G. Smith et al., 2004; see Lilienfeld, 2007, for information on psychotherapy harms).

Psychotherapy With Children and Adolescents

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change. Consistent with the current scientific evidence, those working with children and adolescents strive to have a developmentally appropriate perspective that includes a client-centered multicultural perspective to reduce self-stigma and mitigate minority stress. This includes interventions that (a) reduce stigma and isolation, (b) support the exploration and development of identity, (c) facilitate achievement of developmental milestones, and (d) respect age-appropriate issues regarding self-determination. Such services are ideally provided in the least restrictive setting and with, at a minimum, the assent of the youth. However, LMHP are encouraged to acquire developmentally appropriate informed consent to treatment.

Affirmative approaches encourage families to reduce rejection and increase acceptance of their child and adolescent (Perrin, 2002; Ryan et al., 2009). Parents who are concerned or distressed by their children's sexual orientation can be provided accurate information about sexual orientation and sexual orientation identity and offered anticipatory guidance and psychotherapy that supports family reconciliation (e.g., communication, understanding, and empathy) and maintenance of their child's total health and well-being. Interventions that increase family, school, and community acceptance and safety of sexual minority children and youth appear particularly helpful. Such interventions are offered in ways that are consistent with aspects of diversity such as age, gender, gender identity, race, ethnicity, culture,

national origin, religion, sexual orientation, disability, language, and socioeconomic status.

Special Concerns of Religious Individuals and Families

Many religious sexual minorities experience significant psychological distress and conflict due to the divergence between their sexual orientation and religious beliefs. To support clients who have these concerns, LMHP can provide psychological acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. LMHP working with religious individuals and families can incorporate research from

The goal of treatment is for the client to explore possible life paths that address the reality of his or her sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life.

the psychology of religion into the client-centered multicultural framework summarized previously. The goal of treatment is for the client

to explore possible life paths that address the reality of his or her sexual orientation while considering the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives (e.g., Pargament & Maloney, 2005). Such an approach would focus on increasing positive religious coping, understanding religious motivations, integrating religious and sexual orientation identities, and reframing sexual orientation identities to reduce or eliminate self-stigma.

Ethical Considerations

LMHP strive to provide interventions that benefit clients and avoid harm, consistent with current professional ethics. Psychologists aspire to provide treatment that is consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) with a special focus on ethical principles such as Beneficence and Nonmaleficence; Justice; and Respect for People's Rights and Dignity (including self-determination). LMHP reduce potential harms and increase potential benefits by basing their professional judgments

and actions on the most current and valid scientific evidence, such as that provided in this report (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgments).

LMHP enhance principles of social justice when they strive to understand and mitigate the effects of sexual stigma, prejudice, and discrimination on the lives of individuals, families, and communities. Further, LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.

Self-determination is the process by which a person controls or determines the course of her or his own life (*Oxford American Dictionary*, 2007). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client herself or himself to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. We were not persuaded by some accounts that suggest that providing SOCE increases self-determination, because these suggestions encourage LMHP to offer treatment that (a) has not

... therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

provided evidence of efficacy; (b) has the potential to be harmful; and (c) delegates important professional decisions that should be based on qualified

expertise and training—such as diagnosis and the type of intervention. Rather, therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

Education, Training, and Research

We were asked to provide recommendations for education, training, and research as they pertain to such affirmative interventions. We examine these areas separately.

EDUCATION AND TRAINING

Professional education and training

Training of LMHP to provide affirmative, evidence-based, and multicultural interventions with individuals

distressed by their same-sex sexual attractions is critical. Research on LMHP behaviors indicates a range of interventions, some of which are based on attitudes and beliefs rather than evidence, especially as some LMHP may have been educated during the period when homosexuality was pathologized (cf. Bartlett et al., 2001; Beutler, 2000; M. King et al., 2004; Liszcz & Yarhouse, 2005). We recommend that LMHP increase their awareness of their own assumptions and attitudes toward sexual minorities (APA, 2000; R. L. Worthington et al., 2005). This occurs by increasing knowledge about the diversity of sexual minorities (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status), as well as the management of the LMHP's own biases in order to avoid colluding with clients' internalized stigma and with the negating environments in which clients and LMHP live (APA, 2000; Dillon et al., 2004; Israel & Hackett, 2004; R. L. Worthington et al., 2005). We recommend that training in affirmative, evidence-based, and multiculturally informed interventions for sexual minorities be offered at all graduate schools and postgraduate training programs.

An important resource for LMHP is the APA (2000) *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients*,⁷⁰ which advises LMHP to be competent in a variety of domains, including knowledge of the impact of stigma on mental health, the unique issues facing same-sex relationships and families, and the range of diversity concerns for sexual minority individuals. We recommend that several areas in which LMHP working with clients seeking SOCE obtain additional knowledge and skills include: (a) sexuality, sexual orientation, and sexual identity development; (b) the psychology of religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion; (c) identity development models, including those that integrate multiple identities and facilitate identity conflict resolution; and (d) adaptive ways to manage stigma, minority stress, and multiple aspects of identity. We also recommend that practitioners review publications that explicate the above-mentioned topics and evidence-based, LGB-affirmative, and multicultural approaches to psychological interventions (APA, 2000, 2002a, 2002c, 2004, 2005b, 2006, 2007b, 2008a; Bartoli & Gillem, 2008; Brown, 2006; Fowers & Davidov, 2006; Schneider et al., 2002).

⁷⁰ These guidelines are being revised, and a new version will be available in 2010.

Those less familiar with religious perspectives can broaden their views on religion and religious individuals and reduce their potential biases by seeking relevant information on religious faith and the psychology of religion (e.g., Ano & Vasconcelles, 2005; Exline, 2002; Emmons, 1999; Emmons & Paloutzian, 2003; Fowler, 2001; Goldstein, 2007; Pargament & Mahoney, 2005; Pargament et al., 1998, 2005). Training programs for practitioners can increase competencies in these areas by including comprehensive material on religion and spirituality (Bartoli, 2007; Hage, 2006; Hathaway et al., 2004; Yarhouse & Fisher, 2002; Yarhouse & VanOrman, 1999) and on ways to incorporate religious approaches into psychotherapy (see, e.g., Richards & Bergin, 2000, 2004; Sperry & Shafranske, 2004). Additionally, publications that illustrate affirmative integration and resolution of religious and sexual minority identity are helpful (Astramovich, 2003; Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Ritter & O'Neil, 1989, 1995).

Conservative religious practitioners can increase their compassionate and understanding responses to sexual minorities. Some focus on increasing compassionate responses toward sexual minorities by conservative religious students or individuals (Bassett et al., 2005; Benoit, 2005; Fischer & DeBord, 2007; McMinn, 2005; Yarhouse, Burkett, & Kreeft, 2001; Zahniser & Boyd, 2008; Zahniser & Cagle, 2007). One study found an evolution of positive attitudes toward sexual minorities among LMHP who hold conservative religious values (E. Adams, Longoria, Hitter, & Savage, 2009). These perspectives are based on established social psychology research, such as the contact hypothesis, where increasing personal contact with members of minority groups of equal status reduces bias, including attitudes toward sexual minorities (e.g., Herek & Capitanio, 1996; Herek & Glunt, 1993; Pew Forum on Religion and Public Life, 2003).

Finally, although this report has limited information regarding sexual minorities in other countries, the research review and practice recommendations may be helpful to professionals. We recommend dissemination of this report to international mental health organizations and LGBT advocacy groups.

We recommend the following steps be taken by the APA to educate LMHP and support training programs in providing education:

1. Disseminate this report to accredited doctoral programs, internships, and other postdoctoral

programs in psychology both in the United States and other countries to encourage the incorporation of this report and other relevant material on LGBT issues into graduate school training programs and internship sites.

2. Disseminate information to faculty in psychology departments in community colleges, colleges, and university programs as information and for use in curriculum development.
3. Maintain the currently high standards for APA approval of continuing professional education providers and programs.
4. Offer symposia and continuing professional education workshops at APA's annual convention that focus on treatment of individuals distressed by their same-sex sexual attractions, especially those who struggle to integrate religious and spiritual beliefs with sexual orientation identity.
5. Pursue the publication of a version of this report in an appropriate journal or other publication.

Public education

The information available to the public about SOCE and sexual orientation is highly variable and can be confusing. In those information sources that encourage SOCE, the portrayals of homosexuality and sexual minorities tend to be negative and at times to emphasize inaccurate and misleading stereotypes (Kennedy & Cianciotto, 2006; SPLC, 2005). Sexual minorities, individuals aware of same-sex sexual attractions, families, parents, caregivers, policymakers, religious leaders, and society at large can benefit from accurate scientific information about sexual orientation and about appropriate interventions for individuals distressed by their same-sex sexual attractions both in the United States and internationally. We recommend that APA:

1. Create informational materials for sexual minority individuals, families, parents, and other stakeholders on appropriate multiculturally competent and client-centered interventions for those distressed by their sexual orientation who may seek SOCE.
2. Create informational materials on sexual orientation, sexual orientation identity, and religion for all stakeholders, including the public and institutions of faith.
3. Create informational materials focused on the integration of ethnic, racial, national origin and

cultural issues, and sexual orientation and sexual orientation identity.

4. Integrate the conclusions of this report into existing APA public information resources, including print, media, and the Internet.
5. Collaborate with other relevant organizations, especially religious organizations, to disseminate this information.

RESEARCH

Our systematic review of research has highlighted the methodological problems pervasive in recent research on SOCE. This raises two issues: (a) the publication of poorly designed research and (b) whether more research on SOCE should be conducted to pursue questions of benefit, harm, and safety. These two issues are addressed separately.

Much of the recent research on SOCE has had serious methodological problems. Although this research area presents serious challenges (e.g., obtaining a representative sample, finding appropriate measures, and using evidence-based constructs), many of the problems were avoidable. Problems included (a) inappropriate use of statistical tests, (b) poor measurement, and (c) designs that did not permit valid causal conclusions to be drawn.

Hunt and Carlson (2007) have argued that studies with immediate social relevance that have an impact on social policy or social issues should be held to a higher standard because this literature has the potential to influence policymakers and the public, and incomplete or misleading information has serious costs. Research published on SOCE needs to meet current best-practice research standards. Many of the problems in published SOCE research indicate the need for improvement in the journal review process. It is recommended that professional and scientific journals retain reviewers and editors with expertise in this area to maintain the standards of published research.

We concluded that research on SOCE (psychotherapy, mutual self-help groups, religious techniques) has not answered basic questions of whether it is safe or effective and for whom. Any future research should conform to best-practice standards for the design of efficacy research. Additionally, research into harm and safety is essential. Certain key issues are worth highlighting. Future research must use methods that are prospective and longitudinal, allow for conclusions about

cause and effect to be confidently drawn, and employ sampling methods that allow proper generalization.⁷¹

Future research should also include appropriate measures in terms of specificity of measurement of sexual orientation, sexual orientation identity and outcomes, and psychometric adequacy. Mixed-method research, in which methods and measures with offsetting weaknesses are simultaneously employed, may be especially advantageous. Alternative physiological means of measuring sexual orientation objectively may also be helpful. Recent research has used alternatives to genital gauges for the assessment of sexual orientation in men and women, such as functional magnetic resonance imaging (Ponseti et al., 2006). Physiological measures often use visual portrayals of nude individuals that some religious individuals may find morally unacceptable. Jlang, Costello, Fang, Huang, and He (2006) have explored the use of invisible images and have measured selective inattention/attention as an alternative to assess sexual arousal. Such methods or the development of methods that are less intrusive and are more consistent with religious values would be helpful to develop for this population.

Additionally, preexisting and co-occurring conditions, mental health problems, participants' need for monitoring self-impression, other interventions, and life histories would have to be given appropriate consideration so that research can better account for and test competing explanations for any changes observed in study participants over time. Specific conceptual and methodological challenges exist in research related to sexual minority populations, such as the conceptualization of sexual orientation and sexual orientation identity and obtaining representative samples. Researchers would be advised to consider and compensate for the unique conceptual and

⁷¹ A published study that appeared in the grey literature in 2007 (S. L. Jones & Yarhouse, 2007) has been described by SOCE advocates and its authors as having successfully addressed many of the methodological problems that affect other recent studies, specifically the lack of prospective research. The study is a convenience sample of self-referred populations from religious self-help groups. The authors claim to have found a positive effect for some study respondents in different goals such as decreasing same-sex sexual attractions, increasing other-sex attractions, and maintaining celibacy. However, upon close examination, the methodological problems described in Chapter 3 (our critique of recent studies) are characteristic of this work, most notably the absence of a control or comparison group and the threats to internal, external, construct, and statistical validity. Best-practice analytical techniques were not performed in the study, and there are significant deficiencies in the analysis of longitudinal data, use of statistical measures, and choice of assessment measures. The authors' claim of finding change in sexual orientation is unpersuasive due to their study's methodological problems.

methodological challenges in this area (Meyer & Wilson, 2009; Moradi, Mohr, Worthington, Fassinger, 2009).

Safety issues continue to be important areas of study. As noted previously, early research indicates that aversive techniques have been found to have very limited benefits as well as potentially harmful effects. These documented harms were serious. An additional finding is that these treatments had extremely high dropout rates, which has been linked to adverse effects. Some individuals report harm from recent nonaversive techniques, and some individuals report benefits.

Some authors have stated that SOCE should not be investigated or practiced until safety issues have been resolved (Davison, 1976, 1991; Herek, 2003), as it is still unclear which techniques or methods may or may not be harmful. Assessing the safety of recent practices is a high priority given that this research is the least rigorous. Given that types of harm can be multiple, outcome studies with measures capable of assessing deterioration in mental health, appearance of new symptoms, heightened concern regarding existing symptoms, excessive dependency on the LMHP, and reluctance to seek out new treatment are important to include in future research (Lilienfeld, 2007). Other areas to assess are types of harm to others (e.g., some individuals have noted that advocating other-sex marriage or promising sexual orientation change may negatively affect spouses, potential spouses, and children) (Buxton, 1994, 2007; Wolkomir, 2006).

Finally, LMHP must be mindful of the indirect harms of SOCE, such as the “opportunity costs” (Lilienfeld, 2007) and the time, energy, effort, and expense of interventions that offer limited benefit and have the potential to cause disillusionment in psychotherapy. However, as concerns regarding harm have been raised, addressing risks to research participants and concerns regarding voluntary participation (see Standard 8.02 in APA, 2002b) must be carefully considered in any future research.

Research that meets these scientific standards and addresses efficacy and safety might help to clarify the issues. Even so, scientific research may not help to resolve the issues unless it can better account for the complexity of the concerns of the current population. The results of current research are complicated by the belief system of many of the participants whose religious faith and beliefs may be intricately tied to the possibility of change. Future research will have to better account for the motivations and beliefs of participants in SOCE.

Emerging research reveals that affirmative interventions show promise for alleviating the distress

of children, adolescents, and families around sexual orientation and identity concerns (D’Augelli, 2002, 2003; Goodenow et al., 2006; Perrin, 2002; C. Ryan et al., 2009). However, sexual minority adolescents are underrepresented in research on evidence-based approaches, and sexual orientation issues in children are virtually unexamined (APA, 2008d). Specific research on sexual minority adolescents and children has identified that stigma can be reduced through community interventions, supportive client-centered approaches, and family reconciliation techniques that focus on strengthening the emotional ties of family members to each other, reducing rejection, and increasing acceptance (D’Augelli, 2003; Goodenow et al., 2006; C. Ryan et al., 2009). This line of research should be continued and expanded to include conservatively religious youth and their families.

Finally, we presented a framework for therapy with this population. Although this model is based on accepted principles of psychotherapy and is consistent with evidence-based approaches to psychotherapy, it has not been evaluated for safety and efficacy. Such studies would have to be conducted in the same manner as research on SOCE and in ways that are consistent with current standards (see, e.g., Flay et al., 2005).

Recommendations for basic research

To advance knowledge in the field and improve the lives of individuals distressed by same-sex sexual attractions who seek SOCE, it is recommended that researchers, research-funding organizations, and other stakeholders, including those who establish funding priorities, work together to improve our knowledge of sexuality, sexual orientation, and sexual orientation identity in the following areas:

1. The nature and development of sexuality, sexual orientation, sexual orientation identity across the life span and the correlates to these variables, incorporating differences across age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
2. Religious identity and faith development (inclusive of all world religions) and their intersection with other aspects of human life and identity, such as sexual orientation, sexual orientation identity, and the multiple social identity statuses related to privilege and stigma.

3. Identity integration, reduction in distress, and positive mental health for populations of religious sexual minorities and ethnic minority populations.
4. Culture, gender, religion, and race/ethnicity in the experience and construction of sexual orientation and sexual orientation identity.
5. Mental health outcomes of those who choose not to act on their sexual orientation by living celibately or in relationships with other-sex partners.

Recommendations for research in psychotherapy

We recommend that researchers and practitioners rigorously investigate multiculturally competent and affirmative evidence-based treatments for sexual minorities and those distressed by their sexual orientation that do not aim to alter sexual orientation but rather focus on sexual orientation identity exploration, development, and integration without prioritizing one outcome over another, for the following populations:

1. Sexual minorities who have traditional religious beliefs
2. Sexual minorities who are members of ethnic minority and culturally diverse communities both in the United States and internationally
3. Children and adolescents who are sexual minorities or questioning their sexual orientation
4. Parents who are distressed by their children's perceived future sexual orientation
5. Populations with any combination of the above demographics

Policy

We were asked to make recommendations to APA to inform the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and to support public policy that furthers affirmative therapeutic interventions.

The debate surrounding SOCE has become mired in ideological disputes and competing political agendas (Drescher, 2003; Drescher & Zucker, 2006). Some organizations opposing civil rights for LGBT individuals advocate SOCE (SPLC, 2005). Other policy concerns involve religious or socially conservative agendas where issues of religious morality conflict with scientific-based conceptions of positive and healthy

development. We encourage APA to continue its advocacy for lesbian, gay, bisexual, and transgender individuals and families and to oppose prejudice against sexual minorities (APA, 2003, 2005, 2006, 2008b). We encourage collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles. These collaborative relationships can be designed to integrate humanitarian perspectives and professional expertise (Tyler, Pargament, & Gatz, 1983).

Thus, the task force urges APA to:

1. Actively oppose the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and take a leadership role in responding to such distortions.
2. Support the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based on lack of scientific knowledge about sexual orientation.
3. Encourage advocacy groups, elected officials, policymakers, religious leaders, and other organizations to seek accurate information and avoid promulgating inaccurate information about sexual minorities.
4. Seek areas where collaboration with religious leaders, institutions, and organizations can promote the well-being of sexual minorities through the use of accurate scientific data regarding sexual orientation and sexual orientation identity.
5. Encourage the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns to prioritize initiatives that address religious and spiritual concerns and the concerns of sexual minorities from conservative faiths.
6. Adopt a new resolution: the Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (see Appendix A).⁷²

⁷² The resolution was adopted by the APA Council of Representatives in August 2009.

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APPENDIX A: RESOLUTION ON APPROPRIATE AFFIRMATIVE RESPONSES TO SEXUAL ORIENTATION DISTRESS AND CHANGE EFFORTS

Research Summary

The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation (Bell, Weinberg, & Hammersmith, 1981; Bullough, 1976; Ford & Beach 1951; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005).

APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of sexual orientation change efforts (SOCE).^{A1} SOCE has been controversial due to tensions between the values held by some faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other (Drescher, 2003; Drescher & Zucker, 2006).

Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be embedded within the larger context of conservative religious political movements that have supported the stigmatization of homosexuality on political or religious grounds (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 2005). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a, 2008c).

In response to these concerns, APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the association. The task force reached the following findings.

Recent studies of participants in SOCE identify a population of individuals who experience serious distress related to same-sex sexual attractions. Most of these participants are Caucasian males who report that their religion is extremely important to them (Beckstead & Morrow, 2004; Nicolosi, Byrd, & Potts,

^{A1} APA uses the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a same-sex sexual orientation to heterosexual, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Shidlo & Schroeder, 2002, Spitzer, 2003). These individuals report having pursued a variety of religious and secular efforts intended to help them change their sexual orientation. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals.

There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975) found that sexual orientation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose. Some individuals appeared to learn how to ignore or limit their attractions. However, this was much less likely to be true for people whose sexual attractions were initially limited to people of the same sex.

Although sound data on the safety of SOCE are extremely limited, some individuals reported being harmed by SOCE. Distress and depression were exacerbated. Belief in the hope of sexual orientation change followed by the failure of the treatment was identified as a significant cause of distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behavior, and values (Nicolosi et al., 2000). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Based on the available data, additional claims about the meaning of those outcomes are scientifically unsupported.

On the basis of the task force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent (Bartoli & Gillem, 2008; Brown, 2006) and client-centered approaches (e.g., Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Lasser & Gottlieb, 2004) that recognize the negative impact of social stigma on sexual minorities (Herek, 2009; Herek &

Garnets, 2007)^{A2} and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity (APA, 1998, 2002; Davison, 1976; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002).

Resolution

WHEREAS, The American Psychological Association expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005, 2006, 2008c);

WHEREAS, The American Psychological Association takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008c);

WHEREAS, Psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008c);

WHEREAS, Psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008c);

WHEREAS, Those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while

^{A2} We use the term *sexual minority* (cf. Blumenfeld, 1992; McCann & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of both their own and the other sex. This term is used because we recognize that not all sexual minority individuals adopt an LGB bisexual identity.

also recognizing they can appropriately speak to the theological implications of psychological science (APA, 2008c);

WHEREAS, The American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008c);

WHEREAS, Societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

WHEREAS, Some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968);

WHEREAS, Sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997) who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciatto & Cahill, 2006; Ryan & Futterman, 1997); and

WHEREAS, Research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hersherberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE, BE IT RESOLVED, That the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED, That the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren, & Prince, 2004; Norcross, 2002; Ryan & Futterman, 1997);

BE IT FURTHER RESOLVED, That the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles:

Bases for Scientific and Professional Judgments, Beneficence and Harm, Justice, and Respect for People's Rights and Dignity;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma and contribute to variations in sexual orientation identity development, expression, and experience;

BE IT FURTHER RESOLVED, That the American Psychological Association opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

BE IT FURTHER RESOLVED, That the American Psychological Association supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation; and

BE IT FURTHER RESOLVED, That the American Psychological Association encourages advocacy groups, elected officials, mental health professionals, policymakers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the well-being of sexual minorities.

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APPENDIX B: STUDIES INCLUDED ($N = 55$) IN THE SYSTEMATIC REVIEW (CHAPTERS 3 AND 4)

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Experimental studies							
McConaghy, 1969	40	100	Clinical (6 by court order; 18 with arrest history)	3 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversion apomorphine therapy and aversion relief therapy	Penile circumference
McConaghy, 1976	157	100	Clinical (21 by court order)	None reported	4 experimental substudies (<i>ns</i> = 40, 40, 46, 31, respectively) with random assignment to one of two or three treatment alternatives	Aversive apomorphine therapy or aversion-relief; aversive therapy or apomorphine or avoidance conditioning; classical, or avoidance, or backward conditioning; classical aversive therapy or positive conditioning	Sexual feelings; sexual behavior; penile circumference; sexual orientation
McConaghy & Barr, 1973	46	100	Clinical	26 had incomplete treatment exposure; 2 of 20 with complete exposure lost to follow-up	3 treatment group randomized experiment	Classical conditioning, avoidance conditioning, backward conditioning	Heart rate; penile circumference; galvanic skin response
McConaghy, Proctor, & Barr, 1972	40	100	Clinical (police and psychiatric referrals)	16 with incomplete follow-up data and 2 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversive apomorphine therapy; immediate and delayed anticipatory avoidance learning	Penile circumference
Tanner, 1974	16	100	Clinical	None reported	Random assignment experiment with wait list control	Aversive shock therapy	Penile circumference; sexual behavior; personality
Tanner, 1975	10	100	Clinical	None reported	2 treatment group randomized experiment	Aversive shock therapy with/without booster sessions	Penile circumference; self-reported arousal; sexual behavior; personality

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Quasi-experimental studies							
Birk, Huddleston, Miller, & Cohler, 1971	18	100	Clinical	2 withdrew participation	Nonequivalent 2 treatment group comparison design	Aversive shock therapy vs. associative conditioning	Sexual behavior; clinical judgment; personality
S. James, 1978	40	100	Court-referred	None reported	Nonequivalent 2 treatment group comparison design	Anticipatory avoidance, desensitization, hypnosis, anticipatory avoidance	Sexual orientation; personality
McConaghy, Armstrong, & Blaszczynski, 1981	20	100	Clinical	None reported	Nonequivalent 2 treatment group comparison design	Aversive therapy; covert sensitization	Sexual feelings
Nonexperimental studies							
Bancroft, 1969	16	100	Clinical	6 withdrew participation prior to treatment and 1 during treatment	Case study	Aversive shock therapy	Sexual behavior
Barlow & Agras, 1973	3	100	Clinical	None reported	Case study	Fading	Penile circumference; sexual urges; sexual fantasies
Barlow, Agras, Abel, Blanchard, & Young, 1975	3	100	Clinical	None reported	Single case pre-post within-subject	Biofeedback	Penile circumference
Beckstead & Morrow, 2004	50	80	Purposive	None	Qualitative retrospective, grounded theory	Conversion therapy, ex-gay ministries, and/or support groups	Subjective experiences of treatment; subjective appraisal of sexual orientation identity, attraction, & behavior
Birk, 1974	66	100	Clinical	13 withdrew participation	Pre-post within-subject	Psychotherapy	Sexual orientation
Blitch & Haynes, 1972	1	0	Clinical	None reported	Case study	Relaxation therapy and masturbation reconditioning	Sexual behavior
Callahan & Leitenberg, 1973	23	100	Clinical with 2 by court order	9 men withdrew participation and 8 excluded from data analyses	Pre-post within-subject	Aversion shock therapy and covert sensitization	Penile circumference
Colson, 1972	1	100	Clinical	None reported	Case study	Olfactory aversion therapy	Sexual behavior

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Conrad & Wincze, 1976	4	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior; sexual fantasies; penile circumference
Curtis & Presly, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual orientation
Feldman & MacCulloch, 1965	43	100	Clinical	7 withdrawals	Pre-post within-subject	Anticipatory avoidance	Sexual orientation
Fookes, 1960	27	100	Clinical (7 exhibitionists, 5 fetishists, and 15 bisexual and homosexual men)	None reported	Pre-post within-subject	Aversion shock therapy and calorie deprivation	Clinical judgment
Freeman & Meyer, 1975	9	100	Clinical	None reported	Pre-post within-subject	Aversion shock therapy and masturbation reconditioning	Sexual behavior; sexual orientation
Freund, 1960	67	100	Clinical	20 withdrawals	Pre-post within-subject	Aversion apomorphine therapy	Clinical judgment
Gray, 1970	1	100	Clinical	None reported	Case study	Desensitization and masturbation reconditioning	Sexual behavior
Hallam & Rachman, 1972	7	100	Clinical (2 pedophiles, 1 fetishist, 3 bisexual and homosexual men, and 1 voyeur)	None reported	Pre-post within-subject	Aversion shock therapy	Heart rate; galvanic skin response
Hanson & Adesso, 1972	1	100	Clinical	None reported	Case study	Desensitization and aversive counter-conditioning	Sexual behavior
Herman, Barlow, & Agras, 1974	4	100	Clinical	None reported	Case study	Counter-conditioning	Penile circumference; self-reported arousal
Herman & Prewett, 1974	1	100	Clinical	None reported	Case study	Biofeedback	Penile circumference
Huff, 1970	1	100	Clinical	None reported	Case study	Desensitization	Sexual behavior; personality
B. James, 1962	1	100	Clinical	Treatment stopped due to adverse reaction	Case study	Aversion apomorphine therapy	Sexual fantasies; sexual behavior
Kendrick & McCulloch, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual fantasies; sexual behavior
Larson, 1970	3	100	Clinical	None reported	Case study	Anticipatory avoidance	Sexual fantasies; sexual behavior
Levin, Hirsch, Shugar, & Kapche, 1968	1	100	Clinical	None reported	Case study	Desensitization, avoidance conditioning	Personality

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
LoPiccolo, 1971	1	100	Clinical	None reported	Case study	Desensitization	Masturbation fantasies
LoPiccolo, Stewart, & Watkins, 1972	1	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior
MacCulloch & Feldman, 1967	43	?	Clinical (18 by court order and 4 psychiatric referrals)	7 withdrawals	Pre-post within-subject	Anticipatory avoidance with aversion shock therapy	Sexual orientation; sexual behavior
MacCulloch, Feldman, & Pinshoff, 1965	4	100	Clinical (3 by court order)	1 withdrawal	Case study	Anticipatory avoidance with aversion shock therapy	Attractions; pulse rate
Marquis, 1970	14	79	Clinical	None reported	Case study	Orgasmic reconditioning	Clinical judgment
McCrady, 1973	1	100	Clinical	None reported	Case study	Forward fading	Sexual preference, sexual behavior
Mintz, 1966	10	100	Clinical	5 withdrawals	Case study	Therapy	Clinical judgment
Nicolosi, Byrd, & Potts, 2000	882	78	Convenience (NARTH and ex-gay ministry members)	None reported	Retrospective pretest	Conversion therapy	Sexual orientation; sexual behavior
Pattison & Pattison, 1980	11	100	Convenience	None reported; 19 declines to participate	Qualitative retrospective case study	Religious folk therapy	Subjective experience
Ponticelli, 1999	15	0	Purposive (ex-gay ministry)	None reported	Ethnography	Ex-gay ministry	None
Quinn, Harbison, & McAllister, 1970	1	100	Clinical	None reported	Case study	Desensitization and hydration deprivation	Penile circumference
Rehm & Rozensky, 1974	1	100	Clinical	None reported	Case study	Therapy and orgasmic reconditioning	Sexual behavior
Sandford, Tustin, & Priest, 1975	2	100%	Clinical	1 withdrawal reported	Case study	Differential reinforcement and punishment	Penile circumference
Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000	248	74	Convenience (Exodus International conference attendees)	None reported	Retrospective pretest	Varied counseling and conversion therapies	Sexual behavior; sexual feelings; sexual orientation identity
Schroeder & Shidlo, 2001	150	91	Convenience	None reported	Qualitative retrospective case study	Varied, including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Perceived harmfulness or helpfulness of SOCE

Study	N	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
Segal & Sims, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Self-report of continued need for treatment
Shidlo & Schroeder, 2002	202	90	Convenience	None reported	Qualitative retrospective case study	Varied including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Sexual orientation; sexual orientation identity
Solyom & Miller, 1965	6	100	Clinical	None reported	Case study	Aversive shock therapy	Galvanic skin responses; penile circumference
Spitzer, 2003	200	71	Convenience (Ex-gay ministry members)	None reported; 74 not eligible	Retrospective pretest	Varied including ex-gay and religious support groups and therapy.	Sexual attraction; sexual orientation identity; sexual behavior;
Thorpe, Schmidt, & Castell, 1963	1	100	Clinical	None reported	Case study	Classical conditioning	Sexual fantasy; ability to orgasm in response to female stimuli
Thorpe, Schmidt, Brown, & Castell, 1964	8	75	Clinical (referred for variety of mental health concerns)	2 withdrawals	Case study	Aversion relief	Anxiety; personality
Wolkomir, 2001	n/a		Purposive	None reported	Ethnography	2 Bible study support groups	Subjective experience

No. 19-14387

**IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

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,

Plaintiffs–Appellees,

v.

CITY OF TAMPA, FLORIDA,

Defendant–Appellant

On Appeal from the United States District Court
for the Middle District of Florida
in Case No. 8:17-cv-02896-T-02AAS before the Honorable William F. Jung

**PLAINTIFFS-APPELLEES’ SUPPLEMENTAL APPENDIX
VOLUME III**

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VAZZO, etc., et al. v. CITY OF TAMPA, FLORIDA

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**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION**

**ROBERT L. VAZZO,
DAVID H. PICKUP, SOLI DEO
GLORIA INTERNATIONAL, INC.
d/b/a NEW HEARTS OUTREACH
TAMPA BAY**

Plaintiffs,

v.

Case No. 8:17-cv-2896-T-02AAS

CITY OF TAMPA,

Defendant,

_____ /

REPORT AND RECOMMENDATION

The plaintiffs—Robert Vazzo, David Pickup, and New Hearts Outreach—move for a preliminary injunction enjoining the City of Tampa from enforcing Ordinance 2017-47. (Docs. 85, 145). The City and amicus Equality Florida oppose the plaintiffs’ motion. (Docs. 98, 99, 142, 143). The plaintiffs’ motion for a preliminary injunction focuses on two of the eight claims in their first amended complaint: their free-speech claims under the First Amendment (Count I) and their claim that the City lacked the authority to enact Ordinance 2017-47 under the Florida Constitution (Count VI). (Docs. 85, 145).

The plaintiffs failed to establish a substantial likelihood of success on the merits of their claim that the City lacked the authority to enact Ordinance 2017-47

(Count VI). But the plaintiffs established a substantial likelihood of success on the merits of their free-speech claims under the First Amendment (Count I). The plaintiffs also established they will suffer irreparable injury if the court enters no injunction; the threatened injury to the plaintiffs outweighs the damage a limited injunction would cause the City; and a limited injunction against enforcing Ordinance 2017-47's ban against non-coercive, non-aversive SOCE counseling—that consists entirely of speech or “talk therapy”—is in the public interest. Therefore, the plaintiffs' motion for a preliminary injunction should be **GRANTED-IN-PART** and **DENIED-IN-PART**.

I. GENERAL BACKGROUND

The plaintiffs move to enjoin the enforcement of Ordinance 2017-47, which prohibits mental health professionals from practicing conversion therapy on minors. (Doc. 85, Doc. 24-1). The ordinance defines conversion therapy to include counseling or treatment aimed at changing an individual's sexual orientation or gender identity. (Doc. 24-1, p. 6). Conversion therapy, under the ordinance, also includes counseling an individual with the goal of eliminating or reducing “sexual or romantic attractions or feelings toward individuals of the same gender or sex.” (*Id.*).

Messrs. Vazzo and Pickup are licensed marriage and family therapists¹ whose practices include providing sexual-orientation-change-efforts (SOCE) counseling.

¹ Mr. Vazzo is licensed to practice mental health counseling in Florida. (Doc. 78, ¶14). Mr. Pickup is not licensed in Florida, but he is in the process of obtaining his Florida license. (*Id.* at ¶15).

(Doc. 78, ¶¶14–15, 102, 116). According to the plaintiffs, SOCE counseling helps clients, including minors, “reduce or eliminate same-sex sexual attractions, behaviors or identity.” (*Id.* at ¶60). During SOCE counseling, Messrs. Vazzo and Pickup use speech to help their clients “understand and identify their anxiety or confusion regarding their attractions, or identity and then help the client formulate the method of counseling that will most benefit that particular client.” (*Id.* at ¶65).

According to the plaintiffs, clients, including minors, initiate SOCE counseling by giving their informed consent. (*Id.* at ¶8). The plaintiffs allege some clients request SOCE counseling to “address the conflicts between their sincerely held religious beliefs and goals to reduce or eliminate their unwanted same-sex attractions, behaviors, or identity.” (Doc. 78, ¶9).

New Hearts Outreach is a Christian ministry in Tampa. (*Id.* at ¶¶16, 126). Part of its ministry is to refer individuals, including minors, “struggling with unwanted same-sex attractions, behaviors, and identity” to mental health professionals to receive SOCE counseling. (*Id.* at ¶¶132–34).

Messrs. Vazzo and Pickup cannot provide SOCE counseling to minors in Tampa under Ordinance 2017-47. (*Id.* at ¶¶112, 116). Nor can New Heart Outreach refer minors to Messrs Vazzo and Pickup for SOCE counseling in Tampa. (*Id.* at ¶135). If Messrs Vazzo and Pickup provided SOCE counseling to minors in Tampa, they would be subject to penalties of a \$1,000 fine for the first violation and a \$5,000 fine for each following violation. (Doc. 24-1, p. 7).

The plaintiffs sued the City and allege Ordinance 2017-47 violates their federal and state constitutional rights. (Doc. 78). Most relevant to their motion for preliminary injunction, the plaintiffs allege Ordinance 2017-47 violates their right to freedom of speech under the First Amendment (Count I). (*Id.* at ¶¶177–96). The plaintiffs also allege Ordinance 2017-47 violates the Florida Constitution because the state legislature preempted the field of regulating mental health professionals (Count VI). (*Id.* at ¶¶262–75).

Before turning to the substance of the plaintiffs’ motion for a preliminary injunction, the undersigned will provide the procedural background leading to this point of the litigation.

II. PROCEDURAL BACKGROUND

The City adopted Ordinance 2017-47 on April 6, 2017, and the mayor approved the ordinance four days later. (Doc. 24-1, p. 8). The plaintiffs began this lawsuit against the City on December 4, 2017. (Doc. 1). At the same time they filed their complaint, the plaintiffs moved for a preliminary injunction enjoining the City’s enforcement of Ordinance 2017-47. (Doc. 3).

After moving for an extension of time, which the undersigned granted, the City moved to dismiss the plaintiffs’ original complaint on January 12, 2018. (Docs. 19, 22). The city also submitted its response to the plaintiffs’ motion for preliminary injunction on January 12th. (Doc. 23). The plaintiffs moved to submit a consolidated response that would include a response to the City’s motion to dismiss and a reply in

further support of their motion for preliminary injunction. (Doc. 37). The undersigned allowed the plaintiffs to submit a consolidated response, which the plaintiffs submitted on January 29, 2018, after asking for a one-day extension. (Docs. 39, 41, 43).

Between January and March 2018, the plaintiffs and Equality Florida—a civil-rights organization that helped draft Ordinance 2017-47—argued over whether the court should allow Equality Florida to intervene. (Docs. 30, 42, 45, 50). The plaintiffs and the City also argued over whether the court should allow the City to file DVDs and other documents of the legislative proceedings for Ordinance 2017-47. (Docs. 27, 44). On March 15, 2018, the undersigned granted the City’s motion to file its DVDs and other documents. (Doc. 51). That same day, the undersigned issued a report that recommended allowing Equality Florida to participate in this litigation as *amicus curiae*. (Doc. 52). After the parties’ two-week period to object to the undersigned’s March 15th report and recommendation, the court adopted the undersigned’s report and recommendation. (Doc. 60).

The plaintiffs and the City then jointly moved to stay discovery pending the court’s ruling on the plaintiffs’ motion for preliminary injunction and the City’s motion to dismiss. (Doc. 49). The court denied the parties’ motion to stay discovery. (Doc. 61). In the meantime, the undersigned scheduled a hearing on the plaintiffs’ motion for preliminary injunction and the City’s motion to dismiss. (Doc. 59). The undersigned scheduled the hearing for June 7, 2018, despite providing the parties

multiple dates in April because, according to the parties and Equality Florida, June 7th was the earliest date available for all parties. (Doc. 59, p. 2 n.2).

On May 25, 2018—less than two weeks before the scheduled hearing on the plaintiffs’ motion for preliminary injunction and the City’s motion to dismiss—the plaintiffs moved to amend their complaint. (Doc. 71). As a result, the undersigned cancelled the June 7th hearing. (Doc. 72). The court granted the plaintiffs’ motion to submit an amended complaint and denied as moot the plaintiffs’ original motion for preliminary injunction and the City’s motion to dismiss. (Docs. 76, 79, 80).

The plaintiffs submitted their first amended complaint, the operative complaint, on June 12, 2018. (Doc. 78). The plaintiffs also submitted their current motion for preliminary injunction on June 26th—the same day the City moved to dismiss the plaintiffs’ first amended complaint. (Docs. 84, 85).

Following the parties’ joint request, the undersigned adopted the parties’ proposed briefing schedule. (Doc. 88). Under that schedule, the last briefing concerning the plaintiffs’ motion for preliminary injunction and the City’s motion to dismiss was due August 10, 2018. (Doc. 87, p. 2). At the same time the undersigned adopted the parties’ briefing schedule, the undersigned provided the parties multiple dates in August and September to hold the hearing on the motions. (Doc. 88, p. 2). The parties could not choose from the dates provided, so the undersigned provided dates in October to hold the hearing. (Doc. 94).

The parties eventually agreed to hold the hearing on October 10, 2018, which

the undersigned then scheduled. (Docs. 97, 99). But the parties then had discovery disputes, which resulted in the October 10th hearing being rescheduled to November 15, 2018. (Docs. 106, 111, 118, 119, 121, 125, 128, 130).

On November 15th, the undersigned finally held the hearing on the plaintiffs' motion for preliminary injunction and the City's motion to dismiss. (Doc. 136). At the conclusion of the hearing, the undersigned allowed the parties and Equality Florida to submit supplemental briefs by December 3, 2018, which they did. (Docs. 142, 143, 145). Undisputedly, the plaintiffs' motion for a preliminary injunction is fully ripe for the court's determination.

III. LEGAL STANDARD

A party moving for a preliminary injunction must establish (1) the party has a likelihood of success on the merits; (2) the party will suffer irreparable injury if the court issues no injunction; (3) the threatened injury to the moving party outweighs whatever damage the injunction may cause the opposing party; and (4) the injunction is in the public interest. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (citations omitted); *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (citations omitted). The burden is on the moving party to clearly establish that all four factors for a preliminary injunction are met. *Siegel*, 234 F.3d at 1176 (citations omitted).²

² The Eleventh Circuit requires the party moving for a preliminary injunction to satisfy all four factors. *Siegel*, 234 F.3d at 1176 (citations omitted). A question exists whether the Supreme Court requires all four factors to be met. *See Winter*, 555 U.S.

A preliminary injunction is an extraordinary remedy. *Winter*, 555 U.S. at 24 (citation omitted). When a court enjoins a municipal ordinance, “the court overrules the decision of the elected representatives of the people and, thus, in a sense interferes with the processes of democratic government.” *Ne. Fla. Chapter of Ass’n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990). As a result, courts must grant preliminary injunctions against municipal ordinances only if an injunction “is definitely demanded by the Constitution and by the other strict legal and equitable principles that restrain courts.” *Id.* Courts must particularly consider the public consequences of issuing a preliminary injunction. *Winter*, 555 U.S. at 24.

The plaintiffs focused only on their free-speech claims under the First Amendment (Count I) and their claim that the City lacked authority to enact Ordinance 2017-47 under the Florida Constitution (Count VI) in their briefing in support of their motion for a preliminary injunction and at the November 15th hearing. Therefore, the undersigned will focus on those claims only and will not analyze the merits of issuing an injunction based on the plaintiffs’ other six claims.

The undersigned’s analysis will begin with determining whether the plaintiffs established a likelihood of success on the merits on their preemption and First

at 391–92 (Ginsburg, J., dissenting) (stating that preliminary-injunction analyses require a sliding-scale approach, which *Winter* did not reject). In this case, whether the court adopts the Eleventh Circuit’s approach or a sliding-scale approach, the plaintiffs meet all four factors on their free-speech claim under the First Amendment.

Amendment claims. The undersigned will then turn to whether the plaintiffs satisfied the other requirements for a preliminary injunction

IV. ANALYSIS

A. Likelihood of Success on the Merits

1. Count VI: The Plaintiffs' Claim that the City Lacked Authority to Enact Ordinance 2017-47

In their briefing and oral arguments concerning Count VI of the amended complaint, in which the plaintiffs allege the City lacked authority under the Florida Constitution to enact Ordinance 2017-47, the plaintiffs argue three theories: the Florida Legislature expressly preempted the area of regulating mental health professionals; the Florida Legislature impliedly preempted the area of regulating mental health professionals; and Ordinance 2017-47 conflicts with Florida law governing mental health professionals. (Docs. 85, 114, 145). The undersigned will address each argument, beginning with the plaintiffs' conflict-of-laws argument.

a. Conflict-of-Laws Argument

Although missing from Count VI of their amended complaint, the plaintiffs argue they are likely to succeed on a claim that Ordinance 2017-47 conflicts with Chapter 491, Florida Statutes, which governs "Clinical, Counseling, and Psychotherapy Services." (Doc. 85, pp. 23–24). The plaintiffs argue the ordinance conflicts with Chapter 491 because it imposes additional fees and penalties on conduct—in this case, SOCE counseling—legal in other parts of Florida. (*Id.* at 23).

The plaintiffs failed to allege a conflict-of-laws claim in their first amended

complaint. Their claim under Article VIII, Section 2(b) of the Florida Constitution focuses exclusively on preemption. (See Doc. 78, ¶¶262–75) (alleging Chapter 491, Florida Statutes, preempts regulation of mental health professionals). In fact, the plaintiffs only use the word “conflict” to describe the alleged conflict between clients’ “unwanted same sex attractions, behaviors, or identity,” clients’ religious beliefs and Ordinance 2017-47. (*Id.* at ¶¶4, 9, 45, 79, 97–99, 208, 211, 213, 246, 249, 251, 296, 299). The plaintiffs cannot establish a likelihood of success on a claim they failed to plead in their amended complaint. A preliminary injunction based on a conflict-of-law claim—which the plaintiffs never alleged—is therefore inappropriate.

b. Express-Preemption Claim

The plaintiffs allege Ordinance 2017-47 violates Article VIII, Section 2(b) of the Florida Constitution because the City had no authority to adopt a law in a field preempted by the Florida Legislature—in this case, the field of regulating mental health professionals. (*Id.* at ¶¶262–75).

Article VIII, Section 2(b) of the Florida Constitution states the following:

POWERS. Municipalities shall have governmental, corporate and proprietary powers to enable them to conduct municipal government, perform municipal functions and render municipal services, and may exercise any power for municipal purposes except as otherwise provided by law. Each municipal legislative body shall be elective.

A city ordinance may be beyond the city’s authority under the Florida Constitution if the legislature preempted a particular subject area. *Sarasota Alliance For Fair Elections, Inc. v. Browning*, 28 So. 3d 880, 885–86 (Fla. 2010) (citation

omitted); *Orange Cty. v. Singh*, No. SC18-79, ___ So. 3d ___, 2019 WL 98251, at *3 (Fla. Jan. 4, 2019) (citations omitted).³

The Florida Legislature can preempt an area of law in two ways: express or implied preemption. *Sarasota Alliance*, 28 So. 3d at 886. Express preemption requires a specific legislative statement—courts cannot imply or infer express preemption. *Id.* (citations omitted). The Florida Legislature accomplishes express preemption when the legislature uses clear language stating its intent. *Id.* (citation omitted).

Finding express preemption “is a very high threshold to meet.” *D’Agastino v. City of Miami*, 220 So. 3d 410, 422 (Fla. 2017) (citations omitted). If a preemption claim requires inferences, that claim fails the test for express preemption. *Id.* at 23 (citations omitted). Courts have little justification to create preemption in a state statute because the legislature can easily do so by including clear language that expressly preempts an area of law. *Phantom of Clearwater, Inc. v. Pinellas Cty.*, 894 So. 2d 1011, 1019 (Fla. 2d Dist. Ct. App. 2005) (citation omitted).

The plaintiff failed to establish a likelihood of success on the merits on an express-preemption claim. In their complaint, the plaintiffs cite no express statement or specific language in Chapter 491, Florida Statutes, which governs “Clinical,

³ *Singh* supersedes *Sarasota Alliance* because the ordinance at issue in *Singh* (challenged under preemption theory) was adopted in reaction to the holding in *Sarasota Alliance*. See *Singh*, 2019 WL 98251, at *3 (discussing the ordinance at issue). The legal standards *Sarasota Alliance* explained, however, remain unchanged. See *Singh*, 2019 WL 98241, at *4 (explaining the court’s decision).

Counseling, and Psychotherapy Services,” in which the legislature expressly preempted local regulations over mental health counseling. Nor does Chapter 491 have such an express statement. *See* Fla. Stat. §§ 491.002–491.016 (listing laws that apply to mental health counseling). The plaintiffs’ exemption claim instead requires inferences. (*See* Doc. 85, pp. 22–24) (arguing Chapter 491 creates a pervasive regulatory scheme). So, the plaintiffs can only plausibly claim the Florida Legislature impliedly preempted the field of regulating mental health professionals. A preliminary injunction based on an express-preemption claim is therefore inappropriate.

c. Implied-Preemption Claim

The plaintiffs argue they are likely to succeed on the merits of their implied-preemption claim. (Doc. 85, pp. 22–24). The City argues the plaintiffs failed to demonstrate the Florida Legislature intended to preempt the area of regulating mental health professionals. (Doc. 99, pp. 22–25).

Implied preemption exists when “the legislature scheme is so pervasive as to evidence an intent to preempt the particular area, and where strong public policy reasons exist for finding such an area to be preempted by the Legislature.” *Id.* (quotation marks and citation omitted). The Florida Legislature impliedly preempts an area of law when local legislation might endanger the legislature’s “pervasive regulatory scheme.” *Sarasota Alliance*, 28 So. 3d at 886 (citation omitted).

The court must look at the whole state regulation and the regulation’s object

and policy to determine if implied preemption applies. *State v. Harden*, 938 So. 2d 480, 486 (Fla. 2006) (citation omitted). “The nature of the power exerted by the legislature, the object sought to be attained by the statute at issue, and the character of the obligations imposed by the statute” are vital to determining if implied preemption applies. *Sarasota Alliance*, 28 So. 3d at 886 (citation omitted). Another crucial factor in determining whether implied preemption exists is whether the state’s statutory scheme specifically recognizes the need for local control. *See id.* at 887 (discussing *GLA and Assocs., Inc. v. City of Boca Raton*, 855 So. 2d 278 (Fla. 4th Dist. Ct. App. 2003)).

Courts must be careful when imputing an intent that prohibits “a local elected governing body from exercising its home rule powers.” *D’Agastino*, 220 So. 3d at 421 (citation omitted); *see also Black’s Law Dictionary*, 850 (10th ed. 2014) (defining “home rule” as the measure of autonomy state legislatures give local governments). A municipality in Florida has broad authority to exercise its home rule powers not expressly limited by the constitution, general or special law, or county charter. Fla. Stat. § 166.021(4); *Masone v. City of Aventura*, 147 So.3d 492, 494–95 (Fla. 2014) (citations omitted). Implied preemption is limited to areas where the Florida Legislature expressed its will to be the sole regulator. *Phantom of Clearwater*, 894 So. 2d at 1019 (quotation and citations omitted).

Some factors weigh in favor of concluding the Florida Legislature intended to preempt the area of regulating mental health professionals. To begin, Chapter 491

has no language expressly recognizing local regulation of mental health professionals. *See* Fla. Stat. §§ 491.002–491.016 (listing laws that apply to mental health counseling). Statutory language that expressly recognizes local regulation weighs against finding implied preemption. *See Sarasota Alliance*, 28 So. 3d at 887–88 (finding no implied preemption in the state Election Code, which “specifically delegates certain responsibilities and powers to local authorities”); *Phantom of Clearwater*, 894 So. 2d at 1019 (finding no implied preemption in Chapter 791, which regulates the sale of fireworks, because the statute “expressly delegates enforcement to local government” and “authorizes boards of county commissioner to set and require surety bonds” from fireworks vendors). The lack of language expressly recognizing local control in Chapter 491, therefore, weighs in favor of finding implied preemption.

Another factor that weighs in favor of finding implied preemption in Chapter 491 is the reluctance to allow municipalities to regulate an area traditionally left to the state. The state legislature has the power to regulate professions that affect the health, safety, and welfare of the public. *Gillett v. Fla. Univ. of Dermatology*, 197 So. 852, 855 (Fla. 1940). If doubt exists about whether a municipality has a specific power, that doubt is resolved against the municipality. *City of Miami Beach v. Fleetwood Hotel, Inc.*, 261 So. 2d 801, 803 (Fla. 1972) (citation omitted). A municipality has no power “in the absence of specific delegation of power” in its city charter. *Fleetwood Hotel*, 261 So. 2d at 803 (citation omitted). An area of statewide

concern is not the proper subject of a municipal government's legislation. *Lowe v. Broward Cty.*, 766 So. 2d 1199, 1204–05 (Fla. 4th Dist. Ct. App. 2000).

Mental health counseling is a profession the state legislature has the power to regulate. *See* Fla. Stat. § 491.002 (referring to mental health counseling as a profession). And the City failed to cite to a specific delegation of power in its charter that allows the City to regulate mental health counseling. These two facts, combined with the presumptive doubt against municipal powers, weigh in favor of finding implied preemption in Chapter 491.

Perhaps the most notable factor weighing in favor of finding implied preemption in Chapter 491 is the statute's disciplinary provision. *See* Fla. Stat. § 491.009 (listing "acts that constitute grounds for denial of a license or disciplinary action"). Section 491.009 states that mental health professionals can be penalized if they violate Section 456.072(1), Florida Statutes. Chapter 456 regulates health professions and occupations. Fla. Stat. §§ 456.001–456.50. Section 456.072 lists acts that constitute grounds for discipline and specifically states the following:

The purpose of this section is to facilitate uniform discipline for those actions made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Fla. Stat. § 456.001(8).⁴ When read together, Sections 491.009 and 456.001(8) state

⁴ The doctrine of incorporation by reference requires some expression in a document of an intention to be bound by the referenced document. *See Kanter v. Boutin*, 624 So. 779, 781 (Fla. 4th Dist. Ct. App. 1993) (discussing the doctrine of incorporation by reference in the context of contract law).

the purpose of the disciplinary provisions in Section 491.009 is to have uniform discipline standards for mental health counselors.

The legislature's intent for uniform discipline is an important consideration in determining whether implied preemption exists. *See D'Agastino*, 220 So. 2d at 426 (concluding county's disciplinary proceedings conflicted with those outlined in state law); *Classy Cycles, Inc. v. Bay Cty.*, 201 So. 3d 779,788 (Fla. 1st Dist. Ct. App. 2016) (concluding the legislature impliedly preempted county ordinances, which included penalties for failure to obtain motorcycle insurance, because the legislature "created a pervasive scheme of regulation" for motor-vehicle insurance).

Ordinance 2017-47 threatens the legislature's desired uniformity because other municipalities may choose to allow mental health professionals to provide conversion therapy. A mental health professional could therefore be subject to discipline in Tampa for providing conversion therapy but subject to no discipline in a neighboring municipality within the same county. This potential threat to uniform discipline under Section 491.009 weighs in favor of finding implied preemption.

But factors also weigh against finding implied preemption in Chapter 491. Courts are notably hesitant to impute an intent to the legislature because the legislature knows how to expressly preempt an area of regulation. *See City of Hollywood v. Mulligan*, 934 So. 1238, 1245–46 (finding no express preemption in the Florida Contraband Forfeiture Act because the legislature removed previous statutory language that reserved power to regulate forfeiture to the state);

D'Agastino, 220 So. 3d at 423 (stating implied preemption involving a municipality's home rule powers is disfavored). So, the hesitancy to find implied preemption in state statutes weighs in favor of finding no implied preemption.

The plaintiffs also failed to cite a case in which a court concluded the Florida Legislature preempted regulation of a profession, like mental health counseling. Nor did the undersigned find such case law. These factors—courts' hesitation to conclude implied preemption exists and lack of case law concluding the state legislature preempted regulation of a profession—weigh in favor of concluding no implied preemption in Chapter 491—at least at this early stage of the litigation.

A plaintiff moving for a preliminary injunction establishes substantial likelihood of success on the merits when the plaintiffs shows a probability he or she will succeed on the merits. *Shatel Corp. v. Mao Ta Lumber and Yacht Corp.*, 697 F.2d 1352, 1354 n.2 (11th Cir. 1983) (citations omitted). “A probability signifies that an event has a better than fifty-percent chance of occurring.” *Mercantile Texas Corp. v. Bd. of Gov. of Fed. Reserve Sys.*, 638 F.2d 1255, 1268 (5th Cir. Unit A 1981).⁵ “[T]he word ‘substantial’ does not add to the quantum of proof required to show a likelihood of success on the merits.” *Shatel Corp.*, 697 F.2d at 1354 n.2.

The undersigned concludes that, although the plaintiffs demonstrated they might succeed on the merits of their implied-preemption claim, the plaintiffs' success

⁵ The former Fifth Circuit's decisions are binding precedent. *Bonner v. City of Prichard*, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc).

is not necessarily likely nor probable considering the general reluctance to find implied intent and the lack of case law concluding the legislature preempted regulation of a profession like mental health counseling. The plaintiffs therefore failed to establish a likelihood of success on the merits of their implied-preemption claim based on the record currently available to the court.

A party moving for a preliminary injunction must establish all four factors needed for a preliminary injunction. *Siegel*, 234 F.3d at 1176 (citations omitted). The court should not grant a preliminary injunction based on the plaintiffs' implied-preemption claim because the plaintiffs failed to establish a likelihood of success on the merits. The court also need not consider whether the plaintiffs satisfied the other three factors for a preliminary injunction based on their implied-preemption claim because the plaintiffs failed to establish a likelihood of succeed on the merits.

* * *

The plaintiffs cannot demonstrate a substantial likelihood of success on a claim that Ordinance 2017-47 conflicts with Florida law because the plaintiffs failed to allege a conflict-of-laws claim in their amended complaint. The plaintiffs also failed to demonstrate a likelihood of success on the merits of their claim that the Florida Legislature preempted the area of regulating mental health professionals. The court therefore should not enjoin enforcement of Ordinance 2017-47 based on the plaintiffs' claim that the City lacked authority to enact Ordinance 2017-47 (Count VI).

The undersigned will now turn to whether the plaintiffs demonstrated a

likelihood of success on the merits on their free-speech claims under the First Amendment.

2. Count I: Plaintiffs' Claim that Ordinance 2017-47 Violates their Freedom of Speech under the First Amendment

Count I of the plaintiffs' first amended complaint, which alleges Ordinance 2017-47 violates the free-speech protections under the First Amendment, alleges six theories on why the ordinance is unconstitutional: Ordinance 2017-47 is an unconstitutional content-based law; the ordinance commits viewpoint discrimination; the ordinance is unconstitutionally vague; the ordinance is unconstitutionally overbroad; the ordinance is underinclusive; and the ordinance is an unconstitutional prior restraint on free speech. (Doc. 78, ¶¶179, 180, 182, 192–94).

In their briefing and oral arguments at the November 15th hearing, the plaintiffs focused on the likelihood of success on their claims that Ordinance 2017-47 is a content-based law; the ordinance commits viewpoint discrimination; the ordinance is unconstitutionally vague; the ordinance is unconstitutionally overbroad; and the ordinance is an unconstitutional prior restraint of free speech. The undersigned will therefore focus on whether the plaintiffs demonstrated a substantial likelihood of success on those claims.

a. Content-Based-Law Claim

The First Amendment protects freedom of speech. U.S. Const. amend. I; *see also* 42 U.S.C. § 1983 (prohibiting persons acting under color of any ordinance from violating individuals' constitutional rights). Two types of laws commonly come into

play in First Amendment challenges: content-neutral laws and content-based laws. *Ward v. Rock Against Racism*, 491 U.S. 781 (1989); *R.A.V. v. City of St. Paul*, 505 U.S. 377 (1992); *United States v. Playboy Ent. Group*, 529 U.S. 803 (2000); *Reed v. Town of Gilbert*, 135 S. Ct. 2218 (2015).

A law is content-neutral when its restrictions “are justified without reference to the content of the regulated speech.” *Clark v. Comm. for Creative Non-Violence*, 468 U.S. 288, 293 (1984) (citations omitted). A law that has an incidental effect on some speakers or messages is content-neutral if the regulation serves a purpose unrelated to the content of expression. *Ward*, 491 U.S. at 791 (citation omitted).⁶

A law is content-based if it “applies to particular speech because of the topic discussed or the idea or message expressed.” *Reed*, 135 S. Ct. at 2227 (citations omitted). Content-based laws also include laws that cannot be justified without reference to the content of the regulated speech and laws the government adopted because it disagrees with the message the regulated speech conveys. *Id.*; *Ward*, 491 U.S. at 791 (citation omitted).

Content-based laws must satisfy strict-scrutiny analysis. *Playboy*, 529 U.S. at 813. That is, the law must be narrowly tailored to promote a compelling

⁶ A content-neutral law must be narrowly tailored to serve a significant governmental interest. *Creative Non-Violence*, 468 U.S. at 293 (citations omitted). A law is narrowly tailored when it is “not substantially broader than necessary to achieve the government’s interest.” *Ward*, 491 U.S. at 799. The regulation need not be the least restrictive or least intrusive means of serving a significant governmental interest. *Id.* at 798–99. But the law must “leave open ample alternative channels” for communicating the affected speech. *Id.* at 791.

governmental interest. *Id.* If a less strict alternative would promote the government's compelling interest, the government must use that alternative. *Id.* Content-based laws are presumptively invalid. *R.A.V.*, 505 U.S. at 382 (citations omitted).

The plaintiffs argue Ordinance 2017-47 is an unconstitutional content-based law because the ordinance prohibits Messrs. Vazzo and Pickup from providing SOCE counseling, which “takes place only through speech.” (Doc. 114, p. 3). According to the plaintiffs, the City adopted Ordinance 2017-47 because the City disagrees with the content of the speech that takes place during SOCE counseling. (*Id.* at 4; Doc. 85, p. 11). So, the plaintiffs argue strict-scrutiny analysis applies and the ordinance fails that test because it is not the least restrictive means of furthering a compelling governmental interest. (Doc. 114, pp. 16–27).

The City argues the plaintiffs failed to demonstrate a likelihood of success on their content-based-law claim because the ordinance is narrowly tailored to satisfy a significant governmental interest. (Doc. 99, pp. 8–19). Equality Florida similarly argues the plaintiffs failed to demonstrate a likelihood of success on their First Amendment claims. (Doc. 98, p. 4).

The undersigned concludes the plaintiffs demonstrated a likelihood of success on their content-based-law claim. To understand this conclusion, an overview of the four most relevant cases is necessary—two of which directly address bans on conversion therapy, including SOCE counseling.

The first case is *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014). *Pickup* addressed a California law banning SOCE counseling. *Id.* at 1221. The plaintiffs in *Pickup* included SOCE counselors, including David Pickup (also the plaintiff in this case), who claimed the California ban on SOCE counseling violated their free-speech rights under the First Amendment. *Id.* at 1224. *Pickup* held the state ban on SOCE counseling regulated conduct—not speech. *Id.* at 1229. *Pickup* then applied rational-basis review (meaning the law must bear a rational relationship to a legitimate state interest) to the California ban on SOCE counseling because any effect the ban had on the plaintiffs’ speech during SOCE counseling was “merely incidental.” *Id.* at 1231. Finding the state had a legitimate interest in protecting minors and the legislature reasonably relied on reports and opinions that asserted SOCE counseling was harmful and ineffective, *Pickup* held the state ban on SOCE counseling satisfied rational-basis review and was therefore constitutional. *Id.* at 1231–32.

The next case to consider is *King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014). *King*, decided over eight months after *Pickup*, addressed a New Jersey law that banned SOCE counseling. *Id.* at 221–22. The plaintiffs in *King* also included counselors who brought free-speech claims under the First Amendment against the state law. *Id.* at 220–21. *King* disagreed with *Pickup* and held communications during SOCE counseling between the counselor and client are speech—not conduct—for First Amendment analyses. 767 F.3d at 224–29. *King* also held, however, speech during SOCE counseling is professional speech and laws prohibiting professional

speech “are constitutional only if they directly advance the state’s interest in protecting its citizens from harmful or ineffective practices and are no more extensive than necessary to serve that interest.” *Id.* at 223. *King* held the state ban was constitutional because the state had a substantial interest in protecting citizens from harmful professional practices; the legislature relied on substantial evidence when passing the state ban, including reports from professional and scientific organizations; and the plaintiffs provided no other adequate suggestion on how the state could protect minors. *Id.* at 236–40.

The first binding case most relevant here is the 2017 decision in *Wollschlaeger v. Governor, Florida*, 848 F.3d 1293 (11th Cir. 2017) (en banc). *Wollschlaeger* addressed Florida law provisions prohibiting doctors and medical professionals from asking patients whether they had firearms in their homes. *Id.* at 1303. *Wollschlaeger* holds a communication between a doctor and a patient about ownership of firearms is speech under the First Amendment. 848 F.3d at 1307 (citing *King*’s holding that communication during SOCE counseling is speech under the First Amendment). *Wollschlaeger* further holds prohibiting doctors from discussing firearm ownership with their patients is a content-based law. *Id.* But *Wollschlaeger* declined to decide whether heightened-scrutiny analysis or strict-scrutiny analysis applied to the doctors’ speech about firearm ownership. *Id.* at 1308. Instead, *Wollschlaeger* did not need to reach strict-scrutiny analysis because the majority of the Eleventh Circuit, sitting en banc, concluded the prohibition on doctors asking about firearm ownership

failed heightened (intermediate) scrutiny because the challenged provision failed to address concerns identified by the six anecdotes the legislature relied on when passing the law. 848 F.3d at 1317.

The last, and most recent, case to consider is *National Institute of Family and Life Advocates* (NIFLA) *v. Becerra*, 138 S. Ct. 2361 (2018). At issue in *NIFLA* was a California law requiring pregnancy centers to post a notice advising patients the state provided free or low-cost abortions for women. *Id.* at 2369. The plaintiffs, including pregnancy centers devoted to opposing abortion, claimed the California law violated their free-speech protections under the First Amendment. *Id.* at 2370. In *NIFLA*, a divided Supreme Court held the California law was content-based because the law altered the pregnancy centers’ speech by requiring the centers “to inform women how they can obtain state-subsidized abortion.” *Id.* at 2371.

NIFLA expressly rejected the analyses in *Pickup* and *King* recognizing “professional speech” as a separate category of speech subject to different constitutional analysis. *Id.* at 2371–72.⁷ Instead, professional speech is usually given less protection if it is commercial speech or if a law regulates professional conduct that incidentally involves speech. *NIFLA*, 138 S. Ct. at 2372. Although stating traditional strict-scrutiny analysis applies to a content-based law that regulates neither commercial speech nor conduct that incidentally involves speech, *NIFLA*

⁷ Although *NIFLA* rejected the free-speech analysis in *Pickup* and *King*, the Supreme Court denied petitions for writs of certiorari in *Pickup* and *King*. *Pickup v. Brown*, 134 S. Ct. 2871 (2014); *King v. Christie*, 135 S. Ct. 2048 (2015).

applied intermediate scrutiny to the California law requiring pregnancy centers to post notices. *See NIFLA*, 138 S. Ct. at 2375 (stating, “We need not [determine whether professional speech is exempt from ordinary First Amendment principles] because the licensed notice cannot survive even intermediate scrutiny”).

These four cases taken together indicate strict-scrutiny analysis applies to laws banning SOCE counseling. The Ninth Circuit’s holding in *Pickup* that SOCE counseling is conduct—not speech—was rejected by the Third Circuit in *King*, which held communications during SOCE counseling are speech under the First Amendment. 767 F.3d at 224–29. The Eleventh Circuit, sitting en banc, held in *Wollschlaeger* a doctor-patient communication about firearm ownership is speech under the First Amendment and approvingly cited *King*’s similar holding. 848 F.3d at 1307. And *NIFLA* held that traditional First Amendment analyses apply to professional speech that is neither commercial nor incidentally affected by a law regulating conduct. 138 S. Ct. at 2372.⁸

Importantly, the City and Equality Florida’s arguments that SOCE counseling is conduct and therefore Ordinance 2017-47 regulates conduct is undermined by the

⁸ *But see NIFLA*, 138 S. Ct. at 2373 (suggesting if speech is “tied to a procedure” it can be subject to content-based regulation) (citations omitted); *Planned Parenthood v. Casey*, 505 U.S. 845 (1992) (plurality) (rejecting free-speech claim under the First Amendment against state law that required doctors to give women information about abortion because the doctors’ free-speech rights were affected “only as part of the practice of medicine, subject to reasonable . . . regulation by the state”); *Pickup*, 740 F.3d at 1229 (stating the law prohibiting SOCE counseling “bans a form of treatment”).

language in Ordinance 2017-47 itself, which specifically refers to counseling as speech in a “whereas clause” adopted as part of Section One of the ordinance. (See Doc. 24-1, p. 4) (stating “courts found that counseling is professional speech, subject to a lower level of judicial scrutiny”); (Doc. 134-2, p. 10) (a city attorney’s PowerPoint presentation on code enforcement refers to conversion therapy as professional speech); (see also Doc. 52, p. 10) (acknowledging Equality Florida’s claim that it was “actively involved in the enactment of [Ordinance 2017-47]”).

Under *King*, *Wollschlaeger*, and Ordinance 2017-47, a communication during SOCE counseling is speech. Under *King* and *Wollschlaeger*, laws that ban certain communications between medical professionals and their patients are content-based laws. And under *NIFLA*, content-based laws that prohibit professional speech that is neither commercial nor incidentally affected by a law regulating conduct are subject to traditional First Amendment analyses. See also *Wollschlaeger*, 848 F.3d at 1323–27 (Wilson, J., concurring) (stating strict-scrutiny analysis applies to the state law that prohibited doctors from asking patients about firearm ownership). Therefore, applying this case law, Ordinance 2017-47 is a content-based law subject to strict-scrutiny analysis. The plaintiffs must therefore establish Ordinance 2017-47 is not narrowly tailored to promote a compelling governmental interest.

The undersigned will now analyze whether the plaintiffs are likely to succeed in proving Ordinance 2017-47 fails strict scrutiny.

i. Compelling Governmental Interest

The stated purpose of Ordinance 2017-47 is to protect the physical and psychological well-being of minors from harms caused by conversion therapy. (Doc. 24-1, p. 5). The government has a compelling interest in protecting the physical and psychological well-being of minors. *Sable Commc'ns of Calif., Inc. v. FCC*, 492 U.S. 115, 126 (1989). So, Ordinance 2017-47 serves a compelling governmental interest.

ii. Narrowly Tailored

A content-based law must be narrowly tailored to serve a compelling governmental interest. *Reed*, 135 S. Ct. at 2231 (citation omitted). To meet the narrow-tailoring requirement, the government must prove plausible alternatives, which burden less speech than the enacted law, would fail to achieve the government's interest. *Ashcroft v. ACLU*, 542 U.S. 656, 665 (2004) (citation omitted); *see also McCullen v. Coakley*, 134 S. Ct. 2518, 2530 (2014) (stating the Court considered less-restrictive alternatives when analyzing whether a law is narrowly tailored).

The court will not assume plausible alternatives will fail to protect compelling interests; “there must be some basis in the record, in legislative findings or otherwise, establishing the law as enacted as the least restrictive means.” *Denver Area Educ. Telecommuc'ns Consortium, Inc. v. FCC*, 518 U.S. 727 807 (1996) (citations omitted) (Kennedy & Ginsburg, JJ., concurring in part, concurring in the judgment in part, dissenting in part). If a less restrictive means would serve the compelling

governmental interest, the government must use that alternative. *Playboy*, 529 U.S. at 813 (citations omitted).

The plaintiffs sufficiently demonstrated they are likely to succeed in proving Ordinance 2017-47 is not narrowly tailored to serve the City's interest in protecting minors because the City considered no lesser restrictions on mental health professionals' speech. The City's designated party representative under Federal Rule of Civil Procedure 30(b)(6), who was also the City Council member who sponsored the ordinance, testified the City considered no alternatives to its total ban on conversion therapy. (Doc. 133-2, p. 98). Consistent with that testimony, the City put forward no evidence at the hearing to show it considered any alternatives to a complete ban on conversion therapy despite the ordinance's language that minors "are not effectively protected by other means." (Doc. 24-1, p. 5).

The plaintiffs, on the other hand, put forward suggested alternatives to Ordinance 2017-47's total ban on conversion therapy—none studied or considered by the City. For example, the plaintiffs argue the City could have enacted a ban on involuntary SOCE counseling—as opposed to the voluntary, consensual counseling the plaintiffs provide. (Doc. 114, p. 22). The plaintiffs also suggest the City could have more narrowly banned aversive conversion therapy techniques, like electroshock therapy, while permitting the plaintiffs' "speech-only talk therapy."

(*Id.*).⁹ And the plaintiffs suggest the City could have required informed consent from minors and parents before a mental health counselor could provide SOCE counseling to a minor. (*Id.* at 31–32); *but see King*, 767 F.3d at 239–40 (finding an informed-consent requirement would not adequately protect minors).

The City failed to demonstrate how plausible alternatives, which the City apparently never considered before enacting Ordinance 2017-47, could not achieve the City’s compelling interest in protecting minors. The plaintiffs are likely to succeed in proving that Ordinance 2017-47 is not narrowly tailored to promote the City’s interest in protecting the physical and psychological well-being of minors. Therefore, the plaintiffs are likely to succeed on the merits on their claim that Ordinance 2017-47 is an unconstitutional content-based law under the First Amendment.

b. *Viewpoint-Discrimination Claim*

The plaintiffs sufficiently demonstrated they are likely to succeed on the merits of their First Amendment claim that Ordinance 2017-47 is viewpoint discrimination. Section IV(A)(2)(a) of this report discusses how Ordinance 2017-47 is a content-based

⁹ At the hearing on the plaintiffs’ motion for preliminary injunction, the City argued it determined both aversive and non-aversive conversion therapies threatened the well-being of minors; so, a ban on just aversive techniques is not plausible. The City’s argument, however, is undermined by Ordinance 2017-47’s legislative findings, which make no distinction between aversive and non-aversive techniques. (*See* Doc. 24-1, pp. 2–6) (listing the City’s findings). Further, the City’s designated party representative testified he did not know what the terms “aversive therapy” and “non-aversive therapy” meant. (Doc. 133-2, p. 36).

law for which the City considered no alternatives. These facts also sufficiently demonstrate the plaintiffs' claim that the City adopted Ordinance 2017-47 because the City disagreed with the viewpoint mental health counselors express during SOCE counseling. (*See also* Doc. 24-1, p. 6) (prohibiting counseling aimed at "chang[ing] . . . gender identity, or gender expression" while allowing counseling "that provides support and assistance to a person undergoing gender transition"); *Rosenberger v. Rector & Visitors of the Univ. of Va.*, 515 U.S. 819, 829 (1995) (citation omitted) (stating viewpoint discrimination occurs when the government targets specific views on a subject); *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 571 (2011) (citations omitted) (stating content-based laws can be viewpoint discriminatory). The plaintiffs therefore sufficiently demonstrated they are likely to prove Ordinance 2017-47 is unconstitutional viewpoint discrimination.

c. Unconstitutionally-Overbroad Claim

The plaintiffs similarly demonstrated they are likely to succeed on the merits of their claim that Ordinance 2017-47 is overbroad. A law is overbroad when every application of the law creates the risk that ideas might be suppressed, such as when the law gives overly broad discretion to the person enforcing it. *Nationalist Movement*, 505 U.S. at 129–30 (citations omitted); *Catron v. City of St. Petersburg*, 658 F.3d, 1260, 1269 (11th Cir. 2011). Because the plaintiffs are likely to succeed in proving Ordinance 2017-47 constitutes viewpoint discrimination, the plaintiffs are likely to prove that every application of the ordinance creates the risk ideas might be

suppressed. In other words, if the City adopted Ordinance 2017-47 because it disagreed with the ideas expressed during SOCE counseling, every application of Ordinance 2017-47 creates the risk the ideas expressed during SOCE counseling might be suppressed. Therefore, the plaintiffs demonstrated they are likely to succeed on the merits of their claim that Ordinance 2017-47 is overbroad.

d. Prior-Restraint Claim

The plaintiffs also sufficiently demonstrated Ordinance 2017-47 restricts the plaintiffs' speech during SOCE counseling before they can express it. *See Black's Law Dictionary* 1387 (10th ed. 2014) (defining prior restraint on speech as a government restriction on speech before its expression); *Foryth Cty. v. Nationalist Movement*, 505 U.S. 123, 129–30 (1992) (citations omitted) (stating there is a “heavy presumption” against prior-restraint laws). So, the plaintiffs sufficiently demonstrated a likelihood of success on the merits of their claim that Ordinance 2017-47 is an unconstitutional prior restraint on the plaintiffs' free speech.

e. Unconstitutionally-Vague Claim

The plaintiffs sufficiently demonstrated a likelihood of success on the merits of their claim that Ordinance 2017-47 is 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). The

plaintiffs sufficiently demonstrated the City adopted Ordinance 2017-47 because it disagreed with the ideas and messages expressed during SOCE counseling. The ordinance therefore authorizes and encourages discriminatory enforcement by code enforcement officers (who may or may not have any medical or mental health counseling training) against the viewpoints of mental health professionals who provide SOCE counseling. So, the plaintiffs established a likelihood of success on the merits on their claim that Ordinance 2017-47 is unconstitutionally vague.

B. Irreparable Harm

The plaintiffs argue they are suffering irreparable harm because of Ordinance 2017-47 and will continue to do so without a preliminary injunction. (Doc. 85, p. 24; Doc. 114, pp. 27–29).

The City and Equality Florida argue the plaintiffs failed to demonstrate they will suffer irreparable harm without an injunction because the plaintiffs waited almost eight months after the ordinance’s enactment to begin this lawsuit and repeatedly delayed in seeking injunctive relief. (Doc. 98, pp. 3–4; Doc. 99, pp. 28–30; Doc. 143, pp. 3–4).

The party requesting an injunction must demonstrate he or she will likely suffer irreparable harm without an injunction. *Winter*, 555 U.S. at 22 (citations omitted). A party’s months-long delay in seeking a preliminary injunction “mitigates against a finding of irreparable harm.” *Wreal, LLC v. Amazon.com, Inc.*, 840 F.3d 1244, 1248 (11th Cir. 2016). Preliminary injunctions are meant to provide “speedy

and urgent action to protect a plaintiff's rights before a case can be resolved on the merits." *Wreal*, 840 F.3d at 1248 (citations omitted). That said, the Supreme Court instructs the loss of First Amendment freedoms constitutes irreparable injury. *Elrod v. Burns*, 427 U.S. 347, 373–74 (citation and footnote omitted).

Section II of this report illustrates the plaintiffs' months-long delay in seeking injunctive relief against Ordinance 2017-47. The plaintiffs' actions in this litigation repeatedly prevented a decision on their motion for preliminary injunction. These actions would normally weigh heavily against finding a likelihood of irreparable injury without an injunction. But the plaintiffs demonstrated they are likely to succeed on the merits of most of their First Amendment free-speech claims. Because of the seemingly automatic conclusion of irreparable injury in a First Amendment action, the plaintiffs sufficiently demonstrated they will likely be irreparably harmed without an injunction.

C. Balance of Equities

The plaintiffs argue the balance of equities tips in their favor because the City will not be harmed if enforcement of Ordinance 2017-47 is enjoined. (Doc. 85, p. 25; Doc. 114, pp. 29–30).

The party moving for a preliminary injunctive must demonstrate the balance of equities tips in his or her favor. *Winter*, 555 U.S. at 20. In other words, the threatened injury to the plaintiff must outweigh any harm the defendant might suffer. *Gen. Contractors*, 896 F.2d at 1284 (citations omitted); *see also Benisek v.*

Lamone, 138 S. Ct. 1942, 1944 (2018) (stating that years-long delay in seeking preliminary injunctive relief weighs against the plaintiff when considering balance of equities).

The plaintiffs sufficiently demonstrated their First Amendment rights will be irreparably harmed without a preliminary injunction. The City, however, failed to show any harm it may suffer if enforcement of Ordinance 2017-47 is enjoined. The City and Equality Florida instead focus on potential harm to non-defendants, especially minors, if the ordinance is enjoined. (Doc. 98, pp. 4–8; Doc. 99, pp. 30–35; Doc. 143, pp. 4–5). But the public interest is a separate factor in determining whether the court should grant a preliminary injunction. *Winter*, 555 U.S. at 20. Further, a “city has no legitimate interest in enforcing an unconstitutional ordinance.” *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1272 (11th Cir. 2006). Therefore, the balance of equities tips in the plaintiffs’ favor because the City failed to show any harm it would suffer if enforcement of Ordinance 2017-47 is enjoined and the City has no legitimate interest in enforcing an ordinance likely to be ruled unconstitutional.

D. Public Interest

The plaintiffs argue enjoining Ordinance 2017-47 is in the public interest because the ordinance is unconstitutional and the City presented no evidence of minors being harmed by SOCE counseling within city limits. (Doc. 85, p. 25; Doc. 114, pp. 29–30). The City and Equality Florida argue enjoining Ordinance 2017-47

is against the public interest because minors could be potentially harmed by conversion therapy while enforcement of the ordinance is enjoined. (Doc. 98, pp. 4–8; Doc. 99, pp. 30–35; Doc. 143, pp. 4–5).

The plaintiffs sufficiently demonstrated Ordinance 2017-47’s overbroad prohibition on non-coercive, non-aversive SOCE counseling consisting entirely of speech or “talk therapy” is likely unconstitutional. The public has no interest in enforcing an unconstitutional ordinance. *KH Outdoor*, 458 F.3d at 1272–73 (citations omitted). Further, the City and Equality Florida’s argument that minors will be harmed by SOCE counseling if Ordinance 2017-47 is enjoined is undermined by the fact the City received no complaints related to any minor harmed by SOCE counseling within the city limits. (Doc. 132-1, p. 8). In the absence of any harm to the public, the plaintiffs, therefore, sufficiently demonstrated it is in the public’s interest to enjoin Ordinance 2017-47’s prohibition on SOCE counseling.

E. Limited Injunction

An injunction should be no broader than necessary to avoid the harm on which the injunction is based. *See Trump v. Hawaii*, 138 S. Ct. 2392, 2426 (2018) (Thomas, J., concurring) (discussing how traditional courts of equity had discretion to “tailor a remedy” to the issue before the court); *Laker Airways Ltd. v. Sabena, Belgian World Airlines*, 731 F.2d 909, 933 n.81 (D.C. Cir. 1984) (discussing limited injunctions in the context of international litigation); *Uber Promotions, Inc. v. Uber Tech., Inc.* 162 F. Supp. 3d 1253, 1281–82 (N.D. Fla. 2016) (granting limited preliminary injunction

narrowly tailored to address the harm to the plaintiff); *Occupy Ft. Myers v. City of Ft. Myers*, 882 F. Supp. 2d 1320, 1339 (M.D. Fla. 2011) (granting limited injunction that enjoined parts of city ordinance found likely to violate the First Amendment in Section 1983 case).

The plaintiffs here repeatedly state that if Ordinance 2017-47 only banned aversive conversion-therapy techniques, like electroshock therapy, the plaintiffs would not be challenging the ordinance's constitutionality because Messrs. Vazzo and Pickup only provide non-aversive therapy. (*See, e.g.*, Doc. 114, p. 3) (stating the plaintiffs would not have filed this lawsuit if the ordinance only banned aversive therapy because Messrs. Vazzo and Pickup do not provide that therapy).

The City and Equality Florida also sufficiently demonstrated minors in the city limits could be harmed by techniques like electroshock therapy if enforcement of Ordinance 2017-47 is completely enjoined. (*See, e.g.*, Doc. 98, p. 6) (discussing dangers of coercive conversion therapy).

The lack of harm to the plaintiffs' First Amendment rights if Ordinance 2017-47's ban on aversive conversion therapy remains and the possible harm to minors if the ordinance is completely enjoined weigh in favor of a limited injunction. The court should preliminarily enjoin the enforcement of Ordinance 2017-47 to the extent the City may not enforce the ordinance against mental health professionals who provide non-coercive, non-aversive, SOCE counseling—which consists entirely of speech, or “talk therapy”—to minors within the city limits. This type of limited injunction will

balance the plaintiffs' First Amendment rights and the health and safety of minors within the city limits.

V. CONCLUSION

The plaintiffs failed to establish a likelihood of success on the merits of their claims that the City lacks authority to enact Ordinance 2017-47 (Count VI). The court should not grant a preliminary injunction on that basis.

But the plaintiffs established a likelihood of success on the merits of most of their First Amendment claims against Ordinance 2017-47 in Count I. The plaintiffs also demonstrated irreparable harm without an injunction; the balance of equities tips in the plaintiffs' favor; and partially enjoining enforcement of Ordinance 2017-47 is in the public interest. Therefore, the plaintiffs' motion for preliminary injunction (Doc. 85) should be **GRANTED-IN-PART** and **DENIED-IN-PART** as follows:

1. The plaintiffs' motion for preliminary injunction should be **GRANTED** to the extent that the City should be enjoined from enforcing Ordinance 2017-47 against mental health professionals who provide non-coercive, non-aversive SOCE counseling—which consists entirely of speech, or “talk therapy”—to minors within the city limits.
2. The plaintiffs' motion for preliminary injunction should be **DENIED** to the extent that the plaintiffs seek to completely enjoin the enforcement of Ordinance 2017-47.

3. If the court agrees a limited preliminary injunction should issue, in its order, the court should require the plaintiffs to provide a proposed preliminary injunction order consistent with the court's order, Local Rules 4.06(b)(1), 4.05(b)(3)(iii), and Federal Rule of Civil Procedure 65(d).

RECOMMENDED in Tampa, Florida, on January 30, 2019.



AMANDA ARNOLD SANSONE
United States Magistrate Judge

NOTICE TO PARTIES

Failure to file written objections to the proposed findings and recommendations contained in this report within fourteen days from the date of this service bars an aggrieved party from attacking the factual findings on appeal. 28 U.S.C. § 636(b)(1).

192-1



Deposition of:
Judith M. Glassgold , Psy.D

July 25, 2019

In the Matter of:
**Vazzo, Robert L, et al. v. City of
Tampa, Florida**

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1 UNITED STATES DISTRICT COURT
2 MIDDLE DISTRICT OF FLORIDA
3 TAMPA DIVISION
4 CASE NO. 8:17-cv-2896-T-02AAS

5 ROBERT L. VAZZO, LMFT, etc., et al.,

6 Plaintiffs,

7 vs.

8 CITY OF TAMPA, FLORIDA

9 Defendant.

/

10 Suite 3200
11 Burr & Forman, LLP
12 201 North Franklin Street
13 Tampa, Florida 33602
14 10:06 a.m. to 4:58 p.m.
15 Thursday, July 25, 2019

16 DEPOSITION OF JUDITH M. GLASSGOLD, PSY.D.
17
18
19
20

21 Taken on behalf of the Plaintiff before Mary
22 Ann Smith, RPR, RMR, Notary Public in and for the
23 State of Florida at Large, pursuant to Plaintiffs'
24 Notice of Taking Depositions of Defendant's Expert
25 Witnesses in the above cause.

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through 27 were not marked in this deposition.)

P R O C E E D I N G S

JUDITH M. GLASSGOLD, PSY.D., called as a witness by the Plaintiffs, having been first duly sworn, testified as follows:

THE WITNESS: I do.

DIRECT EXAMINATION

BY MR. GANNAM:

Q. Good morning, Dr. Glassgold. My name is Roger Gannam, and I am an attorney for the plaintiffs in the lawsuit of Vazzo v. City of Tampa, and we're here today to take your deposition in the capacity as an expert witness for the defendants, or the defendant City of Tampa. Is that also your understanding?

A. That is.

Q. Excellent. I want to go over a few ground rules. First, let me ask have, you ever had your deposition taken before?

A. 20 years ago.

Q. Okay. Well, maybe this will just be a little refresher. Your testimony today will be under oath and transcribed by a court reporter. Is that okay?

A. Yes, it is.

Q. It's important that because the testimony will be taken down by the court reporter that all of your answers be verbal, out loud, as opposed to head

1 gestures or hand gestures like we would normally do in
2 a conversation. Is that okay?

3 A. Sure. That's fine.

4 Q. It's also important that we only speak one at
5 a time, so I will just ask that you wait until I'm
6 finished with my question before answering and I will
7 do my best to wait until you're done talking before I
8 start again. Is that okay?

9 A. Yes.

10 Q. If I ask a question that you don't understand
11 for some reason, please let me know. Is that okay?

12 A. Yes.

13 Q. And if I ask a question and you answer it, I
14 will assume that you heard it and understood it. Is
15 that okay?

16 A. Yes.

17 Q. It is all right to take breaks today. We're
18 not trying to make this an endurance contest. I would
19 just ask that if I have a question pending, that you
20 complete your answer before taking a break. Is that
21 okay?

22 A. Sure.

23 MR. GANNAM: Before we go further, I just
24 want to -- Rob, can you just say on the record
25 who is in the room with us?

1 MR. WILLIAMS: Yes. Well, including myself,
2 Rob Williams, Dana Robbins and Shannon Minter,
3 along with Dr. Glassgold.

4 MR. GANNAM: And Shannon Minter is here in
5 what capacity?

6 MR. WILLIAMS: He's a consultant assisting me
7 in this litigation.

8 MR. GANNAM: And is Mr. Minter affiliated
9 with any organization?

10 MR. WILLIAMS: I'm sure he is.

11 MR. GANNAM: Can you tell me what it is?

12 MR. WILLIAMS: I'm sure he's affiliated with
13 a lot of organizations.

14 MR. GANNAM: Is he employed by a particular
15 organization?

16 MR. WILLIAMS: He can tell you.

17 MR. MINTER: National Center for Lesbian
18 Rights.

19 MR. GANNAM: Also known as NCLR?

20 MR. MINTER: Yeah.

21 MR. GANNAM: Okay. Thank you. And,
22 Mr. Minter, are you an attorney as well?

23 MR. MINTER: Yes.

24 MR. GANNAM: Thank you.

25 BY MR. GANNAM:

1 Q. All right. Dr. Glassgold, please state your
2 full name for the record.

3 A. Judith Miriam Glassgold.

4 Q. And your address, please?

5 A. 4 Wertsville Road, Hillsborough, New Jersey
6 08844.

7 Q. And, as we proceed today, I want to ask, do
8 you currently having any condition or are you under
9 any disability that would affect your ability to
10 testify truthfully today?

11 A. Not that I'm aware of.

12 Q. And are you currently taking any medication
13 that could affect that capacity to testify?

14 A. No.

15 Q. And if this case should go to trial some time
16 in the next year or so, are you currently aware of any
17 reason why you might not be able to fully participate
18 if called as a witness for Tampa?

19 A. I don't think so, no.

20 Q. Please tell me your current employer.

21 A. If I have multiple employers would you like
22 to hear all of them?

23 Q. Yes. Just start with one and we'll go from
24 there.

25 A. The New Jersey Psychological Association.

1 Q. What's your position there?

2 A. Director of professional affairs.

3 Q. How long have you been in that position?

4 A. I believe since June of 2017. I believe --
5 I'm trying to think. Yeah.

6 Q. And, apart from that position, have you held
7 any other positions with that organization?

8 A. Employment positions?

9 Q. Right.

10 A. No.

11 Q. So your employment began in June of 2017
12 approximately in the position of director of
13 professional affairs?

14 A. Yes.

15 Q. Okay. Great. You said you have more than
16 one employer?

17 A. Yes, I do.

18 Q. Who else?

19 A. The College of Saint Elizabeth.

20 Q. And where is that?

21 A. That's in Morristown, New Jersey.

22 Q. And what is your position there?

23 A. Adjunct.

24 Q. Is that a teaching position?

25 A. Yes, it is.

1 Q. How long have you had that position?

2 A. Actually it starts in three weeks, but I do
3 have an employment contract with them.

4 Q. So three weeks you will start?

5 A. Uh-hum.

6 Q. Have you held any other employment positions
7 with the College of Saint Elizabeth?

8 A. No.

9 Q. By the way, where is the New Jersey
10 Psychological Association located?

11 A. Oh, they just moved their office and I
12 telecommute, so I believe it's in -- near Hanover,
13 Parsippany area. Northern New Jersey.

14 Q. But you work from your home town --

15 A. Yes, I do.

16 Q. -- in that position? Okay.

17 All right. Any other employers?

18 A. Rutgers University.

19 Q. What's your position there?

20 A. Lecturer.

21 Q. How long have you had that position?

22 A. A year.

23 Q. And have you had any other positions at
24 Rutgers?

25 A. Yes.

1 Q. What else?

2 A. Visiting professor lecturer. Adjunct
3 lecturer.

4 Q. And have these positions been -- has this
5 been continuous employment by Rutgers or just periodic
6 employment by Rutgers?

7 A. It was more or less continuous for 20 years
8 and then there was a break and I started up again last
9 year.

10 Q. How long was the break?

11 A. 2009 to 20 -- what was last year, 2018.

12 MR. WILLIAMS: Uh-hum.

13 THE WITNESS: Yeah, I think those numbers are
14 right.

15 BY MR. GANNAM:

16 Q. All right. Do you have any other current
17 employers?

18 A. No.

19 Q. Were you employed between 2009 and 2018?

20 A. I'm sorry. 2000 -- okay. So --

21 Q. Before you went back to Rutgers.

22 A. Okay. Which direction do you wish me to go,
23 backwards or forward?

24 Q. Let's go backwards if that's okay.

25 A. Okay. So 2016 to 2018 I was employed by -- I

1 had a position at Princeton University.

2 Q. What was your position there?

3 A. From 2016 to 2017 I was a research fellow at
4 the Center For Health and Wellbeing at the Woodrow
5 Wilson School of Public and International Policy.

6 Q. And after that?

7 A. I was a guest in the department. Just a
8 guest researcher.

9 Q. Same department?

10 A. Same department, yes.

11 Q. All right. And then before that?

12 A. Before that, from August of 2013 to August of
13 2016, I was employed by the American Psychological
14 Association as Associate Executive Director for
15 Government Relations in the Public Interest
16 Directorate.

17 Q. And before that?

18 A. I was employed by the Congressional Research
19 Service of the Library of Congress from, oh, late
20 20 -- summer of 2011 to 8/20/13.

21 Q. And if we could go maybe just one or two more
22 steps earlier than that.

23 A. Then I -- so I can give you two steps. That
24 will take me to 2009.

25 Q. Okay.

1 A. So in 2010 I was employed as a senior -- what
2 was the title exactly. Senior policy professional, by
3 Congressman Sander Levin of Michigan.

4 Q. What was the congressman's name?

5 A. Sander Levin. Sandy Levin.

6 Q. And that was 2010?

7 A. Yeah. 2010 to the 2011 date of CRS.

8 Q. Okay.

9 A. And then before that from 2009, so now we
10 bring it back to 2009, I was employed by -- I was a
11 congressional fellow, which was a fellowship position
12 sponsored by the American Association For the
13 Advancement of Science and the American Psychological
14 Association, and I worked in the office of
15 Representative Xavier Becerra of California.

16 Q. Now, did you work in Xavier Becerra's office
17 as a congressional fellow or in a different position
18 with his office?

19 A. I worked as a congressional fellow, as a
20 health fellow.

21 Q. And Xavier Becerra currently is the attorney
22 general of California; correct?

23 A. Yes.

24 Q. Was he attorney general at the time?

25 A. No, he was a member of congress at the time.

1 Q. He's our opponent in other litigation. I
2 didn't know what he did before --

3 A. He only became an attorney general very
4 recently.

5 Q. He took over for Kamala Harris. Okay.

6 I also understand that you, correct me if I'm
7 wrong, chaired the APA Task Force that prepared the
8 2009 APA report on appropriate therapeutic response to
9 sexual orientation. I may not have said that
10 accurately, but you know what I'm talking about?

11 A. I understand and, yes, that is correct.

12 Q. And in that position as Chair of the Task
13 Force, was that during the same time as your 2009
14 employment?

15 A. No.

16 Q. Tell me about -- the Task Force began when,
17 in 2007?

18 A. Uh-hum. That's correct.

19 Q. And was that a paid position for you?

20 A. No.

21 Q. So where were you employed during your time
22 as Chair of the Task Force?

23 A. I was self-employed and I had a professional
24 practice in clinical psychology in Highland Park,
25 New Jersey, and I was a visiting professor at Rutgers

1 University.

2 Q. And that gets into that earlier 20-year
3 stint?

4 A. Yes, that was that earlier stint.

5 Q. How long did you have your own practice as a
6 clinical psychologist?

7 A. Close to 20 years.

8 Q. Did that generally coincide with your
9 Rutgers, that first Rutgers stint?

10 A. Yeah. So I moved -- I started teaching at
11 Rutgers while I actually was a graduate student in
12 another department. And then I just went into
13 practice. Actually, I didn't. That's not true.
14 Sorry.

15 Q. Your teaching position that you're getting
16 ready to start, what is the -- is there a particular
17 subject matter or area that you will be lecturing in
18 or teaching in?

19 A. Yes. At the College of Saint Elizabeth I've
20 been employed to teach history and systems of
21 psychology.

22 Q. And that's two different subjects, history
23 and --

24 A. No, it's one combined.

25 Q. Okay. History and systems of psychology.

1 Got it.

2 A. It's an intellectual history course at the
3 college.

4 Q. Anything else?

5 A. No.

6 Q. What about at Rutgers when you were a
7 lecturer during the one year?

8 A. The course I taught last year and the course
9 I will teach this year is Policy in Mental Health. Is
10 titled Policy in Mental Health. It's a public policy
11 course on mental health policy.

12 Q. What was the subject of your research at
13 Princeton when you were a research fellow there?

14 A. Mental health policy and mental health
15 economics.

16 Q. And what about during your first 20-year
17 stint at Rutgers, what areas did you teach in?

18 A. I taught psychotherapy classes and topical
19 classes, and the courses included LGBT issues and
20 psychology, gender and psychology, psychoanalysis and
21 gender, community psychology. I think that's it.

22 Q. So is it correct that your last -- apart from
23 your -- to the extent any of your university positions
24 or college positions were with government or public
25 institutions, was the congressional research service

1 position you had from 2011 to 2013 your last
2 government employment?

3 A. Yes.

4 Q. All right. Do you currently hold any officer
5 or leadership positions in any nonprofit groups?

6 A. I believe I am still a board member, but I'm
7 not a hundred percent certain, to be honest, because I
8 haven't heard from anyone in a very long time, of the
9 Born Perfect project at NCLR. I think. I don't know.

10 Q. Okay. Fair enough. When did you become a
11 board member for that project?

12 A. I am not exactly sure, to be honest. Back in
13 2014 or 2015.

14 Q. What is the nature or the purpose of that
15 project?

16 A. It's to, I believe, enhance the wellbeing of
17 LGBT youth and combat negative stereotypes as well as
18 to provide positive therapies and treatments for them.

19 Q. And what kinds of things have you done as a
20 board member for that project? What kind of
21 activities?

22 A. I answer telephone calls when I receive them
23 and provide information about psychotherapy and
24 psychology.

25 Q. So would you look at your role as sort of

1 informational or advisory to the project?

2 A. Yes. I'm considered, I believe, an advisor.
3 I'm not sure I'm actually a board member. I think
4 they dismissed the board. It's a very loosey-goosey
5 kind of thing, to be honest. So I provide information
6 when asked, but I haven't been asked in a year, I
7 believe, for information.

8 Q. Fair enough. Any other organizations that
9 you hold a leadership position or an advisory position
10 with?

11 A. No, I don't believe so.

12 Q. Have you in the past?

13 A. Yes, I have.

14 Q. Let's go back to 2007 at the time that you
15 chaired the APA Task Force. Did you hold any
16 leadership or advisory positions with other
17 organizations back then? Non-employment positions.

18 A. Okay. So I was finishing up my term as
19 president of the New Jersey Psychological Association.

20 Q. How long were you president?

21 A. Just a year. There's a three-year sequence
22 of elected president, president, and past president
23 type of sequence.

24 Q. Okay.

25 A. And you become a board member during that

1 three-year term.

2 Q. So in 2007 you were finishing your term as
3 president. Then did you serve as past president for
4 another year after that?

5 A. Yes, I did.

6 Q. Okay. And at that time were there any other
7 organizations where you held leadership or advisory
8 positions?

9 A. I don't believe so, no.

10 Q. How about in between then and your work with
11 the Born Perfect project, any other organizations?

12 A. No, once I -- starting in 2009 I resigned. I
13 didn't finish my term as past president of NJPA. I
14 resigned all boards and my membership with NJPA. I
15 moved to Washington sort of on a, more or less,
16 part-time basis, but I resigned when I became a
17 congressional fellow. And I didn't hold any
18 leadership roles in professional organizations during
19 my time in Washington, D.C.

20 Q. Apart from professional organizations, and
21 maybe you already covered this, but what about
22 advocacy organizations that you've been involved with?

23 A. From 1995 to 2000 I was the head of an
24 organization or on the board of Friends of
25 Hillsborough, which was -- I'm not sure. I guess it

1 was advocacy. We were a grass roots group concerned
2 about environmental and planning issues in central
3 New Jersey in our town. I've never held any other
4 advocacy positions. Non-paid advocacy positions.

5 Q. And apart from the Born Perfect project, do
6 you have any other official affiliations or ties with
7 NCLR?

8 A. No.

9 Q. Do you have any affiliations or ties with the
10 Southern Poverty Law Center, or SPLC?

11 A. No, not at this time. No, I don't think I
12 ever have.

13 Q. What about an organization called Equality
14 Florida?

15 A. No.

16 Q. We may come back to some of those topics. I
17 think -- let me just check.

18 Let's talk about your preparation for your
19 testimony today.

20 A. Uh-hum.

21 Q. What did you do to prepare for giving
22 testimony today?

23 A. I read my statement and I consulted and met
24 with my attorneys. Or the attorneys for the City of
25 Tampa.

1 Q. All right. And did you consult any other
2 documents besides your declaration that you issued in
3 this case?

4 A. I did review quickly Dr. Rosik's rebuttal and
5 I looked at the APA 2009 report.

6 Q. Any other documents besides those?

7 A. I think maybe some of the references in the
8 2009 report. And documents -- perhaps a few documents
9 cited, it's hard to remember, in my statement.

10 Q. Do you remember specifically any of those
11 that you looked at?

12 A. No. To be honest, I probably didn't review
13 very many of them at all. To be honest.

14 Q. As far as reviewing documents, about how long
15 would you say you spent in hours?

16 A. Let's see. Six.

17 Q. All at one time or --

18 A. Six reviewing documents. No, probably --
19 yeah, split up over several days.

20 Q. What about time spent meeting with attorneys
21 for the City of Tampa?

22 A. I met with them yesterday.

23 Q. Okay. For how long?

24 A. From about 9 to 3, but then we had a lunch
25 break. Including a lunch break.

1 Q. And was that Mr. Williams in that meeting?

2 A. Yes, he was.

3 Q. Any other attorneys for the City of Tampa?

4 A. Ms. Robinson and Mr. Minter.

5 Q. Anyone else in the room?

6 A. No.

7 Q. Okay. And, prior to yesterday's meeting, had
8 you had any other meetings in person with attorneys
9 for the city of Tampa?

10 A. No.

11 Q. How did you get involved with this case? Who
12 first contacted you or approached you about being an
13 expert?

14 A. I believe I received an e-mail from
15 Mr. Minter asking if I would speak to Mr. Williams.
16 Or if Mr. Williams could call me, if I was available
17 to speak to Mr. Williams.

18 Q. And do you know why you were approached by
19 Mr. Minter about being an expert?

20 A. I believe many people consider me an expert
21 in this area.

22 Q. Have you given expert testimony in other
23 litigation?

24 A. So in Schwartz v. New York, I believe, I
25 provided a statement. And in, I believe, a case in

1 New Jersey I provided just a brief declaration.

2 Q. Do you remember the name of the case in
3 New Jersey?

4 A. I believe it's in my vitae.

5 Q. Okay. Do you remember approximately how long
6 ago that was?

7 A. That was a long time ago. It was probably
8 2014.

9 Q. And did you give any court or deposition
10 testimony in the New Jersey case?

11 A. No.

12 Q. You haven't given any in the New York case;
13 have you?

14 A. No.

15 Q. Are you scheduled to give any in the New York
16 case?

17 A. Not that I'm aware of.

18 Q. Do you know whether there have been any
19 rulings in the New York case since you submitted your
20 report in that case?

21 A. No, I am not.

22 Q. About how long ago did Mr. Minter approach
23 you about being an expert in this case?

24 A. I'm not sure I recall. Not very long ago.

25 Q. Do you know if it was before or after the

1 first Rosik and Hudson declarations were issued in
2 this case?

3 A. I don't know.

4 Q. So I take it you did get in touch with
5 Mr. Williams following that call or that e-mail?

6 A. Or he, I believe, called me.

7 Q. Okay. And did you reach an agreement on
8 terms for serving as an expert in this case?

9 A. Yes, we did.

10 Q. And what are the terms of your arrangement
11 with the City of Tampa?

12 A. I am being reimbursed for my costs to attend
13 this deposition and I receive a fee for this
14 deposition and a fee for yesterday's in-person
15 preparation, but I received no fee for the statement.

16 Q. Okay. So your travel costs, as in
17 out-of-pocket costs, are being reimbursed; is that
18 correct?

19 A. Yes, all my travel costs.

20 Q. Are you being paid for time spent traveling?

21 A. No, I am not.

22 Q. And what is your compensation arrangement for
23 time spent meeting with attorneys?

24 A. \$100 an hour.

25 Q. And were you compensated for reading

1 documents to prepare for today?

2 A. No.

3 Q. What about for your appearance today?

4 A. \$200 an hour.

5 Q. And are there any other -- are you due any
6 other compensation or potentially due other
7 compensation for your work in this case?

8 A. No.

9 Q. Will you be paid for testimony at trial if
10 the case goes to trial?

11 A. We haven't discussed that, but I assume so.

12 Q. Is any aspect of your compensation
13 arrangement with the City of Tampa contingent on the
14 outcome of this case?

15 A. No.

16 Q. And I'm assuming it's the City of Tampa who
17 you have an arrangement with. Is that in fact who
18 your arrangement is with?

19 A. No. I believe it's with this law firm.

20 Q. Okay.

21 A. I don't know.

22 Q. Is there a written agreement?

23 A. No.

24 Q. Okay. Who is responsible for payment of the
25 compensation that you agreed to?

1 A. Burr. This firm. I believe so.

2 Q. And do you know ultimately if that cost is
3 being covered by the law firm or being covered by, for
4 example, the City of Tampa or the NCLR or some other
5 organization?

6 A. I do not know specifically, but I assume it's
7 the City of Tampa.

8 Q. But you don't know as you sit here?

9 A. I'm not a hundred percent sure, so I don't
10 want to give you an inaccurate answer.

11 Q. Fair enough. So it really doesn't matter to
12 you, if you get what you've agreed to, who is actually
13 paying it?

14 A. Well, I did provide a discount that was based
15 on my -- I provide a discount for government and
16 non-profits. So they received the government discount
17 for my services.

18 Q. Do you have any -- given that Mr. Minter at
19 NCLR who is the one who initially approached you, do
20 you have any agreement or arrangement with NCLR
21 regarding your work in this case?

22 A. No.

23 Q. Do you have any ongoing -- besides your --
24 and forgive me if I already asked. Besides the Born
25 Perfect project, any other affiliations or

1 arrangements with NCLR?

2 A. No.

3 Q. Do you have any other expert assignments or
4 potential expert employment coming up besides the ones
5 that we've talked about?

6 A. No.

7 Q. Now, where are you currently -- do you
8 currently hold professional licensure?

9 A. My license is active in the State of
10 New Jersey and I have an inactive license in the State
11 of New York.

12 Q. And what is the New Jersey license in
13 specifically? What discipline or field?

14 A. In psychology.

15 Q. Okay. And what about your inactive New York
16 license?

17 A. Psychology.

18 Q. And in terms of generally you would then --
19 in New Jersey, for example, you would be a licensed
20 psychologist; would that be the best description?

21 A. That is the term that is used.

22 Q. And the same in New York?

23 A. I am not sure people with an inactive license
24 can refer to themselves as --

25 Q. As licensed?

1 A. As licensed or even use the term "psychology"
2 in the state.

3 Q. Okay. Do you hold any other professional
4 licenses?

5 A. No.

6 Q. Have you ever held any others?

7 A. No.

8 Q. And do you have any -- within the field of
9 psychology in general, do you have any areas in which
10 you specialize?

11 A. Yes.

12 Q. And what areas would those be?

13 A. Sexual orientation, gender, LGBT issues, and
14 public policy.

15 Q. And apart from licensure as a psychologist,
16 do you hold any certificates or other designations,
17 you know, subsidiary to that to reflect the areas that
18 you focus on or specialize in?

19 A. I'm a fellow of the American Psychological
20 Association.

21 Q. And what does being a fellow of the APA
22 entail?

23 A. It means that your credentials are reviewed
24 by a division or more, one or more divisions of the
25 APA. They review your credentials and feel that you

1 are outstanding expert in your field. Then they
2 forward a nomination packet for you with endorsements.
3 You have to provide your background and vitae and
4 endorsements. They forward that to the fellows
5 committee of the entire organization and then you are
6 voted on by that committee as an expert in the areas
7 that are so designated by the division.

8 I was designated an expert by the division
9 for -- I believe it's now called Sexual Orientation
10 and Gender Identity. It was Sexual Orientation back
11 in 1990 -- back in 1992 or '93 when I was nominated.
12 No. I'm sorry. '97 I was nominated and elected a
13 fellow of APA.

14 I am also a fellow of The Psychology of
15 Women. They also nominated and approved me as a
16 fellow of that division.

17 Q. Psychology of women, is that a division
18 within the APA?

19 A. Yes, that is. They may be -- a lot of
20 divisions now for complicated issues, financial issues
21 I don't understand are incorporated separately, but I
22 couldn't tell you about them. Psychology -- Division
23 35. I think it's just the Psychology of Women.

24 Q. That's also known as Division 35?

25 A. Yes, it is.

1 Q. Any other divisions within the APA where you
2 have credentials?

3 A. No. You have to pay for each division you
4 belong to.

5 Q. So if I were to ask you, generally speaking,
6 in what areas of psychology do you hold yourself out
7 as an expert, how would you answer that?

8 A. As I did before, sexual orientation, LGBT
9 issues, gender, and public policy.

10 Q. Has anyone ever challenged your status or
11 your credentials as an expert in any of those areas?

12 A. No.

13 Q. Are you required to complete any kind of
14 continuing education to maintain your licensure in
15 New Jersey?

16 A. Yes, I am.

17 Q. What were the last continuing ed. courses
18 that you completed?

19 A. Psychology of Opioid Addiction, Adolescent
20 Mental Health are probably the last two. I have to
21 think. How many more would you like me to illuminate
22 on?

23 Q. What is sort of your reporting period or your
24 cycle that you have to comply with for your continuing
25 ed.?

1 A. It's a two-year cycle in advance of your --
2 you have to provide an attestation to renew your
3 license.

4 Q. So in those classes you just mentioned, are
5 those for your current cycle that we're in now or for
6 your prior or previously completed cycle?

7 A. They're for my current cycle. I just
8 completed them about a week or two ago.

9 Q. What did you take to complete your -- to
10 satisfy your requirements for the last cycle?

11 A. I took CE, as required by the State of
12 New Jersey, in domestic violence; telehealth; ethics;
13 LGBT issues.

14 Q. What is telehealth?

15 A. It's the provision of psychotherapy services
16 via two-way interactive video.

17 Q. That's what I would have guessed it was, but
18 I didn't want to assume.

19 A. It is not by telephone.

20 Q. Okay.

21 A. Those are -- I mean -- I'm sorry. I do a lot
22 of -- did 40 credits of CE. I don't recall all of
23 them.

24 Q. So that's just some of them?

25 A. That's just some.

1 Q. But you did 40?

2 A. Yeah. We were required to do 40 credits of
3 CE over two years.

4 Q. What academic degrees do you hold?

5 A. I hold a Doctor of Psychology from Rutgers
6 University and I have a bachelor's degree from Harvard
7 College.

8 Q. What was that in?

9 A. Government. With honors.

10 Q. In the areas that you've identified where you
11 would be considered an expert, sexual orientation,
12 gender, LGBT issues and public policy. Did I say
13 those right?

14 A. That's correct.

15 Q. Has your expertise in those areas been
16 continuous throughout your career or did you add some
17 of them later than others? Was there a period of time
18 where you were sort of less of an expert in those
19 areas? I just want to kind of get a sense for the
20 continuity of your expertise or your status as an
21 expert in those areas.

22 A. So my status in LGBT issues, sexual
23 orientation, gender, has been continuous and I started
24 working in those areas at the end of my graduate
25 career. Public policy I developed an expertise in in

1 2000 -- starting in 2009 began building up my interest
2 and expertise in those areas.

3 Q. And when you say LGBT, does that subsume kind
4 of sexual orientation or gender as well?

5 A. It's sexual orientation predominantly.

6 MR. GANNAM: Let's get into your report.

7 If it's okay with you, I will mark as we go
8 along.

9 THE COURT REPORTER: Sure.

10 MR. GANNAM: For the record, I'm going to
11 start with Exhibit 28 just for continuity from
12 our last depositions exhibits.

13 (Plaintiffs' Exhibit No. 28 was marked for
14 identification.)

15 BY MR. GANNAM:

16 Q. So, Dr. Glassgold, I'm handing you a document
17 I'm marking as Exhibit 28.

18 MR. GANNAM: A copy for you, Rob.

19 MR. WILLIAMS: I forgot to ask, and I
20 apologize, you, I think, contacted Dana yesterday
21 regarding having one or both of your experts
22 participate by Skype.

23 MR. GANNAM: Uh-hum.

24 MR. WILLIAMS: I don't know whether you're
25 doing or that or not.

1 MR. GANNAM: We are. Christopher Rosik is
2 observing the deposition. He's not going to do
3 anything but observe and he is -- we're doing
4 that via Google Hangouts.

5 MR. WILLIAMS: Google Hangouts.

6 MR. GANNAM: It's basically like Skype.

7 MR. MIHET: Say hello.

8 MR. WILLIAMS: Hello. Where is he right now,
9 in California?

10 MR. MIHET: I believe so.

11 MR. WILLIAMS: All right. Well, welcome,
12 Dr. Rosik, I hope you're enjoying it.

13 But Dr. Rosik is the only person that is?

14 MR. GANNAM: That's correct.

15 MR. MIHET: Correct.

16 MR. WILLIAMS: Google, what is it again?

17 MR. GANNAM: Hangouts.

18 MR. WILLIAMS: Okay. I leave all that stuff
19 up to my 13-year-old daughter. She knows it very
20 well.

21 MR. GANNAM: I'm sure we're out of date. I'm
22 sure there's something new.

23 MR. WILLIAMS: Trust me, you are. I can
24 assure you that you are.

25 BY MR. GANNAM:

1 Q. Dr. Glassgold, I've just handed you a
2 document marked Exhibit 28 and the title is
3 Declaration of Judith M. Glassgold. Do you recognize
4 this document?

5 A. Yes.

6 Q. And is this in fact the declaration that you
7 issued or entered in this lawsuit?

8 A. I believe so. I'm not reading the entire
9 thing right now in front of me, but, yes, it looks
10 like it.

11 Q. I will just orient you to what's there. Your
12 declaration includes three exhibits, Exhibit A being
13 your CV; Exhibit B being the 2009 APA report; and
14 Exhibit C is the SAMHSA report from October 2015. And
15 SAMHSA is S-A-M-H-S-A, all caps.

16 A. Yes.

17 Q. Do you see all that in front of you, without
18 reading every word of course?

19 A. Right.

20 MR. WILLIAMS: Would you put on the record,
21 if you would, Roger, representation that Exhibit
22 1 is in fact a genuine authentic copy of
23 Dr. Glassgold's declaration with all of the
24 exhibits?

25 MR. GANNAM: From your mouth to the record.

1 I'm satisfied with that.

2 MR. WILLIAMS: There you go.

3 BY MR. GANNAM:

4 Q. So, Dr. Glassgold, I kind of point you to the
5 last page of the declaration itself, which is page 38.
6 And is it double-sided just to save space. Are you on
7 page 38?

8 A. I believe so.

9 Q. It reads "Executed this June 11, 2019." Do
10 you see that?

11 A. I see that.

12 Q. And is that your signature at the bottom?

13 A. Actually not.

14 Q. Did you authorize someone to electronically
15 sign it on your behalf?

16 A. I guess so. I don't know. I don't remember.
17 I signed a copy.

18 Q. You signed with a pen signature?

19 A. And forwarded it to the law firm.

20 Q. Okay. And is the pages 1 through 38 that
21 we're looking at now the same as the version that you
22 signed?

23 A. I will assume so.

24 Q. And I would accept Rob's representation that
25 it is. I understand the logistics sometimes of

1 getting things signed.

2 But, as signed, and I believe you said you
3 did review your declaration before testifying today,
4 is everything in this declaration still correct?

5 A. I believe so.

6 Q. Is there anything in this declaration that
7 you desire to withdraw or change?

8 A. Not that I'm aware of, no.

9 Q. Have you done any additional research or work
10 on this case since providing this declaration other
11 than your time preparing for today's testimony?

12 A. I'm not sure I totally understand the
13 question.

14 Q. Fair enough. Have you continued working on
15 any issues relating to this case or developing
16 opinions related to this case since you issued your
17 declaration?

18 A. No.

19 Q. Is this declaration complete in the sense
20 that it covers all of the opinions that you intend to
21 provide in this case?

22 A. I'm not sure I totally understand that.

23 Q. Well, what is the scope of your engagement
24 with the Burr Forman law firm to work on this case?
25 What subject matters were you asked to cover or what

1 all have you been asked to do as an expert?

2 A. I have been asked to do this, provide a
3 statement, and perhaps testify.

4 Q. And when you say do this, you mean write the
5 declaration or today's deposition?

6 A. Today's deposition and write the statement.
7 I think my -- I apologize. But I continue to read in
8 this general area of sexual orientation and gender
9 because that's an area that I'm interested in, so I
10 don't believe that -- so that I will continue to read
11 articles that are published in this area.

12 Q. Have you continued to do any work specific to
13 this lawsuit since preparing this declaration and
14 other than your time spent preparing for today's
15 deposition?

16 MR. WILLIAMS: Roger, what do you mean by
17 work? I want to make sure.

18 A. Yeah, I don't understand what that means.
19 I'm sorry.

20 Q. Let's back up. What were the scope of your
21 engagement? You said it was to issue this written
22 declaration --

23 A. Uh-hum.

24 Q. -- marked as Exhibit 28?

25 A. Uh-hum.

1 Q. Testify at today's deposition?

2 A. Uh-hum.

3 Q. And then to testify at trial, if necessary?

4 A. Right.

5 MR. WILLIAMS: You have to say yes.

6 THE WITNESS: Yes. Sorry.

7 MR. WILLIAMS: We all do it.

8 BY MR. GANNAM:

9 Q. Are there any other -- is there any other
10 work or tasks you've been asked to do in connection
11 with the litigation?

12 A. No. No.

13 Q. The answer is no. Let's try not to talk over
14 each other.

15 A. Sorry. No.

16 Q. That's okay. I do it too.

17 So, apart from the continuing research or
18 scholarship that you do in this area anyway because
19 you are an expert in this area, have you done any
20 additional work for this case such as working on a
21 subsequent declaration or developing any opinions on
22 other subjects or anything like that?

23 A. No.

24 Q. And can you just state for me what were the
25 areas you were asked to provide an opinion on for

1 purposes of this case?

2 A. On the ordinance and related information to
3 conversion therapy.

4 Q. And by "the ordinance" are you referring to
5 the City of Tampa ordinance that's the subject of this
6 lawsuit?

7 A. Yes, I am.

8 Q. And, for the record, that's Tampa ordinance
9 number 2017-47. Is that also your understanding?

10 A. That's my understanding.

11 Q. Okay. And I take it you've read the
12 ordinance?

13 A. Yes, I have.

14 Q. Were you ever consulted by anyone with the
15 City of Tampa prior to enactment of the ordinance?

16 A. No.

17 Q. Have you ever worked on any effort or
18 campaign to pass an ordinance like Tampa's or even a
19 state-wide law like Tampa's ordinance?

20 A. No.

21 Q. Have you worked on any advocacy projects or
22 campaigns related to banning conversion therapy or
23 SOCE or related therapies?

24 A. Only providing information to the Born
25 Perfect group or the attorneys or the people there.

1 Q. And is one purpose of the Born Perfect
2 project to promote or seek enactment of bans like
3 Tampa's ordinance?

4 A. I believe its frame is ending conversion
5 therapy, ending the provision.

6 Q. Is that the primary purpose of the Born
7 Perfect project or a purpose of the Born Perfect
8 project?

9 A. At the present time I'm not sure what the
10 purpose is because I haven't been consulted by them,
11 but it's to advise on effective public policies, I
12 believe.

13 Q. And when you say a goal of the project was
14 ending conversion therapy, is that ending it through
15 legal prohibitions like Tampa's ordinance or through
16 some other means?

17 A. I believe one may be through legislation like
18 you're submitting, as well as education and continuing
19 education about alternatives that could achieve client
20 goals in a safe and effective manner.

21 Q. Are you aware of any other modes or
22 categories of therapy that have been legislatively
23 banned like conversion therapy has been in some
24 jurisdictions?

25 MR. WILLIAMS: Object to the question as

1 being vague. At least to me. I'm not sure what
2 you mean by that.

3 But, Dr. Glassgold, if you understand it,
4 feel free to answer.

5 A. My understanding of those efforts is
6 incomplete. The only one I am aware of is banning
7 rebirthing therapy.

8 Q. And I think I've heard of that, but can you
9 just sort of explain what that is?

10 A. To be honest, I couldn't explain it to you.
11 I'm sorry.

12 Q. You're generally aware that something called
13 rebirthing therapy has been banned somewhere?

14 A. Yes.

15 Q. Did you work on any project related to that?

16 A. No.

17 Q. Does rebirthing therapy have any relationship
18 to what is sometimes called conversion therapy?

19 A. I don't believe so, no.

20 Q. Do you intend to give any opinions in this
21 lawsuit that are not reflected in your declaration?

22 A. I don't believe so.

23 Q. Are you the sole author of this declaration
24 marked as Exhibit 28?

25 A. Yes.

1 Q. And does any of the content reflect the work
2 of others even though you may have drafted it?

3 A. I don't believe so.

4 Q. Did NCLR have any involvement in the
5 preparation of your declaration?

6 A. Not that I'm aware of, no.

7 Q. Did you exchange drafts or consult anyone at
8 NCLR before you prepared the final copy that you
9 signed?

10 A. No.

11 Q. What about with any other organizations other
12 than the Burr Forman law firm?

13 A. No.

14 Q. Have you communicated with the SPLC about the
15 preparation of your declaration?

16 A. No.

17 Q. What about Equality Florida?

18 A. No.

19 Q. And no other organizations?

20 A. No.

21 Q. How long did it take you to prepare your
22 declaration?

23 MR. WILLIAMS: You mean actually write it or
24 the whole process?

25 Q. I mean the whole project.

1 A. The whole project. Wait. So could you be
2 more specific by project?

3 Q. Sure. You were contacted at one point by
4 Mr. Minter, you spoke to Mr. Williams and made your
5 arrangements for your engagement. How much time did
6 you spend working on your declaration from the
7 beginning up to when you signed it?

8 A. Probably close to 40 hours total work.

9 Q. And is any part of this declaration work that
10 you've done in another context that you converted into
11 the declaration or was it all new work?

12 A. It probably contained material from articles
13 I have published and material I did prepare for other
14 declarations.

15 Q. What other declarations?

16 A. Schwartz.

17 Q. That's the New York case?

18 A. Yes.

19 Q. Who is your engagement with in that case?

20 A. A private law firm.

21 Q. What is the name of the firm?

22 A. I do not recall. I would have to look it up.

23 Q. Do you know whether that firm represents a
24 party in the New York lawsuit?

25 A. The City of New York.

1 Q. And in that engagement do you know who -- are
2 you being compensated for that engagement?

3 A. No.

4 Q. Not at all?

5 A. Not at all. Well, I just prepared a
6 statement. That's it.

7 Q. You prepared a declaration in that case?

8 A. Yes. That's it.

9 Q. Are you going to testify in that case?

10 A. Not that I'm aware of.

11 Q. So there's no compensation arrangement for
12 what you've done so far?

13 A. That's correct.

14 Q. And apart from work that you may have done in
15 the New York case that you may have used for this
16 declaration, is there any other work that you've done
17 in another context that you've used to prepare this
18 declaration?

19 A. Yes. Testimony I provided in Maine. Oh,
20 right actually. I apologize. I forgot. I testified
21 on behalf of GLAD in the Maine law banning conversion
22 therapy, as an expert.

23 Q. Testified where?

24 A. In front of the legislature. In front of the
25 legislative committee.

1 Q. Okay. And that was testimony arranged by
2 GLAD?

3 A. That's correct.

4 Q. G-L-A-A-D; is that right? Or G-L-A-D?

5 A. Gay and lesbian -- Gay and Lesbian Advocates
6 and Defenders, I believe, is what it stands for.

7 Q. We know it's called GLAD. We're just not
8 sure exactly what all the letters stand for.

9 All right. When was that testimony?

10 A. April.

11 Q. Of 2019?

12 A. Yes.

13 Q. And did Maine -- did the Maine legislature
14 pass a state-wide ban?

15 A. Yes, it did.

16 Q. What committee did you testify before?

17 A. Health services and financing, I believe, or
18 something close to that.

19 Q. How did you get involved in that project?

20 A. I was contacted by an attorney with GLAD.

21 Q. Do you remember who that was?

22 A. Mary Bonauto.

23 Q. And is that someone you knew before she
24 contacted you?

25 A. Only by reputation.

1 Q. Did you prepare any written testimony for
2 that Maine legislative committee?

3 A. Yes, I did.

4 Q. Is that written testimony published anywhere
5 or available online, to your knowledge?

6 A. It's in the record of the committee hearings
7 and it was provided to the committee.

8 Q. Are there any other projects like that that
9 you've worked on?

10 A. No.

11 Q. Was the, for lack of a better word, the gist
12 of your written testimony to the Maine legislative
13 committee similar to what's in your declaration here?

14 A. Similar and different probably.

15 Q. In what ways was it similar?

16 A. It focused on the general principal that
17 conversion therapy is ineffective and harmful and is
18 dangerous to young people.

19 Q. In what ways was it different?

20 A. I believe in this I talked much more --

21 MR. WILLIAMS: This being your declaration?

22 THE WITNESS: So I just wanted to --

23 generally, I believe that statement talked a
24 great deal more about adolescent health and child
25 development generally and adolescent suicide and

1 other mental health concerns. But there are many
2 similarities.

3 MR. WILLIAMS: Just a pause here, Roger.

4 The reason I said that, Doctor, is when you
5 read a dry transcript the word "this" is vague.

6 THE WITNESS: Oh, sure. Of course. I
7 understand that.

8 MR. WILLIAMS: So if you're referring to any
9 documents, it's always good to describe it with
10 some detail. That way, the raw record will know
11 exactly what you're talking about.

12 THE WITNESS: Good point.

13 MR. GANNAM: All right.

14 MR. WILLIAMS: Same thing with pronouns and
15 things like that.

16 THE WITNESS: That's a good point.

17 BY MR. GANNAM:

18 Q. Can I direct you to paragraph 9 of the
19 declaration. It's on page 3.

20 A. Okay.

21 Q. It begins, "I served as the Chair of the
22 American Psychological Association, APA, Task Force on
23 Appropriate Therapeutic Responses to Sexual
24 Orientation, 2007 to 2009, and wrote sections and
25 edited the final report released in 2009." Called

1 here the APA report and attached as Exhibit B to your
2 declaration.

3 Did I read that correctly?

4 A. Yes.

5 Q. Now, the remainder of that paragraph talks
6 some about the process, but could you tell me, how did
7 you get to that position of Chair of the APA Task
8 Force? And before we go on, going forward, if I say
9 the APA Task Force, I'm referring to this 2007 Task
10 Force. Do you understand that?

11 A. Yes, I do.

12 Q. And when I say --

13 MR. MIHET: 2009.

14 THE WITNESS: Right. Correct. Thank you.

15 BY MR. GANNAM:

16 Q. So the Task Force met from 2007 to 2009;
17 correct?

18 A. That's correct.

19 Q. And the report was issued in 2009. So when I
20 say the APA report, I'm referring to the 2009 report.
21 Do you understand that?

22 A. Yes. Yes, I do.

23 Q. Just so we're on the same page.

24 So now, tell me, how did you get to that
25 Chair of that Task Force?

1 A. So, from my understanding and I will explain
2 on the basis of my recollection, my best recollection
3 and understanding, an open call for nominations to
4 this Task Force was issued by APA, I believe within
5 the organization and maybe even more broadly to the
6 professional community. I responded with an
7 application that I believed described my
8 qualifications.

9 In that nomination, the APA listed the charge
10 of the Task Force which is detailed in, I believe, the
11 preface material of the report. I submitted this
12 application. It may have included recommendations as
13 well to APA. I believe I was self-nominated, but I
14 don't exactly recall.

15 Then my -- so I believe this process goes as
16 follows: That my application was reviewed by a
17 standing committee of APA on sexual orientation and
18 LGBT issues. Then my name, as well as other
19 prospective Task Force members as well as alternates
20 and all the nominations, were provided -- were
21 reviewed by this Task Force and they selected people
22 they felt could fulfill the charge. And the charge
23 was very specific because it was a charge to recommend
24 to APA any policy updates to the 1997 APA resolution
25 on conversion therapy. That was the only -- that was

1 the existing resolution.

2 APA issued this charge because I believe they
3 had comments from outside organizations and the public
4 and from members within APA that the 1997 resolution
5 on conversion therapy no longer was suitable or fit
6 the circumstances or the research or the needs of the
7 public or professionals on guidance. So APA, the
8 board of directors, I believe, or the council of
9 representatives voted to issue this charge and
10 constitute a Task Force because it was not budget
11 neutral, it did involve a cost to the organization,
12 you know, to bring in a panel of experts and have them
13 meet, so that they had to -- the Board had to approve
14 the task and the charge.

15 So we were -- the association, my
16 understanding, was responding to a request from
17 professionals and the public to update an internal APA
18 resolution that would reflect the policies of the
19 Association as well as the best scientific evidence.
20 So my application was my qualifications to accomplish
21 that purpose.

22 So the first screening was done by the
23 Committee on Sexual Orientation or the Committee on
24 LGBT issues. The Committee changes its name
25 periodically. I don't recall what it was at that

1 time.

2 After they had a list of candidates and they
3 provided them to the Board, another standing
4 committee, and both the Committee and the Board, the
5 members were chosen for three-year terms and the
6 membership was constituted before the charge was
7 issued. The board for psychology, for social --
8 psychology and the public interest oversees that
9 committee on sexual orientation and a number of other
10 committees in the public interest directorate.

11 I just want to add that both the Committee
12 and the Board are made up of psychologists who provide
13 guidance to the association on these issues among
14 others. The Committee provides guidance on sexual
15 orientation issues and the Board provides guidance to
16 APA policies and staff on all issues relevant to
17 psychology and the public interest.

18 After the Board screened the list that the
19 Committee provided, it also had access to all the
20 applications that had come in, they then referred
21 their nominations up the ladder to -- and I'm not sure
22 if there were any other interim steps, whether APA
23 executive board, in terms of the administrative
24 executive officers, reviewed them. I think that other
25 boards like the board for scientific affairs and the

1 board on practice also reviewed the nominations. Then
2 they were referred to the board of directors. The
3 list of nominees alternates and all the applications
4 were given to the board of directors and they made the
5 final decision about the membership of the committee
6 as well as who would serve as the Chair.

7 So when I received, I believe, a letter from
8 APA, I was just informed that I was both member and
9 Chair.

10 Q. Did you apply specifically for the Chair
11 position?

12 A. No.

13 Q. And why did you apply for membership on the
14 Task Force?

15 A. I had become interested in these topics due
16 to my work in women's issues, sexual orientation and
17 psychoanalysis, as well as my interest and clinical
18 work with women and men, as well as an interest I had
19 and patients I had who had conflicts between their
20 religious beliefs and their sexual orientation. So I
21 had addressed in two previous -- one previous book,
22 maybe a second book, and an article on issues in
23 psychoanalysis in lesbians. So I was particularly
24 interested in this topic.

25 I had also served, from about 1999 to 2003 or

1 '4, on the committee on LGBT issues for APA. My term
2 had expired and I had become interested in some of
3 the, you know, current concerns about quality of
4 psychotherapy for this population.

5 Q. And just so I understand, ultimately the
6 decision to appoint you as both a member and the Chair
7 of the Task Force was made by the board of directors
8 of the APA?

9 A. That is my understanding.

10 Q. And there were several interim reviews by
11 other committees and boards, to your understanding?

12 A. Yes, that is correct.

13 Q. And was that the same for everyone who became
14 a member of the Task Force?

15 A. Definitely, yes.

16 Q. Did you have any input on who was a member of
17 the Task Force?

18 A. None at all.

19 Q. How many members of the Task Force were
20 there?

21 A. Oh, I believe we were a total of five. The
22 list of members is in the report, in the covered
23 materials.

24 Q. Now, did you have any involvement in the
25 issuance of the 1997 APA resolution on conversion

1 therapy?

2 A. No.

3 Q. And was that the actual title, Resolution --

4 A. Oh, no, nothing that simple. It would be --

5 Q. Something more like therapeutic response to,
6 kind of like the 2009 report?

7 A. Right. I believe the text of the original
8 resolution is somewhere in the materials of the report
9 in the appendix or you might find it on the APA
10 website. I don't recall the title. Something long
11 and technical.

12 Q. Now, prior to your appointment as Chair of
13 the Task Force, had you done any scholarly writing or
14 give any testimony opposing the practice of conversion
15 therapy or SOCE?

16 MR. WILLIAMS: Can we start with writing and
17 then go to testimony?

18 MR. GANNAM: Sure.

19 MR. WILLIAMS: So it's not a compound
20 question.

21 A. So if you look at my 1995 edited book, I
22 believe at that point we talked more about inaccurate
23 and faulty constructions of lesbian identity. I do
24 not recall that we actually discussed change therapy
25 in the way I think you're thinking about. I think

1 certainly we criticized and I don't know if my article
2 criticized, but the articles in the book and the
3 introduction I wrote with Dr. Susan Iasenza, talked
4 about how psychotherapy and generally.

5 So you must remember that until maybe even
6 the late 1990s most psychoanalytic therapies, some,
7 not many, so psychoanalytic therapies often still
8 included efforts to change or would represent
9 constructions and perceptions of lesbian sexual
10 orientation and bisexual orientation as faulty or
11 damaged. So that's the topic we were focused on in
12 the book. I don't think we ever dreamed of a
13 legislative ban or anything like that. It was more
14 that psychotherapy should be an accurate
15 representation and not based on stereotypes and
16 stigma.

17 Q. At the time that you became the Chair of the
18 Task Force, did you -- had you developed an opinion as
19 to the efficacy or harm of conversion therapy or SOCE?

20 A. I focused predominantly -- actually,
21 somewhat. I would say somewhat.

22 Q. And what were your opinions at that time that
23 you took the Chair position?

24 A. I believe that certain psychoanalytic
25 theories that some people based conversion therapy

1 interventions were inaccurate and faulty and based on
2 stereotypes and were inaccurate and not based on
3 scientific facts.

4 Q. And can you give me examples of those?

5 A. The work of Nicolosi, Socarides, Segal,
6 Eisenbud.

7 Q. Any others?

8 A. No.

9 Q. And what were your objections to their work,
10 if you can summarize those for me?

11 A. They were fundamentally inaccurate.

12 Q. In what ways?

13 A. Pathologizing. They were just fundamentally
14 inaccurate. That they were based on outdated precepts
15 from 80 years ago that incorporated pathologizing and
16 dehumanizing versions that prescribed faulty mental
17 illness stereotypes.

18 They over-generalized from a clinical
19 population to a general population. They were not
20 based on any actual scientific evidence and were just
21 generally opinion.

22 Q. And can you give me more specific examples of
23 what outdated precepts we're talking about when you
24 say pathologizing?

25 A. Penis envy, preoedipal, undifferentiation. I

1 think there was generally an overgeneralization from
2 clinical samples to the general population. So
3 someone would see someone with a psychotic disorder
4 and then say that all lesbians are psychotic. That
5 kind of types of issues.

6 Q. Any others as far as objections that you had
7 to their work?

8 A. I'm sure there are many, to be honest, but I
9 completed that book in 1995, so that it's been a while
10 since I reviewed those conclusions, to be honest.

11 Q. Did you have any particular goals or
12 objectives in mind when you took the Chair position
13 for the Task Force?

14 A. I hoped we could chart a course to providing
15 safe and effective therapies that were based on the
16 best scientific evidence for this population.

17 Q. Do you believe the Task Force accomplished
18 that?

19 A. Yes, I do.

20 Q. Now, the APA report, the 2009 report that
21 your Task Force issued, generally uses the term
22 "sexual orientation change efforts" or S-O-C-E, or
23 SOCE. We've also talked today and Tampa's ban refers
24 to conversion therapy. What is the difference in
25 those terms, "SOCE" and "conversion therapy," as you

1 understand?

2 A. The Task Force defined sexual orientation
3 change efforts in the report and so I refer you back
4 to that. My sense is conversion therapy is a lay
5 term.

6 Q. Are they synonymous or are there differences
7 in what the two terms cover?

8 A. In the Tampa ordinance, conversion therapy
9 includes gender identity as well as sexual
10 orientation. In the APA report, SOCE, the members,
11 some of them referred to it as that, just refers to
12 sexual orientation.

13 But I believe my understanding in the Task
14 Force report is that we refer to sexual orientation
15 change efforts as change efforts that have the a
16 priori goal, prior to even meeting the client, that
17 homosexuality should be changed or that sexual
18 orientation should be changed. That when we refer to
19 sexual orientation change efforts we looked at and
20 we've really examined theories and practices that
21 assumed, against the scientific consensus, that
22 homosexuality is not a mental disorder or defect, that
23 it was a mental order or defect. And so that they
24 attempted, a priori to seeing the client and listening
25 to the client's concerns, that the client needed to

1 eliminate or eradicate those feelings.

2 MR. WILLIAMS: Roger, before you ask another
3 question, it's 11:25. I don't need a break, but
4 we do have lunch coming up. We could order it
5 out to save time. I'm offering it to you and
6 Harry or you can go your own way, as the song
7 goes.

8 MR. GANNAM: Why don't we go off record, take
9 a break real quick, and we'll discuss it and make
10 a plan and we'll go from there.

11 MR. WILLIAMS: Fine.

12 (Recess from 11:24 a.m. to 11:40 a.m.)

13 BY MR. GANNAM:

14 Q. Continuing on, you told us about your
15 appointment as the Chair of the APA Task Force, and I
16 think you told us the board of directors made that
17 decision to appoint you and the other members; is that
18 correct?

19 A. That's correct.

20 Q. Is your application, is that a public
21 document or is that something held confidential by the
22 APA?

23 A. I have no idea. Sorry.

24 Q. That's okay. Some questions I ask I'm just
25 curious, I'm not expecting a particular answer.

1 All right. Can you tell me kind of just
2 about the process, what did the committee -- I'm
3 sorry -- the Task Force do from when it was empaneled
4 to when it issued its report?

5 A. So we had five members. So we had Roger
6 Worthington, Beverly Greene, Robin Miller, Jack
7 Drescher, Lee Beckstead, and myself. So there were
8 six members, so that's a correction.

9 And there is a staff member with general
10 responsibility for that area who was our
11 administrative lead, sort of helpful person, that was
12 Clinton Anderson. And then Charlene Hunter, I believe
13 that was her last name, was the administrative staff
14 person. So those were the people who were in the room
15 at all times.

16 We met at least twice in 2007 because -- and
17 I believe that was the only meetings we held because
18 that was the only year funding for such a meeting was
19 allocated.

20 Q. Where did you meet?

21 A. We met at the American Psychological
22 Association late spring, early summer, and I think
23 again in the fall, but I could -- that's the base of a
24 12-year-old recollection that I have not consulted
25 my -- if I have an appointment book from that area.

1 So I don't really know the dates.

2 The first year when we were appointed, which
3 was 2007, we didn't get appointed until April-ish
4 potentially. Or maybe it was March. I apologize. Or
5 maybe earlier.

6 So I'm not even sure when the appointments
7 came through, but we couldn't meet because many of the
8 members are academics and they couldn't meet until the
9 semester was over. So that was some time in May,
10 June. And then we met again in the fall. And we
11 proceeded with many conference calls and e-mails to
12 first create a reading list.

13 So, you know, Roger Worthington is an expert
14 in counseling psychology and sexual identity and has
15 published a number of articles. At that time he was
16 most well known for his work on heterosexual identity
17 development. Robin Miller is a statistician and
18 expert in statistical methodology and doing research.
19 Beverly Greene had experience in child and adolescent
20 therapies as well as ethnic minority or related in
21 diversity issues.

22 Lee Beckstead is a psychotherapist and had
23 expertise in concerns of religious individuals and had
24 published a couple of qualitative research papers on
25 the experiences of predominantly men from the LDS

1 faith who had undergone conversion therapy. And Jack
2 Drescher is a psychiatrist who is known for his work
3 predominantly on conversion therapy as well as
4 psychoanalysis.

5 So even though everybody had their area of
6 expertise, it was felt that we all had to have some
7 common background and understanding and people maybe
8 had to review areas that they were not as familiar
9 with because we all had our different areas. So we
10 first compiled this bibliography and reading list for
11 people to review or at least to look at and figure out
12 where they needed to buff up their background,
13 especially maybe in some current concerns or some
14 current publications, so when we all met we could
15 really begin the process with the same background.
16 And we also created an agenda for our first meeting
17 via telephone calls.

18 Because we only had two meetings. They were
19 both a day and-a-half, probably a long weekend. So we
20 would arrive on a Friday, meet Saturday and Sunday,
21 and then leave Sunday night. So you have two days,
22 four days total for the full year, but it was a pretty
23 intensive process so we wanted to create, especially
24 for the first meeting, a really tight agenda. So
25 there was a lot of work involved in creating an

1 agenda, trying to sort out what our priorities needed
2 to be.

3 And I think, in reviewing the bibliography, a
4 decision was made by the entire group that -- so we
5 had to adhere to the charge. We really couldn't go
6 off and do other things. But to complete the charge,
7 which is really to revise the APA resolution to decide
8 if the 1997 resolution was adequate, we weren't told
9 we had to revise the charge, we really were told we
10 had to look at it, think about if it really fit the
11 concerns of 2007 and whether it needed to be updated,
12 revised. That we really needed to do a lot more work
13 and answer some fundamental questions about efficacy
14 and harms and the outcomes of the research on sexual
15 orientation change efforts.

16 And I will try to remember to come back to
17 why we chose SOCE, but I want to finish this train of
18 thought.

19 So a decision was made, and it may have been
20 made at the first meeting or just prior to the first
21 meeting, that we needed to do a really good systematic
22 research review, and Robin Lin Miller was going to
23 undertake that because she had the expertise. She was
24 an editor at a well-regarded journal on those issues
25 and had undergone those kind of reviews.

1 And a systematic review is the standard for
2 really evaluating effectiveness of treatments in most
3 scientific treatment types of things. When you have
4 enough research to review. So that's a common thing
5 that is done. So Robin was going to undertake that.

6 We chose SOCE, I believe Dr. Beckstead, so we
7 had to decide what the scope was. He preferred that
8 term. We all chose that. We didn't like the term
9 "conversion therapy" for a lot of reasons, but it is
10 the lay term.

11 And he wished to include therapies not only
12 done by licensed professionals, but where appropriate
13 and where important to also consider maybe efforts by
14 religious and spiritual leaders or professionals, we
15 chose the word "effort" to include that and maybe
16 because sometimes the treatments were diverse, but
17 that was something he felt was important from his work
18 with people with religious -- strong religious
19 beliefs, he consulted a wide variety of approaches.

20 MR. GANNAM: Can I stop you right there. And
21 can we go off for a second.

22 (Discussion off the record.)

23 BY MR. GANNAM:

24 Q. So can you tell me what is a systematic
25 research review?

1 A. So, again, I defer to the text in the report
2 for a really complete version because I might leave
3 something out. It basically looks at -- does a
4 literature review.

5 First you do a search in all medical -- all
6 relevant journals in your subject area of all studies
7 that evaluate a treatment or report a treatment, and
8 then the systematic review analyzes -- so this is only
9 peer review journals. So after discussion we decided
10 that we had to limit it to peer review journals
11 because that is the best research that will show, in
12 the most robust way, whether there is any harms,
13 benefits, efficacy, effectiveness, change. Because
14 the question was, does this approach work. Does
15 SOCE -- do change efforts yield results.

16 Q. And, when you say peer review journals, what
17 qualifies a journal to be a peer review journal?

18 A. So, generally speaking, and the report may
19 have another more comprehensive definition, the
20 articles are submitted generally anonymously by the
21 authors and then reviewed by members of the editorial
22 board who are appointed by the editor for terms of
23 service, a few years, who are experts in the field.
24 So like the Journal of Educational Psychology will
25 have on its board educational psychologists or

1 educational professionals who can evaluate, research
2 in education or educational psychology and decide
3 whether it meets the standards of the particular
4 journal.

5 In our -- in Chapter 3 of the report, which I
6 think gives a really good explanation of the review,
7 the systematic review process, but also what qualifies
8 as good scientific research. So the systematic review
9 would look at a peer review journal, but then do
10 another evaluation about -- because a lot of articles
11 are published in a lot of, quote, peer review journals
12 and there are many, many journals out there. Does it
13 meet the requirements for efficacy, to determine
14 efficacy. Is it an experiment.

15 So Dr. Miller, who is the real expert, would
16 evaluate, along with us, we would -- I think we all
17 participated in some way to provide safeguards. You
18 know, Robin and Roger, who were actually probably our
19 strongest researchers, you know, looked at the
20 articles, are they true experiments or are they quasi
21 experiments in terms of are they randomly selected or
22 is it a clinical population, do they measure an actual
23 treatment with controls or are they uncontrolled
24 experiments. So they would evaluate them and
25 generally, to prove causality, you have to have some

1 sort of treatment administered, some sort of
2 pre-assessment variables and some post-assessment
3 variables so you can assess change and anything else.

4 And you have to have some sort of goal. Most
5 experiments have a specific goal in mind they want to
6 show. X treatment does these things.

7 Q. And when you said -- what's the difference
8 between a random sample and a clinical population?

9 A. So a random sample is samples from the entire
10 population. So like it's often most common in, like,
11 pharmaceutical research where you do that. Or perhaps
12 you have a broad effort, you sort of can select from a
13 large group of people, and you randomly assign people
14 from the public who are either controlled to the
15 treatment design or sort of the neutral, no
16 intervention.

17 But sampling in this area is, you know, when
18 you're dealing with a special population, minority
19 population, stigmatized population, it's unusual to
20 have a random sample. I'm not sure we know who LGBT
21 people are generally, so it would be hard to do that.

22 Q. When the Task Force made a decision, for
23 example, to use the term S-O-C-E, or SOCE, was this
24 done by vote, did you require unanimity on decisions
25 or how did that work?

1 A. I think generally we aimed for a consensus.

2 Q. Was there a list of articles or studies that
3 were specifically excluded from your systematic
4 research review?

5 A. Yes, I believe. I believe in the -- let me
6 try -- I'm trying to think.

7 So Robin did a literature review --

8 MR. WILLIAMS: Why don't you do a last name
9 with Robin.

10 THE WITNESS: Sorry. I apologize.

11 A. Robin, Dr. Miller, did the literature review
12 from 1960 on and then selected 56 or 57 studies that
13 qualified as peer reviewed research that appeared in
14 peer reviewed literature. She then -- I believe that
15 list is in the appendix, but I'm not a hundred percent
16 sure. And then she selected a number of articles to
17 examine in terms of their evidentiary conclusions
18 because they fit the qualities for quality research.

19 But, to be honest, I don't totally recall.
20 There was, you know, and I'm not sure -- not a hundred
21 percent sure of that.

22 BY MR. GANNAM:

23 Q. And did she make the decision herself as to
24 which of those to include in your review or was that
25 something submitted to the whole committee for vote?

1 A. We didn't vote. We looked at the list. I
2 think she made her recommendations. I believe Roger
3 Worthington probably participated in some way. And
4 the committee did evaluate that.

5 Q. Did the Task Force ever have votes or any
6 kind of parliamentary procedures on various things?

7 A. I don't recall. We were generally a very
8 collegial and professional group and I don't -- when
9 there was a disagreement or a difference in perception
10 we talked it through and came to, I think, a
11 conclusion that everybody felt good about.

12 Q. Did that happen often?

13 A. I don't recall, but I don't think so. I just
14 remember it being a very productive experience and
15 very -- one of the highlights of my professional
16 career in terms of learning from others and having
17 interesting and worthwhile discussions of all sorts of
18 topics related to this.

19 Q. Were any of the Task Force members themselves
20 practitioners of a therapy that could be called SOCE
21 or conversion therapy?

22 A. No. You must recall that the charge of the
23 Task Force was to revise an APA resolution and the
24 document that we produced and the product that was
25 going to be the resolution that was an internal APA

1 product for APA purposes. So, as such, the document
2 had to be consistent with APA policies and
3 resolutions, and in 1975 APA had adopted a resolution
4 that homosexuality was not a mental illness or
5 developmental defect and that the Association should
6 work to end the stigma toward homosexuality.

7 So many people who practiced such therapy
8 such as sexual orientation change therapies stated in
9 their publications that they perceive homosexuality as
10 a defect, so they would not be considered generally
11 able to participate.

12 Q. You testified earlier that there were a lot
13 of reasons why you didn't like the term "conversion
14 therapy." Can you explain what those are?

15 A. I think it's -- for our purposes writing the
16 report, we wanted to have a term that was more
17 specific and didn't perhaps have any connotations one
18 way or the other that people could misinterpret and I
19 think we wanted something that reflected our charge.
20 So, you know, generally, again, this was an APA -- the
21 task we were doing was for the American Psychological
22 Association, so we really focused on what would meet
23 their requirements and, I think, you know, be
24 inclusive of the approaches we were going to think
25 about.

1 Even if the approaches were not going to be
2 considered in the research review, you have to
3 remember that if you saw the final product -- I don't
4 know. I assume, to be honest, that you haven't
5 read -- maybe you have read and enjoyed the report.
6 Or whatever. Found it interesting.

7 MR. WILLIAMS: Is that a yes or a no?

8 Q. Read, yes. I'll reserve judgment on whether
9 I enjoyed it.

10 MR. WILLIAMS: All right.

11 A. And that reminds me of something I left out
12 and I'm going to get back to. That -- now I forgot my
13 train of thought.

14 So I think we wanted it to be comprehensive.
15 I think Lee felt that the word "therapy" was
16 problematic because some of the tech -- some of the
17 approaches he wanted to include, such as the religious
18 and spiritual approaches, weren't perhaps, per se,
19 therapy. So because we are dealing with the provision
20 of efforts by nonprofessionals, we had to expand the
21 term and "efforts" was chosen.

22 MR. WILLIAMS: Lee Beckstead; right?

23 THE WITNESS: Dr. Beckstead, yes.

24 MR. WILLIAMS: The use of first names, I
25 think, reflects the collegiality of your Task

1 Force.

2 THE WITNESS: I apologize for not being
3 specific on that.

4 MR. WILLIAMS: That's all right. I'm going
5 to be a pest on that.

6 BY MR. GANNAM:

7 Q. So did your Task Force coin the term "sexual
8 orientation change efforts"?

9 A. Yes, we did. Yes. We did coin that, for
10 better for worse.

11 I also want to say that, as an APA product,
12 you have to remember that the report was going to be
13 peer reviewed after it was done so that we knew that
14 we were going to write this report and perhaps propose
15 a new resolution. And I think in the first meeting we
16 really determined that the resolution was very
17 outdated and didn't reflect any recent research so we
18 had to revise it and we wanted to, you know, come up
19 with a term that was accurate but that also would deal
20 with the fact that we were going to be peer reviewed
21 both by all the internal APA board and committees, but
22 we were going to submit the report to outside
23 reviewers, just like if it had gone through a peer
24 review journal.

25 So we wanted to pick a term that was

1 appropriate, but we also wanted to do a product, you
2 know. And then at the end the report was going to
3 have to be accepted by -- reviewed by all the boards
4 and committees, accepted by them, then it had to be
5 accepted by the council -- it had to be reviewed by
6 the board of directors and then accepted by the
7 council of representatives and any resolution we came
8 up with had to, of course, be peer reviewed, all those
9 things, and then voted on by the council of
10 representatives.

11 So there was just a lot of pressure or just
12 aware that our activities were going to be highly
13 scrutinized and the work product had to be really
14 quite excellent so we needed to be very, very thorough
15 and thoughtful.

16 Q. At the time that you came up with the term,
17 and when I say you I mean the Task Force, did you
18 personally consider conversion therapy to be a term
19 that carried with it some connotation of approval or
20 disapproval of the practice?

21 A. I think we thought that the term -- I didn't
22 think that per se because some people were positive
23 about the term who used it, some people were negative.
24 I think it had this -- conversion is a strange -- is a
25 word that's unique and didn't reflect the process, but

1 it also, I believe, is the lay term and that's more
2 understandable. S-O-C-E, SOCE, hasn't met with public
3 interest as a term particularly much.

4 Q. Did you discuss or did you think at the time
5 that the term "conversion therapy" had a specifically
6 religious connotation?

7 A. We did discuss that. I'm not sure -- that
8 was certainly something we discussed. I don't recall
9 what side I came up on. I think there were pros and
10 cons to each. I think that opinion was expressed by
11 some people. I don't recall.

12 Q. So in terms of the various practices carried
13 out by licensed professionals, at the time you came up
14 with the term SOCE, what were those licensed
15 professionals calling those practices?

16 A. I'm not sure I recall totally. I mean, I
17 think people like Socarides would just say he did
18 psychoanalysis. I'm not sure. I don't recall that.

19 Some of them may have used that term and I
20 believe that -- it was a professional term before it
21 became a lay term, I believe, but I can't recall who
22 might have used that term in the professional
23 literature, but I believe it was a professional term
24 before it was a lay term.

25 But, you know, I think, you know, we just --

1 we spent a lot of time on that and I don't recall why.
2 I think, again, it was trying to find something that
3 was more -- that was more -- you know, sexual
4 orientation, we were focusing on that and we wanted to
5 really -- that was really the issue of looking at that
6 research and placing it within that context.

7 Q. Before we go further, a moment ago you said
8 there were was something you left out that you wanted
9 to come back to?

10 A. Oh, yeah. I left out this whole notion or
11 this whole actually scrutiny in the peer review
12 process that you had asked me about the Task Force
13 meetings and how the Task Force did its business and I
14 stopped short of -- I stopped at the end of -- I
15 stopped in 2007 though we didn't publish the report
16 until 2009, and as I'm speaking to you I realize that
17 I left out a year and-a-half of the Task Force
18 activities. So if you want to me to go back to that I
19 certainly could, or I don't know what your other
20 questions are at this point.

21 Q. I will. I'm going to ask a couple other
22 questions first.

23 Do you know who applied for membership on the
24 Task Force and was excluded?

25 A. No. I have no idea.

1 Q. Do you have knowledge of anyone who was
2 excluded?

3 A. I believe that Dr. Nicolosi applied, but I
4 don't know why I would think I know that. He wouldn't
5 have told me that personally, I may have just heard
6 that, but I don't know. I think Dr. Yarhouse did,
7 Mark Yarhouse, but I am not sure.

8 Q. Did you know Dr. Nicolosi?

9 A. I have not -- I think I have only formally
10 met him since the report came out. I do know, I was
11 aware -- I had read his books certainly and I knew who
12 he was by reputation.

13 Q. Do you know whether any APA members in good
14 standing were excluded from the Task Force because of
15 their practice of SOCE or related --

16 A. I do not know, no. I was not involved at all
17 of the selection process.

18 Q. Did the Task Force keep minutes or some other
19 written record of their proceedings or meetings?

20 A. I don't believe so, but I am not a hundred
21 percent sure. I don't recall.

22 Q. What about audio recordings or video
23 recordings of meetings?

24 A. I don't believe so.

25 Q. To the extent you communicated by e-mail, for

1 example, are those saved or archived somewhere?

2 A. I doubt it.

3 Q. As the Task Force Chair, when you
4 communicated by e-mail with other Task Force members,
5 what e-mail did you use? What account?

6 A. Either or both a Yahoo account or a Rutgers
7 account.

8 Q. Do you still have both of those accounts?

9 A. I don't have the Rutgers account. I may
10 have -- I think I still do, though it's somewhat
11 inactive, have the Yahoo account.

12 Q. Do you remember what the address was?
13 Something at Yahoo.com?

14 A. Drglassgold, d-r-g-l-a-s-s-g-o-l-d,
15 @Yahoocom.

16 Q. And what would your Rutgers e-mail address
17 have been, the one you're not sure whether you still
18 have?

19 A. I don't recall. They change systems
20 periodically. It's been a long time. And then I had
21 a long gap in my Rutgers employment, so it deactivated
22 and I have no idea.

23 Q. Do you ever recall seeing an official contact
24 list for the Task Force that you would refer to, this
25 is how we're supposed to talk to each other or get in

1 touch with each other?

2 A. We did have a contact list with e-mail
3 addresses that people provided.

4 Q. And apart from those two in-person meetings
5 and e-mail, did you communicate in any other manner?

6 A. Telephone.

7 Q. Telephone conference?

8 A. Telephone conference or perhaps individual
9 conference.

10 So, if you recall, so at one of the last --
11 the last meeting, in-person meeting, we distributed
12 work assignments in order to share the writing. I
13 mean, we had these great discussions, we had an
14 outline of the report, we had some text, but we had to
15 write the report, so we assigned writing assignments.
16 So it was assumed that the people who were -- they
17 were different pairs. Nobody was sort of left on
18 their own. Well, Robin kind of was with Roger.

19 So we all had to work together, so they were
20 individual phone conversations that I assume happened
21 between people. I know I called collaborators on a
22 chapter. Like I would talk to Dr. Beckstead a great
23 deal on the two chapters we worked on, like discussing
24 what we were writing.

25 Q. Did Task Force members consult persons who

1 were not on the Task Force in the course of preparing
2 the report?

3 A. Yes, I believe so. I couldn't speak to who
4 those were. Like I contacted Dr. Zucker at one point,
5 asked him about his research and some of his research
6 findings. I'm sure other people talked to people. I
7 may have talked to other people. I'm not sure I can
8 recall at this moment.

9 Perhaps other people spoke to experts too
10 that were related, but I don't have a list of those.
11 I have no idea.

12 Q. And would that contact with persons not on
13 the committee have been sort of part of the charge or
14 the work that you agreed to as Task Force members?

15 A. I think it was in order to complete our --
16 when we wrote the report we wanted to make sure that
17 we had as much information as possible and we were
18 accurately interpreting things. And quite a few of
19 these of the outside experts would have served as
20 reviewers, so I believe they were contacted to promote
21 the accuracy of the report.

22 Q. Did the Task Force solicit public comment or
23 solicit particular people or organizations to ask for
24 comments on your work or your charge?

25 A. Yes. You will find in the -- I believe it's

1 the preface. I could look at it now if you want me to
2 look at the particular.

3 Q. Yeah, we will get to it eventually.

4 A. We did solicit particular individuals. So
5 some of the individuals who did not serve,
6 Dr. Yarhouse was asked to comment on the report,
7 Dr. Warren Throckmorton was asked. So I believe some
8 of the individuals who were not included in the Task
9 Force membership, but who were interested in the
10 outcomes, were asked to comment and other people who
11 were considered experts in different areas.

12 So because it was such a long report, not
13 everybody could be an expert in all facets, so we
14 tried to gather some information or comments from
15 people from a broad spectrum. I believe we sent out
16 the report to at least 40 unique individuals. Then,
17 if you remember, so APA is a big organization with a
18 large -- and it's set up to solicit member input a
19 great deal. And at the time we did the report it was
20 divided into directorates, so we sent the report to
21 the board of scientific affairs, the board of
22 professional practice, we sent it to divisions, all
23 the boards and committees of APA would review it.

24 And in March of 2009 -- so we met twice in
25 2007. Then we spent 2008 writing the thing. That was

1 basically it. And I think we really pushed to try to
2 finish it by early-ish January of 2009 so that we
3 could -- or maybe December of 2009 was more like it,
4 so we could get it out to all the boards and
5 committees.

6 So we're talking about 25 standing
7 committees, each with about five or six psychologists
8 from different backgrounds who were going to be asked
9 to review the report and provide us in-person feedback
10 at what's called the consolidated meetings, which is
11 when all the boards and committees come together. And
12 that would be in March of 2009.

13 We also asked the ethics officer or ethics
14 specialist. We asked a whole bunch of people. And I
15 think people gave us ideas, Task Force members and
16 other people gave us ideas about who to ask for input.

17 So the process was going to be we finish the
18 report by the end of 2008, we send it out for review
19 to both outside experts and to members of APA
20 Leadership. And the council members were going to get
21 this report. There are 200 council members.

22 Then if people had comments, I and other Task
23 Force members, but predominantly me, and Clinton to
24 some degree, Clinton Anderson, were going to have to
25 respond to all the comments like you would do at a

1 peer review process.

2 So let's say someone says change this, change
3 that, change this, we would have to evaluate what we
4 wanted to -- if their comments made sense. We would
5 then make the changes or, if we didn't feel that was
6 appropriate, we would have to write an explanation of
7 why we didn't make the change.

8 So we wanted to -- our hope was that if we
9 got the report out by the end of 2008 and we got all
10 the comments back, including the in-person comments,
11 by March of 2009, that somehow or other, oh, God, we
12 were going to finish the work and get it to the
13 printer. No, not to the printer. At least get it to
14 the Board for their August meeting in Toronto.

15 So, you know, we had five months to
16 accomplish the goal of responding to the critiques,
17 finalizing the copy, proofreading it, you know, all
18 that stuff so it could be voted on, either accepted or
19 declined, and the resolution can be voted on by August
20 and then it would be printed and available on the
21 internet.

22 Q. Did any of the persons outside the Task Force
23 who you specifically target to send the draft to for
24 review, were any of them non-APA members?

25 A. They may have been, but I would have to look

1 at the list of individuals in the preface. I am not
2 sure I called --

3 We really considered this a scientific
4 document so we wanted -- and a professional document,
5 so we sent it to primarily professionals. I don't
6 know if we sent it to people from the NASW, that's the
7 National Association of Social Workers, or other
8 people. I don't recall. I don't believe we sent it
9 to advocacy groups because we really did consider this
10 a professional document.

11 Q. Did the Task Force or any individual member
12 of the Task Force receive unsolicited input or
13 lobbying even from advocacy groups or persons?

14 A. I don't recall. I don't recall my being
15 contacted. Clinton Anderson may have been contacted.
16 I know some individuals who felt they were included
17 may have met with him. I think he told me that. I
18 was not involved in any of that.

19 I think certain administrators within APA,
20 Clinton's boss at that time, Gwendolyn Keita, who was
21 director of the public interest directorate, I think
22 they tried to protect us from all that and I believe
23 some letters went to the board of directors or to the
24 president of the APA, but we were really kind of in a
25 little cocoon, I believe. But, you know, it's 12

1 years, so it's been a while.

2 Q. And you couldn't speak for other Task Force
3 members and who they spoke with?

4 A. I have no idea. I think, ethically, we did
5 talk about being open and honest with each other and I
6 think if they had felt that something was going on
7 they would have told Clinton and myself if they felt
8 like there was undue pressure or somebody was trying
9 to influence the outcome. I believe they -- everybody
10 really bought into, no matter where they were coming
11 from, that this was a serious task and it was an
12 important task, and we knew that it was really
13 important and we wanted to do a good job.

14 Q. Did every Task Force member read all of the
15 research that was selected for the systematic review?

16 A. I cannot speak to what every Task Force
17 member did. I know I tried to at least skim it
18 though, you know, I cannot speak to that.

19 Q. Was it expected of each Task Force member to
20 have read all of the research selected for review?

21 A. No, it was not. I think some people felt
22 that their primary background was psychotherapy or
23 something like that and, as Dr. Miller had such
24 tremendous expertise, we did lean on her the same way
25 that the psychotherapy sections were primarily

1 Dr. Beckstead, myself, and Dr. Greene. The concerns
2 of religious individuals, which I think is really a
3 terrific chapter, that was primarily Dr. Beckstead,
4 Dr. Greene, myself. So that people carved out certain
5 things and, as you know, I'm sure from serving on the
6 Task Force committees, I'm just assuming, some people
7 were part of others.

8 MR. WILLIAMS: I'll take judicial notice of
9 that fact.

10 Q. Now, in your declaration here you said that
11 you wrote sections and edited the final report at
12 least in 2009. So let's start with what sections did
13 you personally write of the 2009 report?

14 A. May I consult the report, please?

15 Q. Yeah. And, in fact, let's establish it is
16 what it is.

17 In Exhibit B of your declaration in front of
18 you is attached the report of the American
19 Psychological Association Task Force On Appropriate
20 Therapeutic Responses to Sexual Orientation. Did I
21 say that correctly?

22 A. Yes.

23 Q. And this is attached to Exhibit 28, your
24 declaration in this case; right?

25 A. Right.

1 Q. So this is the APA report we have been
2 talking about. Which sections did you write?

3 A. So I will say that I co-wrote the
4 introduction with Clinton Anderson. And perhaps in
5 section 2, the psychology, religion and homosexuality,
6 Lee Beckstead probably reviewed that as well.

7 Then A Brief History of Sexual Orientation
8 Change Efforts I contributed sections to as did Jack
9 Drescher, Lee Beckstead, Roger Worthington all
10 contributed sections to that.

11 Section 3 is primarily the work of Robin
12 Miller. Dr. Robin Miller. Section 4 is primarily the
13 work of Dr. Miller.

14 Section 5, I believe that's primarily the
15 work of Dr. Beckstead, but I may have contributed some
16 to that and maybe Dr. Greene contributed more comments
17 by telephone and other things. Chapter 6 is
18 Dr. Beckstead and myself. Chapter 7 I took primary
19 ownership of. Chapter 8, I wrote most of it, but in
20 close consultation with Dr. Greene.

21 Summary and conclusions, I probably took
22 primary responsibility for with some edits and
23 contribution by Clinton Anderson. The executive
24 summary was probably me with the help of Dr. Anderson
25 in places, perhaps, and Lee may have -- Dr. Beckstead

1 may have contributed too. And the abstract, probably
2 myself and Clinton Anderson.

3 Q. I missed Chapter 8. Who did you say was
4 responsible for Chapter 8?

5 A. Chapter 8 is I participated in that with the
6 participation via telephone and edits of Dr. Greene.

7 Q. So Chapters 3 and 4, both titled A Systematic
8 Review of Research, were primarily Dr. Miller's work?

9 A. Yes.

10 Q. Did you have any involvement in those
11 sections?

12 A. I and Dr. Miller worked -- discussed the
13 framework. We talked a lot about the organization of
14 that chapter. I had suggestions about the
15 organization, I edited it, but the content and format
16 and the conclusions are hers.

17 Q. Was there a --

18 A. But Doctor -- I just want to add -- sorry.
19 I'm sorry to interrupt you. I apologize.

20 Q. No, please.

21 A. Dr. Worthington, who also has background in
22 research, I believe read through some of these things
23 and also probably talked to Robin on the phone and may
24 have contributed some bit, but I wasn't involved in
25 their conversations. But I assume because he -- I

1 think he did engage in that, but I can't really get
2 into specifics.

3 Q. Was there any part of the report, the final
4 report, that was either objected to or not endorsed by
5 one or more members of the Task Force?

6 A. No.

7 Q. Was there any kind of minority report
8 prepared as to any section or any part of it?

9 A. No. I mean, everybody was expected to read
10 the whole thing once we put all the pieces together.
11 And there were changes and reorganization and a lot of
12 comments.

13 So when I say we wrote it for 2008, we had
14 deadlines for chapters. And then we went through this
15 internal review process where people commented and I
16 swear at certain points we had to like start all over
17 again. And, you know, it was a long writing process.
18 But, yeah, everybody read it and everybody, I think,
19 felt really good about it. I think we felt very proud
20 of it.

21 Q. What person or body within the APA ultimately
22 approved the final report for publication?

23 A. The council of representatives. So the APA
24 kind of has an interesting structure where it has a
25 legislative body that determines policies for the

1 association and all the ultimate resolutions, and that
2 is a council of representatives. The council of
3 representatives is made up of elected officials from
4 all the divisions of APA, including all the state
5 psychological associations that exist that participate
6 in APA. For instance, the Florida Psychological
7 Association would have at least one member, I believe,
8 on the council of representatives.

9 Now, the actual numbers -- every division, I
10 believe, is represented and every state psych.
11 association is represented. Some may have more
12 members based on size of membership. So sort of like,
13 I guess, the house of representatives where the more
14 heavily populated you are you get more votes.

15 So let's say some of the biggest divisions in
16 the APA are psychoanalysis, private practice, general
17 psychotherapy. So those people would all vote. So
18 you have over 200, I believe. I couldn't give you the
19 absolute number of people who would vote. As well as
20 people who were elected from the board of directors,
21 they also vote.

22 Q. Apart from those over 200, whatever that
23 number is, of the council of representatives, how many
24 other APA members have participated in the review and
25 comment process?

1 A. So I'm going to give you an estimate because
2 it would be all the committee members and all the
3 board members. So the boards have -- so I'm going to
4 just count out loud.

5 Q. Please.

6 A. The boards have about 10 to 15 people and
7 there are four of them, so that's 40 to 60. Then
8 they're all the committees of the public interest
9 directorate and I believe they're at least 10 if not
10 12, so that's 60 to 72. Then we also added the ethics
11 committee, which is in a separate area. So I'd say
12 about 150.

13 Q. In addition to the council of
14 representatives?

15 A. 200. Yes. So we're talking a great many
16 people. And the board of directors, which is a
17 separate body of, I believe, 20 people.

18 And then so many of the employees in the
19 highest level executive functions such as Dr. Keita,
20 who is the director of the public interest
21 directorate, the head of science directorate, the head
22 of the practice directorate, the head of the education
23 directorate, all those high-level administrators for
24 APA were expected to read it and give us comments.
25 And I know Dr. Keita certainly gave us her comments

1 and the science directorate gave us comments. So that
2 there was also -- so their members, about 500 members
3 gave us comments, and then APA administrators, who are
4 employees, also gave their comments and probably 10 to
5 15 of those in addition.

6 Q. Is there a log or a record of all the
7 comments received and how they were answered or
8 responded to?

9 A. I could not tell you. I know we initially
10 had all of them. I did not keep them. Dr. Anderson
11 may have had them. I have no idea if they are still
12 around. I don't know.

13 Q. Do you recall any conclusions reached in some
14 earlier draft of the report that were changed as a
15 result of comments received from others?

16 A. Let me just think about that for a few
17 minutes. No. I think we added material sometimes. I
18 think we did -- there may have been comments about
19 balance just in terms of how you present evidence
20 perhaps, but I don't recall specifically.

21 I do remember that the president -- so
22 because we took so long to get this done, it was a
23 such a lengthy process, APA presidents change every
24 year. So we were appointed by one president and then
25 Dr. Alan Kazdin, who is an expert in child and

1 adolescent psychology, I believe he's on the faculty
2 of Harvard Medical School or might be, he did change I
3 think -- he decided on the some of the wording of the
4 resolution. And will you permit me to look up that?

5 Q. Sure.

6 A. Let's see. I think the resolution may have
7 had more comments and more edits, but, to be honest,
8 the general gist remained the same. It was, oh, how
9 you express -- scientists can be very detail-oriented
10 sometimes. Some of them. Let's see. Where is the
11 resolution.

12 Q. I think you will find it at page 120.

13 A. Oh, thank you.

14 Q. If we're talking about the same thing.

15 A. Yes, we are. This sentence, "there is
16 insufficient evidence," in page 121, two down, I
17 believe the board of directors, and I think Dr. Kazdin
18 in particular, preferred that wording. I think there
19 was -- you know, they went back and forth too. I
20 think they included us in -- you know, there was --
21 and I forget what the original wording is, was, but
22 that phrase, I think the board of -- some of the
23 scientists on the board of directors and the
24 scientists felt that that was important.

25 Q. I'm going to read for the record the portion

1 I think you're referring to. It reads, "Be it further
2 resolved that the American Psychological Association
3 concludes that there is insufficient evidence to
4 support the use of psychological interventions to
5 change sexual orientation."

6 A. Yes.

7 Q. Did I read that correctly?

8 A. Yes, you did.

9 Q. And which part of that specifically do you
10 recall was changed at the request of the commenters?

11 A. There is insufficient evidence. I believe
12 the conclusion was the same that there is no evidence
13 to support the use. Insufficient evidence, I think
14 that was generally the discussion of how to frame the
15 fact that there is a lack of evidence that sexual
16 orientation change efforts are effective.

17 Q. Okay. Any other conclusions or aspects of
18 the resolution?

19 A. Not that I recall. Not that I recall really,
20 to be honest.

21 Q. Why did this Task Force not address gender
22 identity change efforts?

23 A. We were not asked to.

24 Q. Do you know why?

25 A. That was not in the charge. I couldn't tell

1 you. I believe at that time this was the issue that
2 was on people's minds. Gender identity change efforts
3 were really not the focus.

4 Q. So I am correct, this report does not address
5 gender identity?

6 A. That is correct. However, if you note in
7 Chapter 7 on children, that is somewhat touched on.
8 Because in children, some efforts reported in the
9 1960s in case studies do target gender nonconforming
10 behaviors and gender -- perhaps even gender identity
11 as a proxy for sexual orientation in children.

12 You have to recall that a six-year-old would
13 not say I am gay or lesbian, but they may act in ways
14 that are gender nonconforming that cause parents to
15 assume that they are or that there's something going
16 on and that then would become the focus of treatment.
17 So in that chapter we did discuss those issues and
18 that is why I spoke to Dr. Zucker.

19 But we reached no conclusions. Well, we did
20 discuss that conclusion somewhat.

21 MR. GANNAM: Can we go off for a moment.

22 (Lunch recess from 12:34 p.m. to 1:32 p.m.)

23 BY MR. GANNAM:

24 Q. So we've been talking about the 2009 APA
25 report. Is there any -- since this report came out in

1 2009 I want to ask, is there any part of the report
2 that has been withdrawn or updated or changed by the
3 APA since it came out?

4 A. No. I believe, though, an announcement went
5 out earlier this year that they are reviewing the 2009
6 resolution, so they are interested in updating that
7 resolution on SOCE as well as issuing a resolution in
8 GICE, but those are both in the process. They haven't
9 occurred yet.

10 Q. Do you know where in the process those
11 projects are?

12 A. No. I'm not involved in those processes.
13 May I clarify?

14 Q. Sure.

15 A. So they are updating the resolutions, but
16 there has not been any -- to answer the first part of
17 your question, no part of the report has been
18 withdrawn or changed and there have been -- when it
19 came out the report was praised. I modestly say that.
20 There have been no changes made.

21 Q. And, as we sit here today, are there any
22 changes that -- or any part of the report that you
23 personally would want to back away from or no longer
24 endorse?

25 A. No.

1 Q. Well, let's look at some of the specifics, if
2 we could. Let's go to page 2 of the report. There's
3 a footnote designated by two asterisks that reads, "In
4 this report we use the term sexual orientation change
5 efforts, SOCE, to describe methods, for example,
6 behavioral techniques, psychoanalytic techniques,
7 medical approaches, religious and spiritual approaches
8 that aim to change a person's same-sex sexual
9 orientation to other sex regardless of whether mental
10 health professionals or lay individuals, including
11 religious professionals, religious leaders, social
12 groups and other lay networks such as self-help groups
13 are involved."

14 Did I read that correctly?

15 A. Yes, you did.

16 Q. And is that consistent with your earlier
17 testimony about what the Task Force intended to
18 include within the term SOCE?

19 A. Yes.

20 Q. Given that it includes methods and approaches
21 that are not performed by licensed mental health
22 providers, but rather are performed by religious and
23 spiritual leaders, for example, does that mean that
24 any conclusion in this report that uses that term
25 "SOCE" is not differentiating between practices

1 carried out by licensed professionals and those
2 practices carried out by religious leaders and
3 non-licensed persons?

4 A. Could you repeat that because, I'm sorry, I
5 lost the first part paying attention to the second
6 part.

7 MR. GANNAM: Can you read that back for us.

8 (The question was read by the reporter.)

9 A. So, in my understanding of that question, in
10 the report the conclusions we draw have to do, though
11 we defined SOCE in this way, the research, review, and
12 evaluation only pertains and the conclusion that there
13 is no, or is insufficient or there's no evidence of
14 efficacy is based on a review of the scientific
15 literature. And if you look at actually the list of
16 studies that were examined, predominantly -- so I
17 would have to think about it, but predominantly the
18 behavioral treatment --

19 Actually, let me go back and just say I think
20 the answer is yes, as I review the literature that was
21 reviewed. So we reviewed both literature, reviewing
22 therapies tried by licensed professionals as well as
23 some articles that may have pertained to practices by
24 support groups and by religious or spiritual leaders.
25 We reviewed everything and our conclusions do apply to

1 both.

2 BY MR. GANNAM:

3 Q. Now will you look at page 3.

4 A. Uh-hum.

5 Q. Now that we've defined what SOCE means, and
6 on the left side of the page about two-thirds of the
7 way down is the heading Individuals Who Seek SOCE And
8 Their Experiences. Do you see that?

9 A. Uh-hum.

10 Q. I'll read the first sentence. "Although the
11 recent SOCE research cannot provide conclusions
12 regarding efficacy or safety, it does provide some
13 information on those individuals who participate in
14 change efforts."

15 Did I read that correctly?

16 A. Yes, you did.

17 Q. And that conclusion, is that still valid that
18 the recent SOCE research cannot provide conclusions
19 regarding efficacy or safety?

20 A. What do you mean by recent? Recent -- the
21 research reviewed in the report? I don't understand
22 your question.

23 Q. Whatever the word "recent" means in the
24 report?

25 A. Okay. So let me explain. And I apologize

1 for any confusion in this report.

2 We divided the research on SOCE into two
3 periods, an early period from the 1960s and '70s,
4 maybe one study from 1983, '84 that was empirical
5 scientifically reviewed literature. We called that
6 old SOCE. I'm not sure we even used the word "old."
7 We just called that SOCE research.

8 Then when we did the review we discovered a
9 body of research that, in 2009, was more recent. And
10 this was primarily, but not entirely, the research
11 provided by religiously-oriented professionals,
12 probably not psychologists or social workers. We
13 called that recent research. And when we reviewed the
14 recent research, most of it was not published in
15 scientific journals or some of it was, but it didn't
16 fit the criteria for a true experiment or a quasi
17 experimental design.

18 In other words, maybe it was qualitative like
19 Dr. Beckstead's work, or it was some other study. It
20 was not an empirical study so it could not provide us
21 evidence of harms or benefits. It could only provide
22 information on perceptions of participants. So that's
23 why we said it cannot provide conclusions. It's only
24 the recent research on SOCE that did not meet
25 experimental standards for causality that we said

1 cannot provide conclusions regarding efficacy or
2 safety.

3 Q. And what was the time period covered by which
4 you referred to as old or just plain SOCE?

5 A. Probably -- old SOCE. So if you go to the
6 back of the report, Appendix B, studies included, you
7 had asked for a list of all the studies that we
8 actually reviewed and looked at, even the ones that
9 maybe weren't commented on directly. So we list the
10 experimental studies and in 1981 the quasi -- yeah, so
11 it's like early '80s I would say. So non-experimental
12 studies also are there.

13 So it looks to be 1981 might be the last
14 study. But -- yeah, it's the last experimental study.
15 Though Ponticelli is a qualitative psychological
16 study. But let's say 1981 approximately.

17 Q. And going back to page 2, in the right column
18 about two-thirds of the way down it reads, "None of
19 the recent research," and then it gives a range, 1999
20 to 2007?

21 A. Right. So, yeah, so it explains itself.
22 There you go.

23 Q. So does that recent research there on page 2
24 correspond to that conclusion on page 3?

25 A. Yes. Thank you. That would have been

1 easier. And it explains what I tried to just explain
2 to you.

3 Q. So subject to that qualification of what
4 recent SOCE research is, this conclusion that's stated
5 here that it cannot provide conclusions regarding
6 efficacy or safety is still valid?

7 A. Right. So that conclusion on page 3 refers
8 to the data defined as recent 1999 to 2007. The
9 earlier research, 1960 to -- most states conducted to
10 1981, in the paragraph above it, those were the
11 studies that were an adequate methodological adequacy
12 to provide conclusions on causality and those found
13 that SOCE was not effective.

14 Q. Now will you turn to page 7, please.
15 Actually 6 and 7. At the lower right-hand corner of
16 page 6 is the heading that reads "Research." Do you
17 see that?

18 A. Uh-hum.

19 Q. And the first sentence says, "The Task Force
20 was asked to provide recommendations for future
21 research."

22 Did I read that correctly?

23 A. Yes.

24 Q. And then the next paragraph begins, "The
25 research on SOCE has not adequately assessed advocacy

1 and safety."

2 Did I read that correctly?

3 A. Right.

4 Q. And this statement does not differentiate
5 between old research and recent research; does it?

6 A. No. I think it would apply to all research
7 because it's talking about future research, not past
8 studies.

9 Q. And so the context for recommending future
10 research is that the current body of research has not
11 adequately assessed efficacy and safety; is that
12 correct?

13 A. I mean, I would say that we know what the
14 current research has done or research to date. We
15 would ask for improvements. Adequately -- it has
16 tried to assess. It may not have adequately assessed
17 it, but it has tried to assess it.

18 Q. So, as written, the statement still stands
19 that it has not adequately assessed efficacy and
20 safety?

21 A. Uh-hum.

22 MR. MIHET: Is that a yes?

23 Q. Please say yes or no and not uh-hum.

24 A. Sorry. The sentence is accurate.

25 Q. Thank you. Let's go to page 37. In the

1 lower right there's a heading that says "Recent
2 Studies"?

3 A. Uh-hum.

4 Q. In here are we talking about the same time
5 frame that was identified before, '99 to 2007?

6 A. Yes.

7 Q. So in this paragraph about recent studies,
8 the second full sentence after the citations begins
9 "These studies." Do you see that?

10 A. Yes, I do.

11 Q. It reads, "These studies all use designs that
12 do not permit cause and effect attributions to be
13 made. We conclude that although these studies may be
14 useful in describing people who pursue SOCE and their
15 experiences of SOCE, none of the recent studies can
16 address the efficacy of SOCE or its promise as an
17 intervention."

18 Did I read that correctly?

19 A. Yes, you did.

20 Q. So as describing the recent studies in that
21 time frame that's identified, does this statement
22 still stand, that the studies use designs that do not
23 permit cause and effect attributions to be made?

24 A. That is correct.

25 Q. Will you go to page 42. Recent studies,

1 again, is the heading on page 42 and it begins,
2 "Although the recent studies do not provide valid
3 causal evidence of the efficacy of SOCE or of its
4 harm, some recent studies document that there are
5 people who perceive they have been harmed through
6 SOCE." Followed by citations. And then it reads,
7 "Just as other recent studies document that there are
8 people who perceive that they have benefited from it."

9 Did I read that correctly?

10 A. Yes.

11 Q. Now, again, we're talking about the same time
12 frame of studies; correct?

13 A. Correct.

14 Q. And so here does this statement stand, that
15 the recent studies do not provide valid causal
16 evidence of the efficacy of SOCE or of its harm?

17 A. That's correct. Well, do not provide -- so
18 do not provide valid causal efficacy. And then
19 there's the rest of the sentence, some studies
20 document that some people perceive they have been
21 harmed or have benefited from it.

22 Q. Okay. So I want to look down towards the
23 bottom of that paragraph that begins "Among those
24 studies reporting on the perceptions of harm." Do you
25 see that?

1 A. Right.

2 Q. It continues, "The reported negative social
3 and emotional consequences include self reports of
4 anger, anxiety, confusion, depression, grief, guilt,
5 hopelessness, deteriorated relationships with family,
6 loss of social support, loss of faith, poor self
7 image, social isolation, intimacy difficulties,
8 intrusive imagery, suicidal ideation, self hatred, and
9 sexual dysfunction."

10 Did I read that correctly?

11 A. Yes.

12 Q. And it says, "These reports of perceptions of
13 harm are countered by accounts of perceptions of
14 relief, happiness, improved relationships with God,
15 and perceived improvement in mental health status
16 among other reported benefits."

17 Did I read that correctly?

18 A. Right. Yes.

19 Q. So what I want to ask is did the Task Force
20 attempt to quantify the prevalence of the described
21 reported harms as compared to the described reported
22 benefits?

23 A. I think in a gross way, yes, though the
24 different studies, there were different numbers of
25 studies, different number we -- I'm not sure the

1 results were quantifiable, no.

2 Q. Now, understanding that this particular
3 paragraph is taking about recent studies, but given
4 this list of reported harms, does the Task Force
5 report attempt to assign any number or percentage on
6 the increased likelihood of one of these enumerated
7 harms occurring from SOCE as compared to psychotherapy
8 in general?

9 A. No.

10 Q. And I'll give an example just so I'm clear.
11 The first reported harm in this list is anger. So,
12 for example, did the Task Force attempt to quantify
13 how much more likely it is that a person who receives
14 SOCE will have increased anger as a result compared to
15 how many people would have increased anger as a result
16 of psychotherapy in general?

17 A. You have to remember that these studies,
18 because of their quality, would not permit that kind
19 of comparison.

20 Q. And so can -- asking not only about the
21 recent studies then, but about all of the research
22 that was reviewed, was the Task Force able to assign
23 any percentage of likelihood to these various reported
24 harms from SOCE as compared to the likelihood of those
25 reported harms from psychotherapy in general?

1 A. Dr. Miller did not complete that type of
2 analysis. The later research did not lend itself to
3 any sort of ability to do that. You have to remember,
4 the early research showed some serious harms, but we
5 did not do a quantitative analysis because also
6 that -- I'm not sure the harms research for general
7 studies, we did try to look what that might be, was
8 also not difficult to -- was difficult to obtain.

9 So there's so many psychological studies of
10 efficacy, different conditions, so I'm not sure we
11 were -- I'm not sure Robin -- Robin thought about
12 that, I think, maybe, but I'm not a hundred percent
13 sure. So it's not quantifiable.

14 MR. WILLIAMS: Robin who?

15 THE WITNESS: Dr. Miller. Sorry.

16 BY MR. GANNAM:

17 Q. And so is the answer then the difference in
18 percentages or the likelihood of one of these negative
19 or harms resulting from SOCE compared to one of these
20 negatives resulting from psychotherapy in general is
21 not quantifiable?

22 A. The research does not lend itself to that
23 type of quantification.

24 Q. So the answer is yes?

25 A. Could you repeat the question. Sorry.

1 MR. GANNAM: Could you repeat my last
2 question, please.

3 (The question was read by the reporter.)

4 A. I'm just pausing to think that through. I
5 believe it might be -- you know, might be quantifiable
6 for early research, but we -- I don't believe we did
7 that analysis. It would not be possible with the
8 later research.

9 BY MR. GANNAM:

10 Q. And are you aware of anyone who has done such
11 an analysis with the earlier research?

12 A. I am not aware.

13 Q. In the recent studies that are identified
14 here, was the prevalence of these various reported
15 harms resulting from SOCE by non-licensed persons
16 differentiated from the prevalence of these reported
17 harms from SOCE by licensed professionals?

18 A. No, I do not believe so.

19 Q. Did the Task Force make any attempt to
20 distinguish between those two categories, licensed
21 persons and unlicensed persons?

22 A. We may have, but I am not sure. I don't
23 recall.

24 Q. And there's no result of such an analysis in
25 the report?

1 A. I don't believe so, no.

2 Q. I want to go -- staying on page 42 in this
3 section titled Summary, which is the summary of
4 Chapter 4, the first sentence says, "We conclude that
5 there is a dearth of scientifically sound research on
6 the safety of SOCE."

7 Did I read that correctly?

8 A. Uh-hum. Yes.

9 Q. And then it continues, "Early and recent
10 research studies provide no clear indication of the
11 prevalence of harmful outcomes among people who have
12 undergone efforts to change their sexual orientation
13 or the frequency of occurrence of harm because no
14 study to date of adequate scientific rigor has been
15 explicitly designed to do. Thus, we cannot conclude
16 how likely it is that harm will occur from SOCE."

17 Did I read that correctly?

18 A. Yes.

19 Q. And does that conclusion still stand today?

20 A. What, the conclusion in the report regarding
21 that research reviewed?

22 Q. The final sentence, for example, we cannot
23 conclude how likely it is that harm will occur from
24 SOCE.

25 A. Are you talking about only with regard to

1 this research included in this report, not -- in other
2 words, I don't understand your question.

3 Q. Okay. The summary itself qualifies it by
4 saying early and recent research studies provide no
5 clear indication of the prevalence of harmful outcomes
6 among people who have undergone efforts to change
7 their sexual orientation or the frequency of
8 occurrence of harm because no study to date of
9 adequate scientific rigor has been explicitly designed
10 to do so. So I think we're talking about only studies
11 available to date at the time of this report.

12 A. Okay.

13 Q. So, based on those studies, is it still a
14 correct conclusion that we cannot conclude how likely
15 it is that harm will occur from SOCE?

16 A. So the conclusion on studies to date, so that
17 would be studies to 2007. So it only -- that sentence
18 is accurate with studies to date to 2007.

19 Q. Okay. Now, if there happens to be one from
20 '08 that got in here, would it still apply? I mean --

21 A. Right. If it's included in here, yes.

22 Q. Okay.

23 A. So the formal review was for -- yes, that's
24 correct.

25 Q. Can we go to 72 now. Page 72. This is in

1 the Chapter 8, Issues For Children and Adolescents and
2 Their Families. On page 72 there's a section titled
3 Literature Review. Do you see that?

4 A. Yes, I do.

5 Q. The first subheading is Literature on
6 Children and the first sentence reads, "There is a
7 lack of published research on SOCE among children."

8 Did I read that correctly?

9 A. Yes.

10 Q. And as of the time of this report, is that an
11 accurate statement?

12 A. Yes.

13 Q. And, going to page 73, the next subheading is
14 Literature On Adolescents. Do you see that?

15 A. Uh-hum.

16 Q. And the first sentences says, "We found no
17 empirical research on adolescents to request SOCE."

18 Did I read that correctly?

19 A. Yes.

20 Q. And is that still an accurate statement as to
21 the state of the empirical record at the time of this
22 report?

23 A. Yes.

24 Q. Now I'm going to flip back a bit to page 22
25 just for a definition.

1 MR. WILLIAMS: Two two?

2 MR. GANNAM: Two two, yes.

3 BY MR. GANNAM:

4 Q. Page 22 near the bottom of the first column
5 begins the sentence "Behavior therapists tried." Do
6 you see that?

7 A. Yes.

8 Q. It says, "Behavior therapists tried a variety
9 of aversion treatments such as inducing nausea,
10 vomiting, or paralysis, providing electric shocks, or
11 having the individual snap an elastic band around the
12 wrist when the individual became aroused to same-sex
13 erotic images or thoughts. Other examples of aversive
14 behavioral treatments included covert desensitization,
15 shame aversion, systematic desensitization, orgasmic
16 reconditioning and satiation therapy."

17 Did I read that correctly?

18 A. Yes.

19 Q. Is that an adequate or an accurate summary of
20 what aversion treatments are in this realm of SOCE?

21 A. I believe so.

22 Q. Is there any other --

23 A. Well --

24 Q. Go ahead.

25 A. In the United States, I believe that is an

1 accurate statement. There are, in international
2 settings, efforts to change sexual orientation that do
3 use, I believe, aversive treatments and mandatory
4 inpatient treatments, and I don't know the extent of
5 the aversive treatments. Okay.

6 Q. Just so I understand what you're saying, the
7 term "aversive treatments" could cover other things
8 besides what are listed here on page 22, but you
9 believe that what's listed on page 22 is a
10 representative list of things that have happened in
11 the United States?

12 A. Since the 1960s on. It might not cover -- I
13 think we left out the treatments from the 1920s, '30s,
14 and '40s such as hormone therapies, electric shock.
15 Did we include electric shock?

16 Q. Yes.

17 A. We didn't include hormone treatments and some
18 other treatments that occurred probably in the early
19 20th century.

20 Q. To kind of have a working definition of what
21 an aversion treatment or aversive treatment is, would
22 it be fair to say aversive treatments involve some
23 kind of intentional pain or discomfort inflicted on
24 the patient?

25 A. Not -- so it would be that plus any form of

1 punishment. Of punishing, punishment. So, you know,
2 some treatments you provide rewards, you give someone
3 a piece of candy afterwards. It's very simplistic.

4 And other treatments are aversive in that
5 it's a unpleasant sensation. Some people would say
6 that the seatbelt noise you get when you don't plug in
7 your seatbelt is unpleasant. There is some
8 subjectivity about aversion, but I think generally
9 it's unpleasant and perhaps a bit more than
10 unpleasant.

11 Q. And if I ask you a question about aversive
12 treatment or aversion therapy that would go beyond
13 what you've just described, just let me know, but I
14 just wanted to come up with some kind of working
15 definition so we're both talking about the same thing.

16 A. Right. But I want to just say that, in
17 general, if you notice there's some references, in the
18 modern era and this current millennium it's highly
19 unusual to have any form of aversive treatments. It's
20 highly, highly and may be, in this country, almost
21 nonexistent generally in psychotherapy.

22 Q. Let me ask you, how many -- or which of
23 these, if you can look at the list on 22, which, if
24 any, of these treatments would be considered unethical
25 if practiced by licensed mental health providers in

1 2019?

2 A. Well, there's some general terms so that I
3 couldn't speak. So covert sensitization, systematic
4 desensitization, satiation therapy may not be
5 aversive.

6 Q. Okay.

7 A. And some people still use the rubber band.
8 And then orgasmic recondition, yeah. But let me just
9 say, I am not a specialist in behavior therapy so I --
10 you know.

11 Q. Would inducing nausea, vomiting, or paralysis
12 in connection with SOCE be considered unethical, in
13 your opinion?

14 A. Yes. A human rights violation most likely.
15 And the electric shocks. Well, in this context.

16 Q. What about using the elastic band around the
17 wrist method in the context of SOCE, would that be
18 unethical?

19 A. Yes, but you must remember -- lost my
20 thought.

21 Q. Okay. Now that we've talked about what
22 aversion treatments look like, let's go to page 41.
23 And on the right column the main heading is Reports of
24 Harm. Do you see that?

25 A. Right.

1 Q. And the first subheading is Early Studies.

2 Do you see that?

3 A. Uh-hum.

4 Q. It says, "Early research on efforts to change
5 sexual orientation focused heavily on interventions
6 that include aversion techniques."

7 Did I read that correctly?

8 A. Yes.

9 Q. The last sentence in that paragraph -- I'll
10 just read the whole thing.

11 The next sentence is, "Many of these studies
12 did not set out to investigate harm. Nonetheless,
13 these studies provide some suggestion that harm can
14 occur from aversive efforts to change sexual
15 orientation?"

16 Did I read that correctly?

17 A. Yes.

18 Q. So would it be fair to say that these early
19 studies suggest that there may be a difference in the
20 quantity or prevalence of harm that can occur from
21 aversive SOCE as compared to non-aversive SOCE?

22 A. I'm not sure that paragraph means that.

23 Q. Okay. Well, let me just ask you, in the
24 whole report or in the research that was examined,
25 would it be fair to say that there may be some

1 difference in the harm that occurs from aversive SOCE
2 as compared to non-aversive SOCE?

3 A. No.

4 Q. And why is that the case?

5 A. Because non-aversive SOCE, or SOCE, can cause
6 suicidal ideation and suicide attempts, and those are
7 very harmful outcomes. They're life threatening. And
8 that can come from non-aversive conversion therapy or
9 SOCE.

10 Q. My question was is it possible there is a
11 difference in prevalence of harmful outcomes comparing
12 aversive SOCE to non-aversive SOCE?

13 A. I don't think the evidence gives us any way
14 to draw that conclusion.

15 Q. And is there -- does this early studies
16 paragraph on page 41 tell us that in the early studies
17 there were more that focused on aversion techniques as
18 compared to early studies that focused on non-aversive
19 techniques?

20 A. So one of the challenges in your question is
21 that the studies that Dr. Miller reviewed in early
22 studies represent only studies that meet certain
23 methodological criteria for determining cause and
24 effect. There were other reports from that era that
25 were not -- was not researched in terms of research

1 quality, you know, the work of Socarides or Bieber or
2 those individuals, so that we're considering a very
3 small sample of all the interventions that were
4 provided to individuals in the name -- into the rubric
5 of SOCE, so that we really can't compare, and I think
6 Dr. Miller would say we can't compare, early and late
7 research and draw these kind of conclusions that you
8 wish to make. Or I can't. I can't respond. I'm
9 sorry.

10 Q. In this category of the early studies, the
11 studies that preceded the recent studies as we've
12 already talked about, was there research in the early
13 studies showing that harm can occur from non-aversive
14 SOCE?

15 A. I would say so. Again, these early studies
16 are not the full spectrum of interventions offered, so
17 that interventions offered to individuals in that era
18 could have -- these are only behavioral treatments.
19 There were a variety of interventions offered to
20 people in that era that we couldn't use because they
21 really were not adequately designed. And they were
22 non -- they might have been considered non-aversive.

23 But we didn't really do a review of those, so
24 we can't compare that. I can't quantify or can't draw
25 a conclusion from that early era comparing

1 non-aversive versus aversive. I mean, Dr. Nicolosi or
2 Dr. Bieber or Dr. Socarides may have considered their
3 interventions non-aversive, but we didn't really look
4 at the outcomes and they didn't keep records that
5 would allow us to figure out outcomes.

6 Q. So the Task Force, I assume, intentionally
7 made this statement about the aversive nature of the
8 early studies that were reviewed. My question is were
9 there also early studies reviewed involving
10 non-aversive techniques where the same thing could be
11 said, that is, harm can occur from these non-aversive
12 therapies?

13 A. Some of that material may be found in a
14 report in more qualitative retrospective studies that
15 we discuss in other chapters. So --

16 Q. And so --

17 MR. WILLIAMS: Are you finished, Doctor?

18 THE WITNESS: Yeah, I'm finished.

19 BY MR. GANNAM:

20 Q. And so just to get back to the question I'm
21 asking, was any early research on efforts to change
22 sexual orientation that involved non-aversive
23 techniques reviewed for purposes of this Task Force
24 report?

25 A. It may have been in the qualitative studies

1 discussed in later chapters. Most likely it did, but
2 I can't -- some of those qualitative studies involved
3 retrospective accounts that may have occurred during
4 that period.

5 Q. And so in any of the research among the early
6 studies that involved non-aversive SOCE, did any of
7 those include reports of harm from that non-aversive
8 SOCE?

9 A. I believe the answer is yes, but I don't
10 really want to give that as my response because I
11 would have to go back and look at those studies in
12 terms of the time period.

13 Q. And so I'll ask a follow-up question. Were
14 there any studies included in the early studies
15 involving non-aversive SOCE showing that non-aversive
16 SOCE causes harm?

17 A. Let me just think. I believe so.

18 Q. And can you point me to where that would be
19 in this Task Force report?

20 A. It would have to be in the list if you look
21 at -- we focused on aversive though let me be honest,
22 the degree aversiveness may depend. Some of the
23 sensitization research may have included that, but, to
24 be honest, the studies are difficult -- it would be
25 difficult for me to draw any conclusions or answer

1 your question in terms of that issue. Though the
2 majority of early studies were aversive, some of the
3 sensitization or desensitization and there was one
4 study about fantasy that I can't -- I would not want
5 to say is necessarily aversive or not, but I just
6 don't remember the details that well.

7 Q. And so to further differentiate between these
8 early studies involving aversive efforts that are
9 expressly mentioned here on page 41, can you identify
10 any specific early study that involved non-aversive
11 efforts that is shown to have reported harm or shows
12 that those efforts caused harm?

13 A. I would have to review the studies again. I
14 don't recall.

15 Q. And so can you not identify any as you sit
16 here right now?

17 A. I can't identify any as I sit here now based
18 on my memory.

19 Q. Did you identify any such studies in your
20 declaration in this case?

21 A. I didn't seek to go back to those studies.

22 Q. So the answer is no?

23 A. That is correct.

24 Q. Can we go to, now, page -- let's go back to
25 page 4 towards the beginning of your report. This is

1 within the executive summary. Will you look at page 4
2 on the top right.

3 The first full sentence in that right column
4 says, "The clinical literature." Do you see that?

5 A. Yes, I do.

6 Q. It reads, "The clinical literature indicated
7 that adults perceive a benefit when they are provided
8 with client centered multicultural evidence based
9 approaches that provide." And then there's a listing.
10 "A, acceptance and report." Excuse me. "Acceptance
11 and support. B, a comprehensive assessment. C,
12 active coping. D, social support. And E, identity
13 exploration and development."

14 Did I read that correctly?

15 A. Yes.

16 Q. And then it reads, "Acceptance and support
17 include unconditional acceptance of and support for
18 the various aspects of the client, respect for the
19 client's values, beliefs, and needs, and a reduction
20 in internalized sexual stigma."

21 Did I read that correctly?

22 A. Yes.

23 Q. And going down to about halfway down the page
24 there's a sentence that begins, "Identity
25 exploration." Do you see that?

1 A. Yes, I do.

2 Q. "Identity exploration and development include
3 offering permission and opportunity to explore a wide
4 range of options and reducing the conflicts caused by
5 dichotomous or conflicting conceptions of self and
6 identity without prioritizing a particular outcome."

7 Did I read that correctly?

8 A. Yes.

9 Q. Now, I want to elaborate on that. On page 5
10 it begins -- in the left column about eight or so
11 lines down, the sentence begins "Given that there."
12 Do you see that?

13 A. Okay.

14 Q. "Given that there is diversity in how an
15 individual is defined and express their sexual
16 orientation identity, an affirmative approach is
17 supportive of clients identity development without an
18 a priori treatment goal concerning how clients
19 identify or live out their sexual orientation or
20 spiritual beliefs. This type of therapy can provide a
21 safe space where the different aspects of the evolving
22 self can be acknowledged, explored, respected, and
23 potentially rewoven into a more coherent sense of self
24 that feels authentic to the client and it can be
25 helpful to those who accept, reject, or are ambivalent

1 about their same-sex attractions. The treatment does
2 not differ although the outcome of the client's
3 pathway to a sexual orientation identity does."

4 Did I read that correctly?

5 A. Yes.

6 Q. So these passages I have just read from, it's
7 in a heading that says "Recommendations and future
8 directions," does this describe a treatment approach
9 that the Task Force approved of or supported?

10 A. Yes.

11 Q. And to differentiate that from SOCE that the
12 Task Force does not support or approve of, and I will
13 ask you to correct me if I'm wrong, it seems like a
14 key ingredient is the lack of an a priori treatment
15 goal concerning how clients identify or live out their
16 sexual orientation or spiritual beliefs; is that
17 correct?

18 A. Yes, that is one of the key aspects.

19 Q. And I believe you mentioned another key
20 aspect of SOCE that the Task Force does not endorse or
21 approve of would be SOCE based on an assumption that
22 homosexuality is a disorder or is somehow a defect
23 that needs to be remedied; is that correct?

24 A. Right. And that is reflected in this issue
25 of sexual stigma, the negative impact of SOCE can be

1 that it increases sexual stigma and thus causes harm.

2 Q. So I want to focus then on this sentence that
3 reads, "The treatment does not differ although the
4 outcome of the client's pathway to a sexual
5 orientation identity does."

6 First let me ask, is there a difference in
7 this report between the terms "sexual orientation" and
8 "sexual orientation identity"?

9 A. Yes, there is.

10 Q. And what is the difference?

11 A. Sexual orientation, it's -- I mean, you may
12 want to just refer to the section of the report that
13 defines it but --

14 Q. I could and I probably will. Sometimes it's
15 better if you can explain it and that will help us
16 with a working conversation about it.

17 A. So sexual orientation refers to attractions
18 and our patterns of arousal. Identity is how a person
19 labels and identifies themselves. So a simplistic
20 explanation would be someone who experiences arousal
21 to both men and women, but chooses to label
22 themselves -- that's their sexual orientation. That's
23 who arouses them sexually and that's who they're
24 attracted to, but, for whatever reason, that person
25 decides to self-label as heterosexual and those are

1 two different things. So those are just two different
2 things. That's an example.

3 Q. So a person can -- based on what you just
4 explained, a person can, at the same time, maintain or
5 present a heterosexual identity while also
6 experiencing same-sex attraction or bisexual
7 attraction?

8 A. That's correct. And that's developed in that
9 section of the report and gone into in quite detail.

10 Q. So, getting back then to the sentence I read
11 that says the treatment does not differ although the
12 outcome of the client's pathway to a sexual
13 orientation identity does, is this referring to the
14 fact that in one counseling session you may have a
15 therapist with no a priori treatment goal and no
16 assumption that homosexuality is a defect or a
17 disorder that needs to be solved, and another therapy
18 room or session we can have a therapist who does
19 assume that homosexuality is a defect and has as a
20 treatment goal to change the client from homosexual to
21 heterosexual. Is this statement saying that coming at
22 the therapy from those two different directions could
23 still look the same as far as the treatment that they
24 deliver?

25 A. No. This paragraph in this section only

1 referred to what we would term appropriate
2 intervention. So this different pathway refers to
3 different client trajectories.

4 So let's say you were working with an
5 individual who is bisexual, okay, that's their arousal
6 pattern, and they are struggling with giving
7 themselves that name, bisexual, because they perceive
8 that the environment or their parents would reject
9 them. So their pathway to perhaps self-acceptance as
10 a bisexual person would be one set of stages dealing
11 with biphobia, coping with the different valuations of
12 the same sex, which is the other sex attractions.

13 Then with a different client let's say we have a man
14 who experiences exclusively heterosexual attractions,
15 his pathway to feeling positive about his sexual
16 orientation may be rather effortless, so he would have
17 a different pathway.

18 So it really just refers to this process
19 that's described in depth, I believe, in Chapter 6 of
20 the appropriate intervention. We're not talking about
21 SOCE here. We're talking about identity development
22 issues and identity exploration issues that really
23 vary with clients based on where they start from, self
24 acceptance, self rejection, whether they -- and what
25 their actual struggles are in integrating into an

1 identity. Some people maybe never integrate anything
2 into an identity. So that's what we're discussing
3 here.

4 Q. And so, talking about, just for shorthand, an
5 affirmative approach as it's described here, it says
6 an affirmative approach is supportive of a client's
7 identity development without an a priori treatment
8 goal concerning how clients identify or live out their
9 sexual orientation or spiritual beliefs. Did I say
10 that accurately?

11 A. Yes, you did.

12 Q. So is it possible then that applying this
13 affirmative approach with no a priori treatment goal
14 on the part of the therapist, you can still have
15 clients who come at their problems from a different
16 direction? You may have one who submits to this
17 affirmative therapy who does desire to reduce same-sex
18 attraction or somehow align with a heterosexual
19 identity, whereas you may have another client who also
20 suffers from -- I don't mean to say suffer. Who
21 experiences same-sex attraction who doesn't want to
22 change that and is satisfied to -- let me just stop
23 there.

24 If you have no a priori treatment goal on the
25 part of the therapist, they can apply this affirmative

1 therapy whether the client's goal is to reduce
2 same-sex attraction or not to alter same-sex
3 attraction; is that accurate?

4 MR. WILLIAMS: Roger, that's about a multiple
5 compound question. I suspect that Dr. Glassgold
6 understands it, but if she doesn't, I don't and I
7 want the court reporter to read it back so I can
8 grasp what where you're going.

9 MR. GANNAM: How about I will strike that and
10 let me just start over.

11 BY MR. GANNAM:

12 Q. Is it true that a therapist can apply an
13 affirmative approach, as described here in the report,
14 that has no a priori treatment goal either to a client
15 who experiences same-sex attraction and wants to
16 reduce it or somehow align attractions with a
17 heterosexual identity and also to a client who
18 experiences same-sex attraction and does not want to
19 align with a heterosexual identity, the treatment
20 doesn't differ, but the pathway is the same?

21 A. Yes.

22 Q. Now, all of this, as you can see from just
23 the number of times I've had to try to ask the
24 question, it all seems very kind of nuance, for lack
25 of a better term. You have -- on one hand you may

1 have a therapist who has a particular treatment goal,
2 on the other hand you have a therapist who doesn't,
3 they might both meet with clients with same-sex
4 attraction who have their own goals for what they want
5 out of therapy.

6 Who is qualified to look at a counseling
7 session or what happens in the counseling session and
8 decide whether an affirmative approach has been
9 applied or whether a non-recommended SOCE has been
10 applied?

11 A. I am not sure I agree with the first phrase
12 of your question which has to do with nuance.

13 Q. Okay. Let me take that out of it then.

14 Suppose there is a client who presents to a
15 licensed therapist, the client is experiencing
16 same-sex attraction and it is the client's goal to
17 reduce that attraction, but it's not the therapist's
18 goal. The therapist is simply open and affirming of
19 whatever direction the client wants to go in. And, on
20 the other hand, you may have a client who presents
21 with same-sex attraction and wants to change that
22 same-sex attraction and the therapist also has a
23 treatment goal of reducing that same-sex attraction.

24 So in the first case there's no a priori
25 treatment goal, in the second case there is. Who

1 would be able to observe what happens in that
2 counseling session and decide whether SOCE has
3 occurred or whether the affirmative therapy that the
4 Task Force endorses has occurred?

5 A. It would depend on who was present in that
6 counseling session or who reports it. So the patient
7 may say, or their parent in the case of a minor may
8 report what the therapist said or did. Or whatever if
9 there -- whoever was present in the room might be able
10 to report what was said and done.

11 Q. And who would be qualified to decide, based
12 on that report, whether SOCE had occurred or an
13 appropriate affirmative therapy had occurred?

14 A. I think it would depend on the individual
15 circumstances.

16 Q. We talked earlier about practices that --
17 aversive practices that would be considered unethical
18 in 2019. Do you recall that?

19 A. Yes, I do.

20 Q. And would it be fair to say that every state
21 has some kind of licensing board for the various
22 licensed mental health disciplines such as psychology
23 or marriage and family therapy or et cetera. Would
24 that be a fair statement?

25 A. I believe, though I have not reviewed every

1 state because not all states license every type of
2 provider. But most states do have licensing boards
3 that cover certain mental health professionals.

4 Q. And would it be appropriate, if a client has
5 a complaint about potentially unethical practice, to
6 bring that complaint to the applicable state licensing
7 board for the licensee who that client was seeing or
8 received therapy from?

9 A. Most states have a complaint process for
10 consumers to report violations, but these complaint
11 processes are geared towards adults reporting
12 complaints.

13 Q. Now, can you say that based on knowledge of
14 all 50 states?

15 A. No, I have not reviewed.

16 Q. Okay. What I'm asking is -- strike that.
17 Let me just move on for now.

18 A. Yeah, that's a good idea.

19 MS. ROBBINS: Can we take a five-minute
20 break?

21 MR. GANNAM: Sure.

22 (Recess from 2:35 p.m. to 2:47 p.m.)

23 BY MR. GANNAM:

24 Q. I'm going to move on from the APA report for
25 now. I'm going to show you a document previously

1 marked in this case as Exhibit 4 at the deposition of
2 Sal Ruggiero.

3 A. Okay.

4 Q. This is the document filed by the City in
5 this case as the Tampa ordinance 2017-47. Do you
6 recognize this document?

7 A. Yes, I do.

8 Q. Have you read it before?

9 A. Yes, I have.

10 Q. I want to ask you, have you discussed with
11 any officials or employees of the City of Tampa how
12 the City intends to enforce this ordinance?

13 A. No.

14 Q. Okay. And have you read anything or heard
15 anything from anyone about how the City intends to
16 enforce this ordinance?

17 A. No, I don't believe so. No.

18 Q. In going back to your report on page 7 of
19 your declaration.

20 A. Oh, sorry. So now we're the declaration.

21 MR. WILLIAMS: We're back there.

22 Q. Yes, Exhibit 28. So I want to look at, in
23 page 7, paragraph 17. It says, "In fact, the
24 conclusions of the reports and policies reported in
25 the findings of the ordinance have been strengthened

1 over time by, A, new studies from separate research
2 groups on individuals who participated in conversion
3 therapy efforts published from 2010, summarized in
4 sections 2 and 3."

5 Did I read that correctly?

6 A. Yes.

7 Q. And then there is a footnote there, number 7,
8 that lists out several studies subsequent to the dates
9 of the APA report; correct?

10 A. Correct.

11 Q. I'm going to talk about some of those with
12 you.

13 MR. WILLIAMS: Some of the studies in
14 footnote 7?

15 MR. GANNAM: Yes.

16 (Plaintiffs' Exhibit No. 29 was marked for
17 identification.)

18 BY MR. GANNAM:

19 Q. So I will show you what I'm marking as
20 Exhibit 29. This is a study by Weiss, Morehouse,
21 Yeager & Berry from 2010, titled A Qualitative Study
22 of Ex-Gay and Ex-Ex-Gay Experiences.

23 Did I read that correctly?

24 A. Correct.

25 Q. I'm going to go to -- and this is numbered

1 according to the journal where it appeared so it
2 starts on page 291. I'm going to turn to page 292.

3 A. Okay.

4 Q. So about halfway down on page 292 in the
5 second full paragraph in the middle it begins
6 "Scientific estimates." Do you see that?

7 A. Okay. I think I see where that sentence
8 begins, yes.

9 Q. And also, before I get there, this is in fact
10 a study that you cite in your declaration at footnote
11 7; correct?

12 A. I believe so. Yes.

13 Q. Okay. Sorry about that. Going back to page
14 292 in the middle, the sentence, "Scientific Estimates
15 of the effectiveness of conversion therapy are
16 essentially nonexistent because of difficulties
17 obtaining samples following individuals after they
18 exit therapy, defining success, and obtaining
19 objective measurements of behavioral and psychological
20 change."

21 Did I read that correctly?

22 A. Yes.

23 Q. Do you have any reason to disagree with that
24 statement?

25 A. I might not have worded the sentence the way

1 they have, I don't like their writing style or
2 whatever, but I wouldn't use the word "estimates" and
3 I wouldn't use the word "effectiveness." Efficacy.
4 But I think the general principal I agree with.

5 Q. Okay. Drop down to the bottom, the last
6 sentence on the page that begins "The combination."
7 Do you see that?

8 A. Okay.

9 Q. It reads, "The combination of the failure
10 rate of conversion therapies and the potential
11 negative effects of participating in conversion
12 therapy makes this an important area for research.
13 However, scientific research on the entire topic of
14 changing one's sexual orientation has been limited
15 and, in many cases, seriously methodologically
16 flawed."

17 Do you have any reason to disagree with that
18 statement?

19 A. Yes, I generally agree.

20 Q. Yes, you generally agree with it?

21 A. Yes.

22 (Plaintiffs' Exhibit No. 30 was marked for
23 identification.)

24 Q. I'm going to go on to Exhibit 30. All right.
25 This exhibit is an article by -- you know, I can't

1 pronounce this name. It's F-l-e-n-t-j-e. Do you know
2 how to pronounce that?

3 A. I believe the J is pronounced like Y, but I
4 think we're okay. I know what you're talking about.

5 Q. I'll go with Flentje. So it's by Flentje,
6 Heck & Cochran. It is an article from 2014 titled
7 Experiences of Ex-Ex-Gay Individuals in Sexual
8 Reorientation Therapy: Reasons For Seeking Treatment,
9 Perceived Helpfulness and Harmfulness of Treatment,
10 and Post-Treatment Identification.

11 A. Uh-hum.

12 Q. Did I say that correctly?

13 A. Yes.

14 Q. And is this another of the studies cited in
15 your declaration?

16 A. Yes.

17 Q. Will you turn to page 1245 of this article.

18 MR. WILLIAMS: Exhibit 30; right?

19 MR. GANNAM: Exhibit 30; that's correct.

20 BY MR. GANNAM:

21 Q. Now, about halfway down the page it reads,
22 "Reorientation therapy." Do you see that?

23 A. Right.

24 Q. Now, were they use term "reorientation
25 therapy" in this article, do you understand that to

1 be, generally speaking, synonymous with SOCE or
2 conversion therapy as we have been discussing already?

3 A. I believe so.

4 Q. So it reads, "Reorientation therapy is a
5 political, emotional, and controversial topic and,
6 perhaps as a result of this, there is little
7 methodologically sound empirical research on this type
8 of therapy."

9 Did I read that correctly?

10 A. Yes.

11 Q. And do you have any reason to disagree with
12 that statement?

13 A. I disagree somewhat with that statement.

14 Q. What do you disagree with?

15 A. I think that this statement was published --
16 I think there is some what we would call -- I would
17 disagree. I think there is some better research at
18 this point. It might not be perfect research, but
19 there is some research on these issues at this point
20 in time published since 2014.

21 Q. So the statement reads, "There is little
22 methodologically sound empirical research on this type
23 of therapy." Do you disagree with that statement
24 specifically?

25 A. I'm not sure what they mean by

1 methodologically sound.

2 Q. Okay. So how would you correct what they
3 said if you were to undertake to do that?

4 A. I would use the word "RCTs." Randomly
5 controlled design trials or rigorous experiments that
6 can provide cause and effect conclusions.

7 Q. So, with that statement, would it be accurate
8 to say there is little research fitting the criteria
9 you just described on this type of therapy?

10 A. Yes. Actually -- oh, okay. I think -- yeah,
11 that's okay.

12 The reason I bring this up is that she
13 discusses Beckstead and though some of his early
14 research was qualitative, it has its strengths too.
15 But we -- I think we are getting into the weeds a bit.

16 Q. Okay. Will you turn to page 1264.

17 MR. WILLIAMS: Six four; correct?

18 MR. GANNAM: Right.

19 BY MR. GANNAM:

20 Q. About halfway down there's a heading that
21 reads, "Future Directions." Do you see that?

22 A. Right.

23 Q. And the first sentence says, "This study also
24 points to the need for future research." Do you agree
25 with that statement?

1 A. I'm not sure. I would have to reread the
2 article.

3 Q. As you sit here, do you know of a reason to
4 disagree with that statement?

5 A. I think it would depend on the kind of
6 research and the population it was applied to and
7 whether it could be -- that's all.

8 Q. So will you look at the -- skip the next
9 sentence and go down where it says, "Future research."
10 Do you see that?

11 A. Right.

12 Q. It says, "Future research could assess the
13 psychological health and wellbeing of individuals with
14 varying levels of motivation for seeking reorientation
15 therapy in an effort to approximate the prevalence of
16 psychological disorders and suicidality among
17 individuals who are highly motivated to seek this form
18 of treatment."

19 Did I read that correctly?

20 A. Correct.

21 Q. Do you agree this is one possible avenue for
22 future research?

23 A. Yes.

24 Q. And would the point of this research be to
25 determine whether a person who is highly motivated to

1 obtain what they call reorientation therapy may have
2 some predisposition or existing psychological disorder
3 that could lead to a feeling or a report of harm
4 following the therapy?

5 A. No. I think this would let us know a bit
6 more about the level of distress and the level of
7 complicating mental health issues in people who seek
8 to change their sexual orientation.

9 Q. And would it be true that in determining
10 whether any therapy, but in this case SOCE or what
11 they call reorientation therapy, can be linked to or
12 can be said to cause harmful outcomes such as
13 suicidality, would it be necessary to know what level
14 of suicidality the individual was experiencing going
15 into the treatment in order to determine how it was
16 changed or exacerbated by the treatment?

17 A. How about if we repeat the question.

18 MR. GANNAM: Can you repeat the question.
19 I'm not sure I could.

20 (The question was read by the reporter.)

21 THE WITNESS: Could you do that again,
22 please. It's just a long sentence and I'm trying
23 to make sure I get all the phrases. Can I borrow
24 a sheet of paper so I can keep track of the
25 sentence. Thank you.

1 (The question was read by the reporter.)

2 A. I would say yes, with the proviso there's
3 also the issue -- yes, in certain instances and then
4 there are others potentially as well.

5 BY MR. GANNAM:

6 Q. When you say others potentially as well, what
7 do you mean?

8 A. Ineffective therapy. You suggested that
9 either exacerbated or changed or not impacted.

10 (Plaintiffs' Exhibit No. 31 was marked for
11 identification.)

12 Q. Okay. Fair enough.

13 I'm showing you an article that I'm marking
14 Exhibit 31. This is an article by Dehlin, Bradshaw,
15 Hyde & Crowell, titled Sexual Orientation Change
16 Efforts Among Current Or Formal LDS Church Members.
17 It's from a 2015 publication. Do you recognize this
18 article?

19 A. Yes.

20 Q. And is this one that's cited in your
21 declaration?

22 A. I believe so.

23 Q. I want to look at the first page in the --
24 not in the abstract, but in the first main paragraph.
25 There's a sentence that begins, about the third

1 sentence down, "Despite a recent increase." Do you
2 see that?

3 A. In the first paragraph?

4 Q. The first paragraph begins, "Many 21st
5 century." Do you see that?

6 A. Right. Okay. Despite. Okay.

7 Q. So I'll read the sentence. "Despite a recent
8 increase in public discourse regarding SSA, SOCE
9 studies have been limited in quantity, scope, and
10 methodology and ultimately have failed to demonstrate
11 either the effectiveness or benefit/harm of SOCE."
12 And it cites the 2009 APA report.

13 Did I read that correctly?

14 A. Yes.

15 Q. And then -- well, let me just ask you, do you
16 believe that's an accurate statement?

17 A. Not necessarily.

18 Q. What do you disagree with in that statement?

19 A. The issue of harm.

20 Q. Oh, okay. What specifically do you disagree
21 with in the statement?

22 A. I think the APA report concluded that there
23 was the possibility of harm.

24 Q. Okay. So would it be fair to say the APA
25 report concluded there is a possibility of harm from

1 SOCE, but it did not -- it did not go so far as to
2 conclude that SOCE causes harm definitively?

3 A. I think it said that patients' perceptions of
4 harm and that there is a risk of harm. I would have
5 to read the report. I would have to look -- we could
6 look at the sentence of the report again, but, yes,
7 there's a risk of harm.

8 I believe the report did conclude that
9 patients' perceptions -- patients did receive there to
10 be harms as well as benefits, but the patients did
11 perceive there to be harms. And in some ways treated
12 those perceptions as credible and worthy of
13 significance.

14 Q. Apart from that qualification, do you
15 otherwise agree with the statement that I just read in
16 this Exhibit 31?

17 A. I agree with SOCE studies have been limited
18 in quantity, scope, and methodology, and ultimately
19 have failed to demonstrate the effectiveness of SOCE.

20 In fact, to go back to the report, I
21 apologize, as you -- as we discussed for a long time,
22 the methodologically adequate studies where there was
23 harm and you pointed out aversive studies, did
24 indicate harm and that was substantial harm.

25 Q. When you say indicated harm, you mean

1 indicated that the patients or clients reported harm;
2 correct?

3 A. No, they, I believe, showed that there were
4 excessive dropout rates, loss of sexual feeling,
5 suicidality. The actual reports documented the harm.
6 The actual studies found harm.

7 The aversive studies -- or the early studies,
8 the aversiveness of the -- the types of aversiveness
9 varied, there was a spectrum, and those did indicate
10 harms. And then the more recent studies and some of
11 the qualitative studies like Dr. Beckstead and
12 Morrow's studies, members of the LDS church, discussed
13 perceived harms and benefits of SOCE.

14 Q. But, as we've already discussed, as far as
15 the recent studies go, the Task Force report concluded
16 that the recent studies do not provide valid causal
17 evidence of the efficacy of SOCE or of its harm;
18 correct?

19 A. Cause and effect, yes.

20 Q. And is it also true that regarding all the
21 studies covered by the 2009 report you concluded or
22 stated, we conclude that there is a dearth of
23 scientifically sound research on the safety of SOCE
24 and also that we cannot conclude how likely it is that
25 harm will occur from SOCE?

1 A. Dearth -- Dearth, I'm sorry, I'm a
2 New Yorker, does not mean there is none, and there is
3 some. It's hard to predict the extent and who will
4 either report harms or benefits.

5 Q. So that statement still is true, that we
6 cannot conclude how likely it is that harm will occur
7 from SOCE?

8 A. That is correct. In some ways that makes it
9 even more risky.

10 MR. GANNAM: I just want to move to strike
11 that last response after that is correct as
12 nonresponsive to the question.

13 MR. WILLIAMS: Ignore that.

14 THE WITNESS: Okay.

15 BY MR. GANNAM:

16 Q. So will you look at page 96 of this Exhibit
17 31.

18 MR. WILLIAMS: Nine six; right, Roger?

19 MR. GANNAM: Yes, nine six.

20 MR. WILLIAMS: Got it.

21 BY MR. GANNAM:

22 Q. On the left column, the second full paragraph
23 begins "Finally." Do you see that?

24 A. Yes.

25 Q. It says, "Finally, qualitative reports have

1 suggested that individuals who engaged in SOCE
2 reported a variety of perceived benefits and harms."

3 Did I read that correctly?

4 A. Yes.

5 Q. The next sentence reads, "Based on a
6 comprehensive review of this work, the APA 2009 SOCE
7 Task Force concluded that no study to date has
8 demonstrated adequate scientific rigor to provide a
9 clear picture of the prevalence or frequency of either
10 beneficial or harmful outcomes."

11 Did I read that correctly?

12 A. Yes.

13 Q. And is that an accurate statement?

14 A. Yes.

15 Q. And then the next sentence reads, "More
16 recent studies claiming benefits and/or harm have done
17 little to ameliorate this concern."

18 Did I read that correctly?

19 A. Yes.

20 Q. And is that an accurate statement?

21 A. I'm not sure I'm familiar with Karten & Wade,
22 but I believe that's accurate. I'm just not familiar
23 with their -- with that article.

24 Q. Okay. Moving to the next column, first full
25 paragraph on the right where it says "The frequency."

1 Do you see that?

2 A. Right.

3 Q. It says, "The frequency and rate of SOCE in
4 SSA populations remain unknown."

5 Did I read that correctly?

6 A. Yes.

7 Q. And, by SSA populations, are they referring
8 to same-sex attracted populations?

9 A. I believe so, but I'm not sure where first
10 usage occurred so I would have -- you know.

11 Q. Is that a normal or standard terminology in
12 the academic literature to refer to same-sex
13 attraction?

14 A. I'm not sure. I think in some, but not
15 others. I think generally that isn't a term. Some
16 people use that term. I think most don't. And I'm
17 not sure APA would, but whatever.

18 Q. Fair enough. The next sentence reads, "No
19 known study to date has drawn from a representative
20 sample of sufficient size to draw conclusions about
21 the experience of those who have attempted SOCE."

22 Did I read that correctly?

23 A. Yes.

24 Q. And is that an accurate statement as of the
25 date of this article?

1 A. Yes.

2 Q. It continues, "Furthermore, no known study to
3 date has provided a comprehensive assessment of basic
4 demographic information, psychosocial wellbeing, and
5 religiosity, which would be required to understand the
6 effectiveness, benefits and/or harm caused by SOCE."

7 Did I read that correctly?

8 A. Yes.

9 Q. And is that an accurate statement?

10 A. As of the date of this article?

11 Q. Yes.

12 A. Yes.

13 Q. Skipping a sentence and getting to the word
14 "finally." Do you see that?

15 A. Okay.

16 Q. It says, "Finally, in spite of the APA's 2009
17 report on SOCE, considerable debate continues about
18 the meaning of the report focusing specifically around
19 the lack of more conclusive SOCE related outcome
20 research."

21 Did I read that correctly?

22 A. Yes.

23 Q. And is it true that considerable debate
24 continues about the meaning of the report?

25 A. I don't think so.

1 Q. And why do you disagree with that?

2 A. I'm not sure how much -- I'm not sure what
3 they're referring to about considerable debate. I'm
4 not sure what that really means in terms of I am
5 trying -- I think just two people, two groups arguing
6 may not be considerable debate.

7 Q. Would you agree that there is some debate
8 that continues about the meaning of the report?

9 A. I actually don't think there's very much
10 debate.

11 Q. So there is some, but you wouldn't quantify
12 it as considerable?

13 A. That's correct.

14 (Plaintiffs' Exhibit No. 32 was marked for
15 identification.)

16 Q. All right. I'm going to show you now Exhibit
17 32. This is a report by Ryan, Toomey, Diaz & Russell
18 from 2018 titled --

19 A. Yes.

20 Q. -- Parent-Initiated Sexual Orientation Change
21 Efforts With LGBT Adolescents: Implications For Young
22 Adult Mental Health and Adjustment."

23 Did I read that correctly?

24 A. Yes.

25 Q. Will you turn to the -- this one has, I

1 guess, a cover page from the service that provided it.
2 Would you turn to the first page of the article
3 itself. It is one over from the cover there. We'll
4 call this page 1.

5 At the bottom, the sentence that begins,
6 "Although." Do you see that?

7 A. Right.

8 Q. "Although research on adult populations has
9 documented harmful effects of sexual orientation
10 change efforts, SOCE, no studies have examined SOCE
11 among adolescents, APA Task Force --

12 THE COURT REPORTER: I'm sorry. One more
13 time for me.

14 Q. "APA Task Force on appropriate therapeutic
15 responses to sexual orientation 2009."

16 So did I read that correctly?

17 A. Yes.

18 Q. And you agree no studies have examined SOCE
19 among adolescents?

20 A. I would have inserted the adjective "research
21 studies" or "scientific research studies."

22 Q. Okay.

23 A. Actually -- yeah, research, research studies
24 or experiments would be the appropriate word, to be
25 honest.

1 Q. So how about starting with the word "no,"
2 read it how it would be accurate.

3 A. Although research in adult populations, blah,
4 blah, blah, SOCE, no empirically based research
5 studies.

6 Q. Have examined SOCE among adolescents?

7 A. I'm still thinking. Have solely no
8 empirically based research studies have focused --
9 have examined or -- examined and focused on SOCE among
10 adolescents.

11 Q. So I will read the clause as I believe you
12 have modified it just so we're clear. No empirically
13 based research studies have examined and focused on
14 SOCE among adolescents?

15 A. Yes.

16 Q. So, as rewritten, that is accurate?

17 A. Or reasonably accurate at the time of this
18 deposition.

19 Q. Okay. July 25, 2019?

20 A. 3:19.

21 Q. And this is a study that you cited in your
22 declaration; correct?

23 A. That is correct.

24 Q. It's probably the newest study that you cited
25 in your declaration being from 2018?

1 A. Probably, yes.

2 Q. I want to turn to page 11 of the study, the
3 bottom of page 11. The paragraph begins "There are."
4 Do you see that?

5 A. There are.

6 Q. "There are several limitations of this
7 study."

8 Did I read that correctly?

9 A. Yes.

10 Q. I want to flip over now to page 12 among the
11 list of limitations. About halfway down that first
12 paragraph appears the word "third." Do you see that?

13 A. Third. Okay.

14 Q. It says, "Third, the design is retrospective
15 and thus causal claims cannot be made."

16 Did I read that correctly?

17 A. Yes.

18 Q. And do you agree that that's the case with
19 this study?

20 A. Yes.

21 MR. WILLIAMS: Which study are you talking
22 about? Let's make sure.

23 THE WITNESS: Ryan.

24 BY MR. GANNAM:

25 Q. The Ryan study. What did I mark that, 32?

1 A. Uh-hum.

2 Q. So that's a correct statement then?

3 A. Uh-hum.

4 MR. WILLIAMS: Yes?

5 THE WITNESS: Yes.

6 MR. GANNAM: Thank you.

7 MR. WILLIAMS: It's getting late in the
8 afternoon.

9 THE WITNESS: Have you had a chance to read
10 all these?

11 MR. WILLIAMS: That's how I go to sleep every
12 night is reading these things.

13 THE WITNESS: Some of them are more
14 interesting than others.

15 MR. WILLIAMS: I told you I sleep very well.

16 THE WITNESS: That's true.

17 MR. MIHET: Is all of this on the record?

18 THE COURT REPORTER: It is.

19 (Plaintiffs' Exhibit No. 33 was marked for
20 identification.)

21 BY MR. GANNAM:

22 Q. I'm going to show you now what I'm marking as
23 Exhibit 33. This is a document filed in this case at
24 document 135-1. Its title is Guidelines For
25 Psychological Practice With Transgender and Gender

1 Nonconforming People, published by the APA. Do you
2 recognize this document?

3 A. Yes.

4 Q. Have you seen it before?

5 A. I have.

6 Q. Okay. Will you turn then to page 841. Are
7 you on page 841?

8 A. Yes, I am.

9 Q. Guideline 8 in the right column about halfway
10 down, do you see that?

11 A. Correct. Yes, I do.

12 Q. It says, "Guideline 8. Psychologists working
13 with gender-questioning and TGNC youth understand the
14 different developmental needs of children and
15 adolescents and that not all youth will persist in a
16 TGNC identity into adulthood."

17 Did I read that correctly?

18 A. Yes.

19 Q. And do you understand TGNC means transgender
20 or gender nonconforming in this article?

21 A. Yes.

22 Q. Now, in that section, the heading of which I
23 just read, over on page 842, about halfway down the
24 left column, the first full paragraph begins "A clear
25 distinction." Do you see that?

1 A. Yes.

2 Q. The second sentence of that paragraph says,
3 "Due to the evidence that not all children persist in
4 a TGNC identity into adolescence or adulthood and
5 because no approach to working with TGNC children has
6 in been adequately empirically invalidated, consensus
7 does not exist regarding best practice with
8 prepubertal children."

9 Did I read that correctly?

10 A. Yes.

11 Q. Do you agree with that statement, at least as
12 of the date of this report, there is no approach to
13 working with TGNC children that has been adequately
14 empirically validated?

15 A. I personally would disagree with that.

16 Q. Why would you disagree?

17 A. I prefer the approach in the SAMHSA report
18 that perhaps doesn't come down on one or two --
19 narrows the range and says would not use the word
20 "no," would probably say -- where is it. I would add
21 another adjective. I think in the SAMHSA report I
22 like the way that prepubertal treatment with this
23 population and this age was described better. I would
24 say does not exist is somewhat strong.

25 Q. So there's two different clauses or phrases

1 here. I just want to make sure we're talking about
2 the same thing. After the word "and" it says,
3 "because no approach to working with TGNC children has
4 been adequately empirically validated." So let's just
5 focus on that statement. Is that an accurate
6 statement?

7 A. No approach. Not entirely, no.

8 Q. How would you modify it to make it accurate
9 in your opinion?

10 A. I would say because approaches, blah, blah,
11 blah, to working with TGNC children are still being
12 investigated and validated.

13 Q. Okay. And then the next clause reads,
14 "Consensus does not exist regarding best practice with
15 prepubertal children."

16 A. I would say best practices are evolving or
17 are in development. But I would refer you -- I really
18 refer you to the SAMHSA report. I think, you know,
19 though there is, again, this way that professionals
20 qualify their work all over the place, as we always
21 do, I like some of the descriptions, more in-depth
22 descriptions of possible practices. I think they're
23 concrete and helpful.

24 Q. So are you saying that the SAMHSA report
25 stands against this APA guidelines that we're reading

1 from?

2 A. I'm not sure against. I think they provide
3 some deeper understanding. I think, again, of course
4 the organizations have different ways they like to
5 frame issues. This makes sense for an APA document.
6 APA has its own internal ways it frames issues and
7 that makes sense for APA.

8 Q. So is it objectively true to say a consensus
9 does not exist regarding best practice with
10 prepubertal TGNC and gender-questioning children?

11 A. I'm not sure I can answer that, no. I don't
12 believe it does, but I defer that. I don't believe
13 it -- I'm not sure that's correct.

14 Q. You're not sure that a consensus does not
15 exist or you're not sure that a consensus does exist?

16 A. I'm not sure a consensus does not exist. I
17 believe that there are trends towards a consensus.

18 Q. Is that the same as saying that there is a
19 consensus? What I'm trying to figure out is do you
20 disagree with it completely or would you qualify it?
21 For example, consensus does not exist, but a trend
22 towards consensus does exist? Or would you say it
23 differently?

24 A. I think that's a reasonable phrasing.

25 Q. Okay. Going down in the same section, the

1 same paragraph actually, do you see where it says "Two
2 distinct"?

3 A. The same paragraph?

4 Q. Yes. The word "two" followed by "distinct."
5 Do you see that?

6 A. Right.

7 Q. It says, "Two distinct approaches exist to
8 address gender identity concerns in children with some
9 authors subdividing one of the approaches to suggest
10 three."

11 Did I read that correctly?

12 A. Yes.

13 Q. Now, the next paragraph begins, "One approach
14 encourages an affirmation and acceptance of children's
15 expressed gender identity."

16 Did I read that correctly?

17 A. Correct.

18 Q. And do you agree that that is one approach
19 that exists regarding treating children with gender
20 identity concerns?

21 A. Yes.

22 Q. The next paragraph reads, "In the second
23 approach, children are encouraged to embrace their
24 given bodies and to align with their assigned gender
25 roles. This includes endorsing and supporting

1 behaviors and attitudes that align the child's sex
2 assigned at birth prior to the onset of puberty."

3 Did I read that correctly?

4 A. Yes.

5 Q. And do you agree that that is also an
6 approach to treating children with gender identity
7 concerns?

8 A. I believe that is an approach though it has
9 been reduced in its -- I think fewer people endorse
10 that approach than in the past when this document was
11 published.

12 Q. So since 2015, when this document was
13 published, December of 2015, you're saying that that
14 second approach is less common or less favored?

15 A. Less favored.

16 Q. Has it fallen out of practice or out of favor
17 all together or is it just diminished to some extent?

18 A. I think it is diminished to a very great
19 extent. I am not sure whether -- how many people
20 actually do provide that kind of treatment or how
21 often it's provided.

22 Q. And what do you base that belief on?

23 A. My conversations with colleagues unrelated to
24 this discussion in the case.

25 Q. Are you familiar with any particular study or

1 group of studies that have reached the conclusion that
2 that approach is not favorable or should not be
3 applied by professionals?

4 A. I am not aware of any studies.

5 Q. Would it be fair to say that you personally
6 haven't undertaken any kind of full survey of the
7 landscape of professionals engaged in this kind of
8 therapy to determine how many are or are not engaging
9 in this second approach of encouraging a child to
10 align with their sex assigned at birth?

11 A. A survey of all the possible professionals
12 who could be implementing a certain treatment in
13 confidential settings?

14 Q. Let me rephrase that. You said you're not
15 aware of any studies?

16 A. Published. But I am not aware personally.
17 Those studies may exist.

18 Q. I understand. What I'm trying to decide or
19 determine is, based on what you do know or believe as
20 to the diminishing of that particular approach, is
21 that based on some formal or thorough attempt you've
22 undertaken to answer that question or is that just
23 based on conversations you've had with people
24 professionally?

25 A. There are some new publications out in book

1 form that provide background and a summation or
2 summary and integration of trends in this aspect of
3 the field. And I am thinking of a book recently
4 published by APA, but whose name escapes me. So that
5 is one book I am familiar with that reviews the
6 issues.

7 The work of Laura Edwards-Leeper is the
8 research I'm most familiar with and she has a chapter
9 in that book and I have reviewed a manuscript she
10 wrote, or was provided with a manuscript she wrote on
11 these topics and that's -- and her work and then Marco
12 Hildalgo has also published in this area. So those
13 are the studies I'm thinking about when I'm reflecting
14 on this topic and they are more recent than this.

15 Q. And what have they concluded regarding this
16 approach?

17 A. That they would probably subscribe to careful
18 assessment and then most likely tend towards the first
19 approach rather than the second approach, especially
20 if the second approach increases dysphoria and
21 distress in children.

22 MR. WILLIAMS: Roger, you about through with
23 this exhibit because I would like to take a
24 break.

25 MR. GANNAM: I will be done shortly.

1 MR. WILLIAMS: All right.

2 BY MR. GANNAM:

3 Q. Did either of those authors you've mentioned
4 conclude that the second approach causes harm or
5 should be discontinued all together?

6 A. Possibly. I would have to review those
7 studies or those chapters.

8 Q. So you don't know as you sit here right now?

9 A. I can't recall.

10 Q. Will you look at page 843. On the right
11 column, second -- third full paragraph begins
12 "Psychologist may encourage." Do you see that?

13 A. Correct. Yes, I do.

14 Q. All right. Maybe a third of the way down
15 that paragraph is the word "emphasizing." Do you see
16 that?

17 A. Uh-hum.

18 Q. It reads, "Emphasizing to parents the
19 importance of allowing their child the freedom to
20 return to a gender identity that align with sex
21 assigned at birth or another gender identity at any
22 point cannot be overstated, particularly given the
23 research that suggests that not all young gender
24 nonconforming children will ultimately express a
25 gender identity different from that assigned at

1 birth."

2 Did I read that correctly?

3 A. Yes, you did.

4 Q. And do you have any reason to disagree with
5 that statement?

6 A. Yes. In most circumstances the phrase
7 "cannot be overstated" I think is intense, but
8 whatever.

9 Q. So you would agree with it in most
10 circumstances maybe without that intensification that
11 the author has included?

12 A. I think the first phrase is the most
13 important up to the word "freedom." The freedom to,
14 you know, develop their own gender identity. I think
15 generally I'd say yes.

16 Q. Okay. So maybe can I try to give an example
17 then. Suppose an adolescent who is biologically male
18 identifies as female for a period of time, adopts a
19 female gender identity, but after some period of time
20 decides on the child's own that the child wants to
21 return to a gender identity that matches the sex
22 assigned at birth. Generally what the author's are
23 saying here.

24 Should, in most cases, a therapist be free to
25 help a child who requests therapy or counseling to

1 assist with that de-transition or return to the gender
2 or the sex assigned at birth?

3 MR. WILLIAMS: I will object to the form of
4 the question as being, frankly, vague and overly
5 generalized.

6 Q. You can answer.

7 A. To be honest, that's such a hypothetical I
8 think is impossible to answer because I don't think
9 there's enough clinical detail and assessment
10 information, that each case is unique and that, to be
11 honest, that there is research, I think, recently
12 published if I recall actually as I think about your
13 example, that returning is actually a very small
14 percent of individuals, probably 1 to 2 percent, and I
15 forget the exact age range where that occurs more. So
16 that I think that -- I can't really -- I think that's
17 a difficult hypothetical provided to provide an answer
18 to.

19 Q. Do you think that licensed professionals
20 should be precluded in all cases from helping a child
21 who requests help with that kind of return or
22 de-transition?

23 A. I think you need to do a very careful
24 assessment of any course of action with children and
25 that any course of action either to assist in any

1 direction needs to be assessed carefully. And the
2 reasons and rationale need to be carefully examined in
3 all instances. I think hypotheticals in clinical
4 cases are very difficult to answer.

5 Q. So, from your answer, would it be fair to say
6 the licensed provider or professional in that case
7 should carefully assess the situation before deciding
8 whether or not to help?

9 A. Right.

10 Q. Is there any reason to legally prohibit that
11 licensed professional from making that determination
12 to assist or not assist the child who requests help in
13 that area?

14 MR. WILLIAMS: Object to the form of the
15 question. It calls for a legal conclusion and
16 assumes facts that really aren't in evidence
17 here.

18 THE WITNESS: Do I still have to answer?

19 MR. WILLIAMS: Yeah, you can answer it if you
20 think you can.

21 A. I'm not sure I can answer that. I think,
22 again, it's too vague. I think it presumes competence
23 on the part of the professional that we haven't
24 established. Or other issues too. So I can't really
25 answer that question.

1 I also can't draw a legal conclusion. I
2 think -- I just find that a very difficult
3 hypothetical question.

4 Q. Let's assume that the licensed professional
5 is competent to assess the situation and make an
6 appropriate determination of whether to help the child
7 or not. My question is is there any reason that that
8 professional should be legally prohibited from ever
9 helping a child with that request?

10 MR. WILLIAMS: I'm going to repeat the
11 objection made to the prior question. Your
12 revision doesn't cure the problem with the
13 question posed.

14 A. I don't think I -- I don't want to speculate
15 and I feel like you're asking me to really speculate
16 here and I feel like any speculation would include
17 such inaccuracies to not be helpful. I mean, to not
18 be accurate.

19 Q. So, going back to the passage from these APA
20 guidelines, where it says emphasizing to parents the
21 importance of allowing their child freedom to return
22 to a gender identity that aligns with sex assigned at
23 birth or another gender identity at any point cannot
24 be overstated. Now, you've objected to that
25 intensifying language "cannot be overstated," but I

1 believe you testified you agree with the general
2 proposition that a child ought to be allowed the
3 freedom to return if the child wants to?

4 A. Yes, in most circumstances. Yes, in general
5 circumstances. Yeah, most circumstances or in certain
6 circumstances.

7 Q. So, generally speaking, should that freedom
8 include the freedom to receive professional assistance
9 with that return or that change if the child wants it?

10 A. I think when we're -- so I think --

11 MR. WILLIAMS: I'm going to object to the
12 form of the question. It just goes back to the
13 prior questions in the sense it assumes facts
14 that aren't in evidence and it calls for
15 speculation based on assumptions that are
16 embedded in the question itself.

17 I'm making an objection for the record,
18 Doctor. If you think you can answer that
19 question, that's fine. It's up to the court to
20 determine whether or not the question is proper.

21 MR. GANNAM: And I just want to say for the
22 record in response to your objection that asking
23 this kind of hypothetical is perfectly acceptable
24 when we're talking with an expert witness, one
25 who has the qualification and training to discuss

1 these matters.

2 MR. WILLIAMS: Well, we disagree on that.

3 That's why judges exist to make rulings.

4 A. I think this topic is complicated and
5 involves some degree of speculation and consideration
6 of issues of coercion and non-coercion so that I think
7 there's just a lot of important issues of how to
8 consider and vagueness and definitions.

9 BY MR. GANNAM:

10 Q. Then let me ask this. Should the freedom
11 that we've talked about for a child to return to a
12 gender identity that aligns with sex assigned at birth
13 include the freedom to consult a competent
14 professional, without coercion, to accomplish that
15 return?

16 MR. WILLIAMS: You mean from a clinical point
17 of view as opposed to a legal point of view?

18 MR. GANNAM: Yeah.

19 A. There's another issue here about the issue of
20 minors and informed consent so, generally speaking,
21 the parents provide informed consent to all these
22 treatments and procedures. So you're talking on a
23 minor consulting with a professional that the parent
24 provides, generally, informed consent to. So freedom
25 is a complicated word here.

1 Q. Well, there's always going to be an informed
2 consent issue any time a minor receives psychotherapy;
3 correct?

4 A. That's correct.

5 Q. So is there something about this situation
6 that is different from any other situation where a
7 minor receives psychotherapy or professional
8 counseling?

9 A. I think it's a very complex situation. I
10 think this is very complex topic.

11 Q. So, to address your response, assume then
12 that this is a situation where the child wants to
13 return to a gender identity that aligns with the sex
14 assigned at birth, that there is a competent
15 professional able to help that child, that there is no
16 coercion, and that the parent appropriately exercises
17 their parental responsibility of informed consent.
18 Should that child, or that child and the parents, have
19 the freedom to get professional help with that return?

20 MR. WILLIAMS: I'm going to repeat the same
21 objections I've been iterating now for the last
22 ten minutes. Vague, overly broad, indefinite,
23 improper hypothetical. You may try to answer the
24 question, Doctor.

25 A. In a hypothetically perfect world where

1 everyone is exquisitely trained and all that, that may
2 be an appropriate course of action.

3 Q. You said that may be an appropriate?

4 A. May be an appropriate.

5 MR. GANNAM: Thank you. Let's take that
6 break that Ron asked for.

7 MR. WILLIAMS: Okay. Great.

8 (Recess from 3:48 p.m. to 4:12 p.m.)

9 MR. WILLIAMS: We've just finished a break
10 and during the break Dr. Glassgold told me what
11 was obvious to me, that she's really getting
12 tired and she was concerned about a particular
13 question that Mr. Gannam asked her, gosh, about
14 20, 30 minutes ago, I don't remember. And she
15 wants to address that question and make sure that
16 her answer is clear and correct in her own mind.

17 So I'm going to ask the court reporter to
18 read that question if you can find it very
19 quickly, madam court reporter, so Dr. Glassgold
20 can address it.

21 MR. GANNAM: I just want to object to your,
22 you know, taking this opportunity to ask a
23 question during my direct examination time. You
24 have the opportunity to redirect after the
25 conclusion of my questions.

1 MR. WILLIAMS: I'm going to go ahead and do
2 it anyway and I understand your objection, but
3 she's getting more tired. I want to make sure.
4 It's only fair to this witness that she have that
5 opportunity.

6 THE WITNESS: So do I need to speak to you
7 about which question it was?

8 MR. GANNAM: Excuse me.

9 MR. WILLIAMS: Do you remember the question?

10 THE WITNESS: Yes, I do. It's one I took
11 notes on.

12 MR. WILLIAMS: All right. Why don't you go
13 ahead and do whatever you need to do to make sure
14 the record is clear.

15 MR. GANNAM: And I will just reiterate, we're
16 within our seven hours still of our time.

17 MR. WILLIAMS: I understand.

18 MR. GANNAM: So I would like to continue.

19 MR. WILLIAMS: Let Dr. Glassgold clarify her
20 answer, if you would, and then we'll move on.

21 THE WITNESS: It has to do with the question
22 about the Caitlin Ryan studies and a measure of
23 suicidality before -- would it be necessary to
24 have a measure of suicidality before assessing
25 suicide or something like that.

1 BY MR. GANNAM:

2 Q. Is there something you would like to change
3 about your answer that you gave previously?

4 A. Yes. I believe I said yes to that and I
5 meant to say no. That was that question we read over
6 at least two times and I took some notes too and I
7 edited it, but then I think it was just I was
8 confused. Tired and confused.

9 MR. GANNAM: All right. Just for the record
10 I want to say after a 22-minute break the witness
11 has given a new answer to a prior question that
12 was some time back. I move to strike the attempt
13 to re-answer the question and I just want to go
14 back on the record. I mean, I just want to
15 continue now with my questioning.

16 BY MR. GANNAM:

17 Q. I guess before I go there, Dr. Glassgold, the
18 new answer that you just gave, did you discuss that
19 with anyone during the break?

20 A. I discussed with Mr. Williams that I felt
21 that my answer had not been accurate and I had not --
22 I thought about it. It was a multi-part question and
23 though the question was read back to me a few times, I
24 felt like that wasn't the answer that reflected my
25 views.

1 Q. And did you decide that your answer needed to
2 be changed or was it brought to your attention by
3 someone else?

4 A. I decided my answer needed to be changed.

5 Q. And I just want to remind you, Dr. Glassgold,
6 when we began the deposition I did ask that if I asked
7 a question that you didn't understand that you let me
8 know that, and I think you agreed that if you answered
9 the question that I could assume that you understood
10 it when I asked you. Do you recall that?

11 A. I do.

12 Q. Before we continue, is there any other aspect
13 of your earlier testimony that you want to change?

14 A. I don't think so.

15 Q. Okay. Let's look at the SAMHSA report that
16 you commuted to me earlier. It's Exhibit C to your
17 expert declaration which was marked Exhibit 28.

18 MR. GANNAM: For the record, SAMHSA is an
19 acronym for Substance Abuse and Mental Health
20 Services Administration, and this report is dated
21 October 2015.

22 BY MR. GANNAM:

23 Q. What was your involvement with this report,
24 Dr. Glassgold?

25 A. I helped support the work of a professional

1 group of experts who came together within a -- we were
2 brought together by SAMHSA to discuss the issues
3 covered in the report, so I was a staff person at APA
4 at the time.

5 Q. And SAMHSA is a governmental organization;
6 correct?

7 A. That is correct. It's an agency of the
8 Department of Health and Human Services.

9 Q. Of the U.S. government?

10 A. Yes.

11 Q. And would it be fair to say this SAMHSA
12 report did not undergo the same layers of review as
13 the 2009 Task Force report that we talked about
14 earlier, at least within the APA?

15 A. It is not an APA product, so it did not
16 undergo review at APA.

17 Q. What review did it undergo or go through
18 before it was published, if you know?

19 A. It went under review in the Department of
20 Health and Human Services, and my understanding is
21 that it was reviewed by different -- I believe it was
22 reviewed within that organization.

23 Q. Will you look at page 13 of the SAMHSA
24 report, please.

25 A. Uh-hum.

1 Q. Earlier we were looking at the APA guidelines
2 on transgender and gender nonconforming children. Do
3 you remember that?

4 A. Yes.

5 Q. And we had a discussion about whether there
6 was or was not a consensus on certain issues. Do you
7 recall that?

8 A. Yes.

9 Q. On page 13 of the SAMHSA report at the top
10 within a section called consensus on efforts to change
11 gender identity. Do you see that?

12 A. Yes.

13 Q. And it reads, "Number 3. There is a lack of
14 published research on efforts to change gender
15 identity among children and adolescents." We stop
16 there. Do you agree with that statement?

17 A. Yes.

18 Q. And it's an accurate statement as of December
19 2015 when this report was published?

20 A. I believe it was October 2015, yes.

21 Q. Okay. Thank you. Will you go to page 25,
22 please.

23 While you're looking for that, did you edit
24 or contribute to the writing of this report?

25 A. I assisted on the executive summary and then

1 I sent in some materials written by Dr. Yarhouse to
2 the writer of this report, as well as I believe I
3 facilitated the connection of the writer to our ethics
4 specialist, or the ethics specialist. This was -- so
5 there was a professional writer who was -- and
6 professional consultants hired by SAMHSA to pull
7 together this report. So I facilitated the
8 communications of Dr. Yarhouse and another expert from
9 the Fordham Center to the person, and then I believe I
10 assisted and edited in the writing of the executive
11 summary.

12 Q. And when you submitted the Yarhouse
13 materials, did the writer of the report receive and
14 consider those materials when you sent them?

15 A. Yes, I believe so.

16 Q. And did they make it into the report or
17 whatever aspect of them you brought to the writer's
18 attention?

19 A. Some aspect of them.

20 Q. So would it be fair to say you had access to
21 the writer of this report before it was published and
22 had an opportunity to give input to it?

23 A. Yes.

24 Q. Would you look at page 25 on the left column.

25 A. Well, I just want to clarify, I was not sent

1 the report, the entire report to edit at all. I did
2 not see the report itself. I had some access to the
3 writer of the report to submit material and I saw the
4 executive summary or I was asked to assist in order to
5 finish by the timeline. I did not see the bulk of the
6 report before it was -- I did not edit the report or
7 see the majority of it until after it came out.

8 Q. Did you receive and read it when it came out?

9 A. I did receive and read it when it came out.

10 Q. And did you -- at the time it came out did
11 you disagree with anything in it or object to anything
12 that had been published in it?

13 A. Not that I recall.

14 Q. As you sit here today, do you object to
15 anything in this report or think it is in any way
16 inaccurate?

17 A. I don't believe so, but even though I've
18 looked at it, glanced at it since then, I haven't read
19 it with intensity or with an editorial frame of mind.

20 Q. So, on page 25, the first paragraph there on
21 the left, the last sentence where it says "No new
22 studies," do you see that?

23 A. Right.

24 Q. Is says, "No new studies have been published
25 that would change the conclusions reached in the APA

1 Task Force's 2009 review."

2 Did I read that correctly?

3 A. Yes.

4 Q. And that's referring to your APA Task Force
5 and its report; correct?

6 A. Right.

7 Q. And that's an accurate statement?

8 A. I would say that it probably is, but part of
9 the problem I have with that sentence is it doesn't --
10 the two previous sentences, as I look at them now, it
11 separates research on adults and research on children.
12 And then the last sentence doesn't qualify whether
13 it's all, both adults and children's studies, or one
14 or the other.

15 And so I'm not sure that -- I'd have to think
16 about whether, as of October 2015, that probably is
17 correct for adults and children, but I think that -- I
18 think that's accurate, yes. Sorry I had to try to
19 think things through.

20 Q. No problem. Will you look at page 26?

21 A. Uh-hum.

22 Q. About halfway down on the first full
23 paragraph is the word "although." Do you see that?

24 A. Yes.

25 Q. It says, "Although no research demonstrating

1 the harms of conversion therapy with gender minority
2 youth has been published." Let me stop there.

3 Do you agree with that statement, that no
4 research demonstrating the harms of conversion therapy
5 with gender minority youth has been published?

6 A. As of October 2015, when that sentence was
7 written, I believe that sentence was accurate.

8 Q. In your declaration that you filed in this
9 case, do you cite to any research that would disagree
10 with that statement from October of 2015 in the SAMHSA
11 report?

12 A. Actually, the Ryan study did include
13 individuals who identify, in her study, as transgender
14 and they perceive and report concerns that would
15 indicate harm.

16 Q. And we're talking about the Ryan 2018 study?

17 A. Yes.

18 Q. And I think we did already discuss that you
19 agreed with that statement in that report, that the
20 design is retrospective and thus causal claims cannot
21 be made from the Ryan report; correct?

22 A. That's why I used patient perception.

23 Q. Apart from that Ryan report, as we've just
24 discussed, do you cite in your declaration any other
25 research demonstrating harm from conversion therapy

1 with gender minority youth?

2 A. I don't believe so, though in the Bradshaw
3 study, one of the Bradshaw studies, they discuss the
4 experiences of individuals who do identify as gender
5 nonconforming who felt -- or felt that their gender
6 nonconforming behaviors were targeted, but I believe
7 those were individuals who experienced therapy as
8 adults, but they might have had therapy as young
9 adults or adolescents, but I am doubtful to that. But
10 I believe it's only Ryan who identified that at this
11 point, but I'm pretty sure. I would have to think
12 about this thing a little bit more.

13 Q. Let me ask you this. I'm sorry. Are you
14 still thinking?

15 A. I'm still thinking.

16 Q. Please finish. I mean, take your time.

17 A. I believe that is -- my answer is correct.

18 Q. Can you go back to your report. Your
19 declaration, excuse me, Exhibit 28. And I'm looking
20 at page 5.

21 A. Uh-hum.

22 MR. WILLIAMS: Give me a second here, Roger.

23 Let me catch up to you, if I may. All right.

24 Thank you.

25 Q. Specifically, paragraph 14.

1 A. Uh-hum.

2 Q. It reads, "The ordinance is supported by the
3 best available scientific research relevant to
4 children and adolescents which is, again, cited in the
5 legislative findings of the ordinance." Let me stop
6 there.

7 Will you look at, for the moment, Exhibit 4,
8 the ordinance itself. In paragraph 14, where you
9 refer to the legislative findings of the ordinance,
10 are those the various whereas clauses appearing on
11 pages 1 through 5 of the ordinance?

12 A. Yes.

13 Q. Okay. The next sentence, going back to
14 paragraph 14 on page 5 in your declaration says,
15 "Specifically, current scientific evidence, including
16 those cited in findings, confirm unequivocally that
17 conversion therapy, CT, in any form is ineffective and
18 harmful."

19 Did I read that correctly?

20 A. Yes.

21 Q. Now, we have looked at your APA report itself
22 that makes a statement, "We cannot include how likely
23 it is that harm will occur from SOCE." And we've
24 looked at the SAMHSA report from 2015 that says, "No
25 studies have changed any of the conclusions in the

1 2009 APA report."

2 My question is how do we get from those
3 studies to your statement that the current scientific
4 evidence confirms unequivocally that conversion
5 therapy in any form is both ineffective and harmful?

6 A. There is no scientific evidence that
7 conversion therapy is effective and I believe patient
8 perception qualitative accounts of harm are valid to
9 be considered substantial enough evidence of harm that
10 the standards for harm are different than standards
11 for efficacy and patient perception of harm is
12 adequate reason to reconsider patient -- to consider a
13 therapeutic program.

14 Q. So isn't it different to say that conversion
15 therapy poses a risk of harm on the one hand and
16 saying that it is harmful on the other hand,
17 scientifically speaking?

18 A. Perhaps I think at some point we're
19 nitpicking, but there is a distinction. I think --
20 so, to answer your question, I believe the totality of
21 the evidence supports my statement and I could go into
22 depth about that if you wish.

23 Q. Well, I just would like to ask you to point
24 me to the study that or the research that was
25 completed or occurred from the 2015 SAMHSA report

1 through the date of your declaration that goes from no
2 conclusions from the APA report in 2009 have been
3 changed by the research to now it's unequivocal that
4 conversion therapy is harmful and ineffective?

5 A. I believe the Ryan report and the research
6 from 2015 on, including Bradshaw, point to strong
7 patient perceptions of harm. And if you look at the
8 accounts in Bradshaw that compare the different types
9 of therapy, there is evidence of perceived harm and,
10 again, the evidence from harm do not have to be RCTs
11 in order for their treatment to be considered
12 extremely risky and seriously harmful.

13 Q. And, apart from the Ryan study and the
14 Bradshaw study, are there any others that support that
15 statement since the 2015 SAMHSA report?

16 A. I believe that the collective work of the
17 Bradshaw daily group, they're a group of studies by
18 that group, the Ryan work, which is most pertinent to
19 adolescents, is strong enough evidence for that
20 statement.

21 Q. And, just so I'm clear, where the Ryan report
22 says causal connections cannot be made, you believe
23 that's strong enough to make a statement that research
24 confirms unequivocally that conversion therapy is
25 harmful?

1 A. Yes, especially given that in the last 100
2 years there is no shred of evidence that is it
3 effective. And providing ineffective treatment in
4 itself is harmful because you delay access to
5 effective care and that can increase the stress or
6 does not mitigate the stress in a timely fashion. It
7 is the responsibility of the provider to provide
8 effective and safe care in a timely manner. Pursuing
9 conversion therapy delays the provision of safe and
10 effective treatment and can worsen symptoms, and that
11 in itself is also harmful.

12 Q. I want to make sure we're clear that since
13 the 2015 SAMHSA report you've identified the Ryan
14 report and the Bradshaw work, which are the LDS
15 studies. I believe there are two of them, correct, in
16 that time frame?

17 A. Two to three; right.

18 Q. Apart from those, are there any others that
19 support that statement that the research confirms
20 unequivocally that conversion therapy is ineffective
21 and harmful?

22 A. In the peer review journal, no, I don't
23 believe so.

24 Q. You don't believe there's any others?

25 A. I don't believe so.

1 Q. You earlier spoke about a -- okay. Let me
2 follow up. Any anything apart from a peer review
3 journal that supports that statement?

4 A. I only have reviewed the peer reviewed
5 statements.

6 Q. So the answer is no, to your knowledge?

7 A. Not to my knowledge.

8 Q. Now, in your paragraph -- or in that
9 statement that the current scientific evidence
10 confirms unequivocally that conversion therapy is
11 ineffective and harmful, you added a footnote number 4
12 that cites to a Weiss, Morehouse, Yeager & Berry
13 study; correct?

14 A. Uh-hum.

15 Q. And we looked at -- and that was from 2010;
16 correct?

17 A. Uh-hum.

18 MR. MIHET: Just a reminder to use verbal
19 answers. Yes or no, please.

20 THE WITNESS: Okay.

21 BY MR. GANNAM:

22 Q. And is there a particular reason why that was
23 the study you cite to support that particular
24 statement as opposed to something newer, for example,
25 or any of the other studies?

1 A. I don't recall, to be honest. I really don't
2 recall.

3 Q. You testified earlier that you gave a
4 declaration in the Schwartz case in New York?

5 A. That is correct.

6 (Plaintiffs' Exhibit No. 34 was marked for
7 identification.)

8 Q. Show you a copy that I will mark as Exhibit
9 34.

10 MR. WILLIAMS: Thank you.

11 Q. This document was filed at document 24-15 in
12 Schwartz v. The City of New York, case number 1:19
13 Civ. 00463. The title is Declaration of Judith M.
14 Glassgold In Support of Defendant's Opposition to
15 Plaintiff's Motion For a Preliminary Injunction.

16 Did I read that title correctly?

17 A. Yes, you did.

18 Q. And I will represent that as I looked at this
19 on the docket it included 30, approximately, exhibits
20 that were attached to it in the original filing in the
21 New York court. Is that also your recollection?

22 A. I did not prepare the filing myself, so I
23 sent -- so I cannot say what it included.

24 Q. As far as what you prepared yourself, is this
25 Exhibit 34 a copy of that document?

1 A. I believe so.

2 Q. I want to refer you to -- you know what, I'm
3 just going to leave it alone as having you
4 authenticate it for the record. I'm not going to ask
5 you any questions about it.

6 MR. WILLIAMS: Authenticate what, Roger?

7 MR. GANNAM: That that was her declaration in
8 the New York case. I'm not going to ask any
9 further questions about it.

10 MR. WILLIAMS: All right.

11 BY MR. GANNAM:

12 Q. I would now like to -- I'm going to go back
13 to something that we talked about earlier and that was
14 your role with the Born Perfect project of NCLR.

15 A. Uh-hum.

16 Q. Since we talked and it earlier today, do you
17 have any more clarity on what your position is or the
18 title of your position with the organization?

19 A. I believe I was part of an advisory body to
20 the Born Perfect. I wasn't a board member. I was on
21 a professional advisory body to provide them some
22 scientific and professional information.

23 Q. And is part of joining that project and the
24 role in which you joined as an advisory -- in an
25 advisory capacity or an advisory board or committee,

1 did you or were you asked to agree to or affirm any
2 kind of mission statement or goals of the project?

3 A. I don't believe so.

4 Q. In accepting that position with the project,
5 were you in fact committed to the goals of the project
6 when you joined it?

7 A. My goals were to try to make sure that the
8 efforts were grounded as much as possible in the
9 professional literature.

10 Q. And by efforts, what specifically are you
11 talking about?

12 A. Whatever efforts they involved in.

13 (Plaintiffs' Exhibit No. 35 was marked for
14 identification.)

15 Q. I'm going to show you a document that I've
16 marked as Exhibit 35. This is a printout of the Born
17 Perfect home page on the internet. At the top it says
18 Born Perfect: The Campaign to End Conversion Therapy.
19 National Center For Lesbian Rights. Do you see that
20 at the very top?

21 A. Right. Uh-huh.

22 Q. And then, going to the center of the page
23 under the Born Perfect logo, it reads, "In June 2014
24 NCLR launched Born Perfect, the campaign to end
25 conversion therapy by passing laws across the country

1 to protect LGBT children and young people, fighting in
2 courtrooms to ensure their safety and raising
3 awareness about the serious harms caused by these
4 dangerous practices."

5 Did I read that correctly?

6 A. I believe so, yes.

7 Q. And, having seen this, does that refresh your
8 recollection as to the purpose of the Born Perfect
9 campaign that you joined?

10 MR. WILLIAMS: Whoa, whoa, whoa. That
11 misstates her prior testimony. She was a member
12 of the advisory committee. That's what she said.
13 That's not the same as joining something.

14 A. So, in 2014, I don't know what their website
15 was or the discussion we had. I was asked by Caitlin
16 Ryan to join the advisory body to ensure that their
17 efforts were to the best reasonable professional
18 level. I don't recall what their website was there or
19 what information I received at that time, to be
20 honest.

21 Q. At the time did you understand the Born
22 Perfect project to have the specific role of ending
23 conversion therapy by passing laws across the country?

24 A. I believe that was one of their goals, but I
25 also believe that not everybody. I'm not sure whether

1 everyone endorsed that or not.

2 Q. Did you endorse that goal?

3 A. In part.

4 Q. And, Caitlin Ryan, is that the same Ryan who
5 authored the 2018 study that you cited in your
6 declaration?

7 A. Right.

8 Q. Are you friends with Ms. Ryan?

9 A. Yes. We've known each other maybe 40 years
10 now.

11 Q. Is -- strike that.

12 On the second page in the middle among
13 that -- below the first graphic that appears on that
14 page it says, "We are committed to ending these
15 dangerous and stigmatizing practices across the
16 country once and for all." Do you see that?

17 A. Oh, okay. Yes, I do.

18 Q. Did you sign onto or share that commitment
19 when you agreed to serve in an advisory capacity to
20 the project?

21 A. In part I'm not sure I -- my understanding
22 was I was to be an advisory person to help their
23 efforts, ensure that their efforts had some rational
24 and what they did had some basis in science and
25 professional practice. I did not -- I was not

1 consulted about any of their actions or lawsuits or
2 approve of or have to endorse any of their actions,
3 specific actions I may or may not agree with, but I
4 was not asked or not committed to endorsing any of
5 them.

6 Q. So did your agreement to serve in an advisory
7 capacity go as far as agreeing to their goal of ending
8 conversion therapy?

9 A. My goal was to improve the quality of care
10 that adolescents and children receive with regard to
11 sexual orientation and gender identity. I did not
12 necessarily agree to all of their actions or all of
13 their strategies.

14 Q. Do you currently support the project's goal
15 of ending conversion therapy?

16 A. Yes. In general.

17 Q. And you testified earlier that it was an NCLR
18 representative who initiated your involvement in this
19 case; correct?

20 A. That's correct.

21 Q. And so was procuring your services as an
22 expert in this case in furtherance of the Born Perfect
23 project and its goals to end conversion therapy?

24 MR. WILLIAMS: I didn't understand that
25 question. Would you read it back.

1 (The question was read by the reporter.)

2 MR. WILLIAMS: Object to the form of the
3 question. It's unintelligible to me, but if you
4 understand it.

5 THE WITNESS: I don't understand it.

6 MR. GANNAM: Rob, I appreciate just making
7 your objection and not suggesting --

8 MR. WILLIAMS: That's what I just did. It's
9 unintelligible. What else can I say.

10 A. I'm not sure I can make the causal leap that
11 that question requires.

12 BY MR. GANNAM:

13 Q. Okay. Do you understand that your
14 involvement in this case has to do with the Born
15 Perfect project of NCLR?

16 A. I don't think -- I'm not sure -- is NCLR
17 involved in this case?

18 Q. Well, NCLR called you to suggest that you
19 serve as an expert in this case; correct?

20 A. So I was introduced -- so I guess if you want
21 to break down your question to did a professional from
22 NCLR introduce me to Mr. Williams, yes, that is
23 correct.

24 Q. The NCLR lawyer who is sitting in the room
25 today; correct?

1 A. That's correct.

2 Q. And did you ask the NCLR lawyer who called
3 you whether it was in connection with the Born Perfect
4 project?

5 A. No, I did not.

6 Q. Was the Born Perfect project discussed during
7 the course of that phone call?

8 A. No.

9 Q. And since you have been engaged to serve as
10 an expert in this case, have you discussed the Born
11 Perfect project with anyone at NCLR?

12 A. No.

13 Q. You said that you generally support the goal
14 of NCLR to end conversion therapy; is that correct?

15 A. That is correct.

16 Q. Is there anything specific about -- or any
17 specific goal of NCLR or any specific action of NCLR
18 in the Born Perfect project that you disagree with?

19 A. To be honest with you, I do not follow
20 their -- what they do, to be honest, in great detail.
21 I generally respond to phone calls for them with
22 specific questions. I don't keep up with what they
23 do.

24 Q. So it'd be fair to say, as you sit here
25 today, you can't identify any goal or action of the

1 project that you disagree with?

2 A. Can't identify any goal or action of the
3 project that I agree or disagree with. I'm not sure
4 what they're doing. I'd have to look -- to answer
5 your question I'd have to review what they're doing,
6 to be honest.

7 Q. But you did say you agree with their goal of
8 ending conversion therapy?

9 A. That goal, but their particular strategy in
10 the goal that's what I'm not sure what they're doing
11 to achieve that goal.

12 Q. So apart from agreeing generally with the
13 goal to end conversion therapy, you can't identify any
14 other goal or action of the Born Perfect project that
15 you agree or disagree with?

16 A. Right, in terms of specific issues.

17 MR. GANNAM: Okay. I think I want to take a
18 break just to consult with my colleague here.

19 (Recess from 4:50 p.m. to 4:53 p.m.)

20 BY MR. GANNAM:

21 Q. Wrap up a couple things. First, I think you
22 testified earlier that you were not being compensated
23 for your expert witness engagement in New York; is
24 that correct?

25 A. That's correct.

1 Q. You are being compensated for your engagement
2 here in Tampa; correct?

3 A. For the physical presence, yes.

4 Q. Any particular reason for the difference in
5 treatment of the two cases?

6 A. I don't necessarily charge for the statement
7 preparation and in Schwartz all I did was prepare a
8 statement. For the physical time when I have to be
9 aware from my other businesses or professional
10 engagements, I do ask to be compensated.

11 Q. So in terms of compensation for the written
12 declaration, it's the same in both cases, you're not
13 being paid by either one?

14 A. That's correct. That's a good way of putting
15 it. Thank you.

16 Q. Thank you. So if you testify in New York,
17 would you charge for your time in that situation?

18 A. I would ask to be compensated for my time,
19 yes.

20 MR. GANNAM: That ought to make you happy
21 that she's not treating Tampa differently from
22 New York.

23 MR. WILLIAMS: I will finally get to sleep
24 tonight.

25 BY MR. GANNAM:

1 Q. A lot of the questions about scientific
2 research and what it does and doesn't support today
3 have been limited by the timing of research in terms
4 of, for example, when I ask you about a particular
5 report you would say, yeah, as of the time of the
6 record that statement is accurate. Do you follow me
7 in general?

8 A. Yes.

9 Q. So I want to ask you specifically about as we
10 sit here today, July 25, 2019, from any of the
11 scientific research that you are familiar with, can
12 you identify quantitatively the likelihood of harm
13 that could occur from SOCE as compared to other kinds
14 of psychotherapy?

15 A. So I will try to be responsive to your
16 question. Ideally, so if one could, and one could
17 identify people who could be harmed or benefited, that
18 would be a great boom to practitioners. But because
19 we cannot predict who will be harmed and who may not
20 be harmed or what their -- may be harmed or not, it
21 makes it more risky because you can't predict the
22 treatment effect. That was my answer.

23 Q. So is the answer, no, you can't quantify the
24 likelihood of harm from SOCE as compared to other
25 therapies?

1 A. That is correct.

2 MR. GANNAM: And so just to give it -- strike
3 that.

4 No further questions.

5 MR. WILLIAMS: My witness?

6 MR. MIHET: Yes, sir.

7 MR. WILLIAMS: Dr. Glassgold, I have no
8 questions.

9 THE WITNESS: Thank you.

10 MR. WILLIAMS: Now, I'm sure you will
11 transcribe this deposition. And once that
12 transcription is completed, I will get a copy and
13 you will have an opportunity to review it and
14 make any corrections and so forth.

15 And how quickly are you going to get this --
16 have you talked to her yet about that?

17 MR. GANNAM: We haven't.

18 MR. WILLIAMS: Well, whenever it is --

19 MR. GANNAM: Regular delivery. I don't think
20 we have a need for rush.

21 MR. WILLIAMS: We're not waiving is my point.
22 We're not going to waive. She's not going to
23 waive. So just put that on the record so
24 everybody can understand.

25 MR. MIHET: Your obligation to read and sign

1 happens whether or not we order a transcript.

2 MR. WILLIAMS: How can I read and sign
3 something that's not transcribed?

4 MR. MIHET: You do what you do, we do what we
5 do.

6 MR. WILLIAMS: That's a new one on me, Harry.
7 I've never done that in 47 years. I don't intend
8 to start now.

9 If it's transcribed, she will read it and she
10 will sign. That's what the errata sheet is for.

11 THE COURT REPORTER: And you're keeping the
12 exhibits?

13 MR. GANNAM: Yes. And I will scan them and
14 distribute them to everyone tomorrow.

15 THE COURT REPORTER: Are you ordering now?

16 MR. GANNAM: Yes, standard delivery.

17 MR. WILLIAMS: We'll take a copy, obviously.

18 THE COURT REPORTER: Anyone want paper or is
19 electronic fine?

20 MR. GANNAM: Electronic.

21 MR. WILLIAMS: Electronic is fine.

22 THE COURT REPORTER: And we're off the record
23 now?

24 MR. GANNAM: Yes.

25 (This deposition concluded at 4:58 p.m.)

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1 RE : Robert L. Vazzo v. City of Tampa
DEPO OF: Judith M. Glassgold, Psy.D.
2 TAKEN : July 25, 2019
3

4 EXCEPT FOR ANY CORRECTIONS
MADE ON THE ERRATA SHEET BY
5 ME, I CERTIFY THIS IS A TRUE
AND ACCURATE TRANSCRIPT.
6 FURTHER DEPONENT SAYETH NOT.
7

JUDITH M. GLASSGOLD

8
9 STATE OF FLORIDA)
) SS:
10 COUNTY OF HILLSBOROUGH)
11

Sworn and subscribed to before me this

12 _____ day of _____, 2019.
13

PERSONALLY KNOWN _____ OR I.D. _____
14

15 _____
Notary Public in and for
16 the State of Florida at
Large.
17

My commission expires:
18
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25

ERRATA SHEET

RE : Robert L. Vazzo v. City of Tampa

DEPO OF: Judith M. Glassgold, Psy.D.

TAKEN : July 25, 2019

DO NOT WRITE ON TRANSCRIPT, ENTER ANY CHANGES HERE

Page	Line	Change	Reason

State of Florida)
County of Hillsborough)

Under penalties of perjury, I declare that I have read
the deposition transcript and it is true and correct
subject to any changes in form or substance entered
here.

_____ Date	_____ Judith Glassgold

CERTIFICATE OF OATH OF WITNESS

STATE OF FLORIDA

COUNTY OF HILLSBOROUGH

I, MARY ANN SMITH, Registered Professional Reporter, Registered Merit Reporter, Notary Public, State of Florida, certify that the witness, Judith Glassgold, Psy.D., personally appeared before me on the 25th day of July, 2019, and was duly sworn by me.

WITNESS my hand and official seal this 9th day of August, 2019.



Mary Ann Smith, RPR, RMR
Notary Public - State of Florida
My Commission No. FF 977637
Expires: May 17, 2020

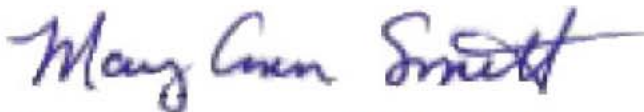
REPORTER'S DEPOSITION CERTIFICATE

STATE OF FLORIDA
COUNTY OF MANATEE

I, MARY ANN SMITH, Registered Professional Reporter, Registered Merit Reporter, certify that I was authorized to and did stenographically report the deposition of Judith Glassgold, Psy.D., the witness herein, on July 25, 2019; that a review of the transcript was requested; that the foregoing transcript, pages 1 through 206 inclusive is a true and complete record of my stenographic notes of the deposition by said witness; and that this computer-assisted transcript was prepared under my supervision.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action.

DATED this 9th day of August, 2019, at Lakewood Ranch, Manatee County, Florida.



Mary Ann Smith, RPR, RMR

No. 19-14387

**IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

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,

Plaintiffs–Appellees,

v.

CITY OF TAMPA, FLORIDA,

Defendant–Appellant

On Appeal from the United States District Court
for the Middle District of Florida
in Case No. 8:17-cv-02896-T-02AAS before the Honorable William F. Jung

**PLAINTIFFS-APPELLEES’ SUPPLEMENTAL APPENDIX
VOLUME IV**

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VAZZO, etc., et al. v. CITY OF TAMPA, FLORIDA

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No. 19-14387

VAZZO, *etc., et al.* v. CITY OF TAMPA, FLORIDA

192-2



Deposition of:
Norman Spack , M.D.

August 1, 2019

In the Matter of:
**Vazzo, Robert L, et al. v. City of
Tampa, Florida**

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No.: 8:17-cv-2896-T-02AAS

ROBERT L. VAZZO, LMFT, etc.,
et al.

Plaintiffs

vs.

CITY OF TAMPA, FLORIDA

Defendant

D E P O S I T I O N

o f

NORMAN SPACK, M.D.

taken on behalf of Plaintiffs

DATE: August 1, 2019

TIME: 11:00 a.m. to 4:13 p.m.

PLACE: Burr & Forman, LLP
201 N. Franklin Street, Suite 3200
Tampa, Florida 33602

BEFORE: Dawn A. Hillier, RMR, CRR, CLR
Notary Public - State of
Florida, at Large

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15 ALSO PRESENT:

Shannon Minter
16 Dr. Bernard Hudson (via telephone)
17
18
19
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21
22
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24
25

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REPORTER'S KEY TO PUNCTUATION:

-- At end of question or answer references
interruption.

... References a trail-off by the speaker.

No testimony omitted.

"Uh-huh" "Um-hum" References affirmative sound.

"Huh-uh" "Um-um" References negative sound.

1 NORMAN SPACK, M.D.

2 was called as a witness and having first been duly
3 sworn, responding "I do," was examined and testified as
4 follows:

5 COURT REPORTER: Thank you.

6 DIRECT EXAMINATION

7 BY MR. GANNAM:

8 Q Good morning, Dr. Spack. My name is Roger
9 Gannam and I'm an attorney for the plaintiffs in the
10 lawsuit against the City of Tampa regarding its ban on
11 conversion therapy as its local ordinance. And we're
12 here to take your deposition today in the capacity as a
13 an expert witness for the City of Tampa. Am I correct
14 so far?

15 A Correct.

16 Q Great. I want to go through a few ground
17 rules and then we'll get into it. Have you had your
18 deposition taken before?

19 A Yes, actually.

20 Q Okay. Some of this may sound familiar, then.
21 But we're going to be taking down everything
22 stenographically today, every word. So it's important
23 that all of your answers be out loud or verbal. Is that
24 okay?

25 A Sure.

1 Q Great. Our normal tendency in conversation is
2 to use, you know, head gestures or hand gestures. But
3 none of that will show up on the transcript and that's
4 why we ask for verbal responses.

5 It's also important for the sake of the
6 transcript that we only speak one at a time. So I will
7 do my best to wait until you're done talking before I
8 ask my next question. And I would just ask that you
9 also wait until I'm done before answering. Is that
10 okay?

11 A Fine.

12 And where is the sound input so I know where
13 to look.

14 Q Well, you have two. The phone, I think, will
15 pick it up and from any direction. And our court
16 reporter, are you using audio today as well?

17 COURT REPORTER: Just me.

18 BY MR. GANNAM:

19 Q Okay. So the best thing to do is just respond
20 to me and if our court reporter has any trouble picking
21 you up, she'll let us know.

22 If I ask any question that you do not
23 understand, just please let me know what's wrong with
24 the question and I'll address it. But if I ask a
25 question and you answer it, I will assume that you both

1 heard me and understood me. Is that okay?

2 A Sure.

3 Q We will try to be respectful of everyone's
4 time and get you out of here in time for your flight.
5 However, this is not an endurance contest. And if you
6 need to take a break, that's certainly appropriate.
7 Just let me know.

8 I would ask that if there is a question
9 pending, that you answer the question before asking for
10 a break. Is that okay?

11 A Fine.

12 Q All right. Currently, are you under any
13 medical condition or disability that would affect your
14 capacity to testify truthfully today?

15 A No.

16 Q Are you currently taking any medication that
17 could affect your capacity to testify today?

18 A No.

19 Q And if this case should go to trial sometime
20 next year, are you aware of any situation or condition
21 that would prevent you from being able to testify at
22 trial?

23 A No.

24 Q Okay. Great.

25 Any questions for me before we go further?

1 A No.

2 Q All right. Please state your name for the
3 record.

4 A Norman Spack.

5 Q And Dr. Spack, your address?

6 A 474 Revere, R-e-v-e-r-e, Beach Boulevard,
7 Apartment 1003, Revere, Mass, 02151.

8 Q All right. Are you currently employed?

9 A No.

10 Q All right. Do you -- are you retired?

11 A Yes.

12 Q Okay. As of when?

13 A Two years ago.

14 Q What was your last employment position?

15 A I was a senior pediatric endocrinologist and
16 founding -- founder and director of the Gender
17 Management Service for the endocrine division at --

18 Q Go ahead.

19 A -- Boston Children's Hospital.

20 Q Okay. And that employment ended about two
21 years ago when you retired?

22 A Yeah.

23 Q And since you retired, have you done any kind
24 of consulting or other work for pay or remuneration of
25 any kind?

1 A Not directly from Children's Hospital. But I
2 voluntarily go in to consult on problematic cases.

3 Q And are you compensated for that?

4 A No.

5 Q All right. So have you done any kind of
6 compensated work since your retirement two years ago?

7 A A fair bit.

8 Q Okay. What kind of work?

9 A It's all visiting professorships at pediatric
10 medical centers.

11 Q Do you currently hold any professorships?

12 A My professorship will never -- it stays with
13 me until I die. So I'm an associate clinical professor
14 of pediatrics at Harvard Medical School.

15 Q Anywhere else? Other institutions?

16 A No.

17 Q What was the last course you taught?

18 A The last course I taught was a major seminar
19 to the second-year Harvard medical students on gender
20 dysphoria in a young adolescent.

21 Q And when was that?

22 A That would have been about March -- they're
23 usually in March -- 2017.

24 Q Was that before or after your retirement?

25 A It was really just about as I was -- the

1 academic year ends on July 30th, so by July 30th that
2 year, I was retired.

3 Q Any other compensated work besides that
4 March 2017 seminar -- or I should say since that
5 March 2017 seminar?

6 A Well, if you consider the visiting
7 professorships.

8 Q Okay.

9 A They're all compensated. And I've probably
10 done about -- since I retired, probably done around
11 five.

12 Q Can you just kind of tell me what that
13 consists of? You said you've done five.

14 A I can tell you a good one from proximity.
15 Last year, I did a two-day professorship right at All
16 Saints (sic) Children's Hospital in St. Petersburg.

17 That would usually -- it always consists of a
18 meeting the night before over dinner with members of the
19 pediatric endocrine department followed by giving a
20 major lecture on the subject of transgenderism in
21 children and adolescents; and following that, a more
22 informal case discussion, cases brought up by the
23 residents and interns that follows the major talk.

24 Q So the five visiting professorships you've
25 engaged in since you retired typically follow that

1 similar pattern?

2 A I would say so.

3 Q Okay. All right. Anything else then besides
4 the visiting professorship, as far as compensated work
5 that you've performed?

6 A No. I would say no because other work that
7 I've done related to the field is co-authoring articles
8 for publication and major journals. And there was one
9 non-compensated work, with probably a fairly big legacy.
10 I was able to win a \$6 million grant from the National
11 Institute of Health for a four-institution collaborative
12 study of -- longitudinal study of transgender youth.
13 And that was a -- it included ourselves, the Children's
14 Hospital in Chicago, the Children's Hospital Los
15 Angeles, and the Children's Hospital at University of
16 California San Francisco.

17 And it was just beginning to take off and
18 enroll patients as I was retiring.

19 And none of us were -- of all the people
20 involved, the only ones who were likely to be partly
21 subsidized in their work were the research psychologists
22 and some of the other number-crunching researchers.

23 Q So would it be fair to summarize your
24 involvement in that project as participating in
25 obtaining the grant, but not doing the work the grant is

1 funding?

2 A That's exactly right.

3 Q And what is the subject -- or more specific
4 subject of that longitudinal study for which that grant
5 was given?

6 A The patients who were enrolled in that study
7 were similar to the patients in age and qualitative
8 issues related to the gender identity as the patients
9 that the Dutch had used ten years before.

10 So the idea was to see if we had comparable
11 results to their -- I should have to say, phenomenal
12 results over the 22 years of age that they have followed
13 their patients.

14 Q And generally speaking, what were the results
15 of the Dutch study that you were trying to analyze or
16 match or compare to?

17 A They studied 55 males and 55 genetic females
18 who were living in the opposite gender. They were
19 subjected to pubertal suppression and cross-gender
20 hormones at approximately age 15, any surgeries were
21 obtained -- that were done by age 18. They had been
22 tested psychologically at the beginning of the study
23 with specific attention to gender identity.

24 They were studied, again, at the midpoint when
25 they were about to get the hormones of the opposite sex.

1 They were studied again before they would be considered
2 eligible for surgery.

3 But the critical thing that was done that was
4 published was they were studied at age 22 to 24, so four
5 to six years after the last formal treatment. Obviously
6 they were continuing on hormonal treatment.

7 The stunning result that they showed -- and
8 Holland is a different place from us. They showed
9 that -- and it was published in The Journal of
10 Pediatrics by de Vries, d-e, capital V, as in Victor,
11 r-i-e-s. De Vries, et al. They showed that at the end
12 of the game, the Dutch patients not only were
13 psychosocially normal but their results were better than
14 a cohort of age-match controlled patients.

15 Q So that's the Dutch study?

16 A Right.

17 Q And did you complete the longitudinal study --
18 or was the longitudinal study for which the six million
19 NIH grant was given completed?

20 A Hardly.

21 Q Okay. Tell me about the process of that
22 study.

23 A Well, it meant that every -- the goal was for
24 every one of the four centers to enroll a hundred
25 patients.

1 Q Okay.

2 A Okay? And to enroll them over the course of a
3 year, maybe take two years to enroll them, and then
4 follow them for -- it would probably be -- they'd start
5 at the very beginning of puberty, and then -- so it
6 would be a six- to eight-year follow-up.

7 When the NIH does this, they do it with the
8 understanding -- and this is a great benefit to the
9 researchers -- that you can keep the patients who fund
10 you to do so.

11 Q So the -- from the inception of the study
12 funded by the NIH grant to its completion, how long a
13 period of time are we talking?

14 A Well, to do -- it could really be -- to get to
15 the same point that the Dutch were at -- remember, they
16 were at two to four years post 18. So they were 20 to
17 22. And our patients, to get to that point, would have
18 to be almost ten years from eight to 12.

19 You understand that a person who is
20 biologically female is more in a pubertal status of
21 starting on average between age ten to 12, whereas natal
22 or genetic males are more likely to be 12 to 14.

23 Q So that particular study that the \$6 million
24 NIH grant went to, we're years away from completing
25 that?

1 A Right. And that amount of money is being
2 divided over four institutions.

3 Q Okay. Very good.

4 All right. So apart from that -- the visiting
5 professorships you identified, your participation on the
6 project that won the \$6 million NIH grant, what other
7 work have you done, even without compensation, since
8 your retirement two years ago?

9 A Since I trained my -- since I trained many of
10 the people around the country who serve as directors of
11 programs like ours, I get a lot of phone calls. And I
12 also get questions based on my experience from my
13 successors at Children's Hospital.

14 Q And have you done any other writing besides
15 the -- for example, the grant application?

16 A Yes. But nowadays, I do it selectively. So I
17 let my -- I let my trainees take the first officership
18 and I take the editing.

19 It suits their careers to be first office.

20 Q Has anything been published that you are
21 author of or co-author of since you retired?

22 A Yes. There was just one review article on the
23 treatment of transgender youth. And that was by Shumer,
24 S-h-u-m-e-r, and I.

25 Q Do you know what publication that appeared in?

1 A I forgot.

2 Q And do you know the year or month and year?

3 A I believe that was published in this year.

4 Q In 2019?

5 A Yeah. Earlier in the year.

6 Q Okay. Do you currently do any work for any
7 non-profit or charitable organizations, either in a
8 formal relationship or in an informal relationship?

9 A Yes.

10 Q Tell me about that.

11 A In a sense, it's actually how I got my start
12 seeing the very first transgender patients that I ever
13 saw.

14 When I was training in adolescent medicines
15 from 1974, and then through my faculty status for at
16 least a decade, I used to -- I used to work for a
17 marvelous organization run by a wonderful nun named --
18 the organization is still thriving. It's called Bridge
19 Over Troubled Waters. And they ran a very elaborate van
20 set up to actually have a full medical treatment room.
21 And we would go travel around the city of Boston, not
22 far from where you were eating because the Boston Common
23 was one place we went.

24 We went to Harvard Square. And we sometimes
25 went to what they call the Combat Zone.

1 But this is a organization that -- the van was
2 a place to look at things medically. But in point of
3 fact, the major function of the van was to be a source
4 of information to the street kids.

5 The organization recognized that if they -- if
6 a kid came off the -- a bus, came off the train, or
7 whatever, and was looking for a place to stay, had no
8 home or whatever, running away from home, we had X
9 number of hours to latch on to that kid and be sure they
10 don't fall in more evil hands.

11 And so I've been on the board of the
12 organization. They run a homeless shelter. They run a
13 program for single mothers. They recognize -- this is
14 interesting -- they recognized that a lot of kids
15 wouldn't go for jobs because they were too embarrassed
16 by their teeth or lack thereof. And they set up an
17 entire dental clinic from Tufts dental school.

18 And they were doing every kind of dentistry.

19 Q Are you still on that board of that
20 organization?

21 A No. I dropped off the board, but I maintain
22 my contacts.

23 Q Do you volunteer for them or still provide any
24 assistance to them?

25 A I provide medical advice to them, on the

1 larger picture.

2 Q And did this organization cater to or
3 specialize in services to children who identified as
4 LGBT or was this open to all kids that it encountered on
5 the street?

6 A It was open to any kid who was on the streets.
7 But I discovered, from talking to the people who do the
8 demographics, that there was an overrepresentation of
9 LGBT kids. And they were, as they told me, not
10 run-aways, but they were throw-aways.

11 Q Meaning?

12 A That they were thrown out of their home
13 because of the sexual orientation.

14 Q Any other organizations that you currently do
15 work -- or that you currently work with besides Bridge
16 Over Troubled Waters?

17 A There's an organization -- actually
18 interesting, it's called Keshet, which is Hebrew for
19 rainbow.

20 Q How do you spell Keshet?

21 A Keshet is K-e-s-h-e-t.

22 Q Oh, Keshet.

23 A And it's interesting that the Jewish
24 federation in Boston has a division devoted specifically
25 for kids who are, in the rainbow sense, LGBT. And I

1 advise them. I do a lot of local speaking gratis for
2 schools and religious organizations.

3 Q Do you do any work either formally or
4 informally for the NCLR or National Center for Lesbian
5 Rights?

6 A No.

7 Q Have you ever?

8 A No. I have done -- in fact, I will soon, in a
9 couple months, do the second major talk for Parents and
10 Friends of Gays and Lesbians, which is a national
11 organization. And I'll be doing a plenary address for
12 them in September in Asheville.

13 Q In Asheville?

14 A Yes.

15 Q And have you spoken for that organization
16 before?

17 A A long time ago.

18 Q Okay.

19 What about, have you ever done any work with
20 or for an organization called Equality Florida?

21 A No.

22 Q What about The Trevor Project?

23 A No.

24 Q And Southern Poverty Law Center?

25 A No.

1 Q Have you ever testified as an expert witness
2 before, either in written testimony or declaration or in
3 a deposition or a trial or hearing?

4 A Yes.

5 Q How many times before?

6 A I think there was -- one particular case comes
7 to mind. An it was not in the realm of LGBT.

8 Q Okay. And when was that case?

9 A I would say that it was probably 1970s. And I
10 remember it vividly.

11 Q Where was it geographically?

12 A It was in Boston at the Boston family court.
13 And it was a case of a care and protection for a
14 12-year-old diabetic young man who family neglect was
15 causing him to be repeatedly admitted.

16 Q And since then, have you done any kind of
17 expert testimony in court?

18 A No.

19 Q All right. I want to talk about your
20 engagement as an expert in this case. How did that come
21 about?

22 A I'm trying to think of who contacted me first.
23 I think -- correct me if I'm wrong, but I think it
24 probably came from this office.

25 Q Well, just testify to the best of your memory.

1 A Yeah.

2 Q Unfortunately, Mr. Williams can't help you
3 answer.

4 A Yeah. I think it was through this office.
5 I'm not necessarily known in these parts. And we don't
6 have a center in these parts.

7 It's possible that I was recommended by the
8 head of endocrinology at All Saints (sic) Children's in
9 St. Petersburg because we happen to be very good friends
10 and he's very senior.

11 Q So at some point in time, you communicated
12 with someone here at this law firm?

13 A Right.

14 Q The Burr Forman law firm?

15 A Right.

16 Q Okay. Who was the first person you spoke with
17 at this firm?

18 A I believe it was Rob Williams.

19 Q Mr. Williams that's sitting next to you there?

20 A Yes. I think, I'm virtually certain.

21 Although it's also possible that Shannon had
22 communicated with me about the situation. Not a
23 specific case. And it's possible that my answer to
24 Shannon was that I would be willing to be involved.

25 Q And by Shannon, you mean Shannon Minter, the

1 attorney for NCLR?

2 A Yes.

3 Q Who's also in the room with us today?

4 A Yes.

5 Q How did you know Shannon before, if you did?

6 A Well, I didn't know Shannon before, but I have
7 subsequently found out that Shannon is very well known
8 to attorneys in Boston -- do you know the organization
9 GLAAD?

10 Q I'm familiar with it.

11 A Yes. So the head of transgender services for
12 GLAAD is somebody I have had a close relationship to and
13 have advised and even -- well, I gave verbal testimony.
14 Not in a court. It was actually in a -- it was actually
15 a joint committee of the main legislature.

16 Q So is it possible that the first person you
17 spoke with about possibly being an expert in this case
18 was Shannon?

19 A I'm not sure it would have been spoken. It
20 would have been an email.

21 Q Okay. So is it possible the first
22 communication regarding your work in this case could
23 have been an email with Shannon?

24 A Right.

25 Q Okay. And when was that?

1 A This is just a ballpark. I would say
2 somewhere around four months ago, maybe.

3 Q And do you still have any email communications
4 that you had with Shannon regarding the engagement?

5 A I believe I do. Not specifically about the
6 engagement but about -- I recall receiving a fascinating
7 email from one of my former trainees. And it had to do
8 with new findings in transgender children, something you
9 should know about. He said, this is hot off the press.
10 And I took Shannon's -- the email came to me and it had
11 a gigantic website. And I forwarded it to Shannon.

12 Q What email address do you use to communicate
13 with Shannon? Or did you use to communicate with
14 Shannon?

15 A I can't remember it. But it was, I believe,
16 the name Shannon was in the email.

17 Q Sorry. Not Shannon. Your email address --

18 A Oh.

19 Q -- that would get to you. Sorry.

20 A Okay. So I have a typical Children's Hospital
21 address. It's Norman.Spack@childrens.Harvard.edu.

22 Q Is that your primary email address?

23 A Yes.

24 Q And even though you retired, would that be a
25 permanent email address that you're allowed to keep?

1 A You're allowed to.

2 Q Do you communicate with any other email
3 accounts?

4 A No.

5 Q Okay. All right. As far as -- you said it
6 was about four months ago when you were engaged. What
7 were you asked to do in this case?

8 A Well, I'm not entirely sure that Shannon was
9 the one to be -- to tell me what was required.

10 Q Okay. Thank you for clarifying that.

11 A It's quite possible that Shannon said they had
12 a case that was a municipal case. And I think that
13 referred me to Rob. And I think it was Rob who gave me
14 a more full picture of what's come out.

15 Q And did Rob communicate that to you in
16 writing, through an email, or some kind of document?

17 A No. I think it was on the telephone.

18 Q Okay. And so going back to that assignment or
19 that request of you, what were you asked to do in
20 connection with this case?

21 A Well, it was looking for -- he was looking for
22 an expert witness in an area that involved treatment of
23 youth, and particularly adolescents. I guess my -- it's
24 possible that my CV is online, but one thing -- there
25 are two things that would make me an appropriate person,

1 and that is -- there are very few people who have --
2 that were boarded in adolescent medicine and
3 endocrinology.

4 Q By "boarded," you mean board certified?

5 A Board certified. Yep.

6 So it seemed that I would be an appropriate
7 person. And on top of that, I had seen about 250
8 adolescents. But early in the game, I volunteered to
9 take care of adults. And I saw about an equal number of
10 adults.

11 Q So understanding, generally speaking, you were
12 asked to be an expert witness. Was there a specific
13 task or specific tasks you were asked to perform in
14 connection with the engagement?

15 A You know, I think it was still somewhat vague.
16 I think it was -- there were some issues -- there were
17 some issues about who should take care of these
18 patients. And I think I was asked for the approximate
19 date in which these things would come together. And
20 that was more important to me than anything.

21 And then it was probable that in a subsequent
22 conversation it was clear that the issues had to do with
23 what we used to call reparative therapy or conversion
24 therapy.

25 Q So understanding that the initial conversation

1 or conversations may have been somewhat general, at some
2 point, did a specific, you know, list of items or
3 requests materialize so that you could, you know, then
4 proceed as the expert?

5 A Well, I think that -- actually, all I had to
6 hear was that it was an issue of reparative or therapy.
7 Anything that related to aversive or reparative therapy,
8 I would be interested in.

9 Q Let me back up a minute. When you testified
10 before the main legislature --

11 A Yeah.

12 Q -- or maybe you said a committee of the
13 legislature. Let me stop there. Was it a committee of
14 the main legislature?

15 A It was a committee of both sides. So it was a
16 joint committee of the Senate and legislature.

17 Q So both houses?

18 A Both houses were represented. But I would say
19 that the total number of sitting in that big horse shoe
20 must have been about 15 people.

21 Q What was the subject matter of your testimony
22 there?

23 A The subject matter of the testimony, it was a
24 question of bathroom use in a 12-year-old genetic male,
25 but an affirmed female, and an identical twin too, who

1 had been always accepted as a female at school, allowed
2 to use the ladies room, et cetera. And things changed
3 when the child who transferred into the school had a
4 grandfather -- told the grandfather the story and the
5 grandfather started spying on the school.

6 Anyhow, they changed -- they gave this girl a
7 monitor to see that she wouldn't use the ladies room;
8 only use the nurse's room. I'll just get to the end, in
9 that the head of GLAAD was testifying. I was, the
10 father was.

11 Ultimately, the girl said we did as good a job
12 as we could have, but we failed. And the only one who
13 could actually win the case would be her.

14 Q So what specifically were you testifying about
15 before this committee?

16 A We were testifying that it was appropriate for
17 her to use the bathroom.

18 Q I see.

19 A And they won the case.

20 Q So let me now -- have you testified before any
21 other legislatures on GLBT (sic) issues?

22 A Only once. And it was before this. There was
23 a bill before the Massachusetts legislature on the
24 rights of GLBT people (sic), and antidiscrimination law,
25 particularly with respect to housing, employment, and a

1 number of other things. It sat in committee for a long
2 time. And then it ultimately passed. I was one of the
3 panel that spoke to a joint committee of house and
4 senate.

5 Q In favor of passage of the law?

6 A In favor of passage, yeah.

7 Q And have you ever testified before any
8 legislative body, either state, municipal, county,
9 regarding a therapy ban similar to Tampa's that we're
10 here about today?

11 A No.

12 Q And earlier, when you said -- you used the
13 term "reparative therapy." Can you tell me what that
14 means to you when you use that word?

15 A To me, it means the same as trying to get the
16 patient to return to living in their birth sex.

17 Q And you also used the word "aversive" a moment
18 ago. What does that mean?

19 A Aversive means where the therapist actually
20 slaps the patient's hand. It actually implies something
21 noxious. Even at some point, these patients, years ago,
22 was subjected to electric convulsive shock. So I would
23 define aversive as a painful and noxious treatment.

24 Q And you, just now when you talk about
25 reparative therapy and aversive treatments, are you

1 speaking specifically in the context of children or
2 persons who identify as transgender or identify as a
3 gender other than their birth sex?

4 A Not really.

5 Q Okay.

6 A I mean, that's my interest.

7 Q Okay.

8 A And I don't claim to have this -- sure, I have
9 experience with gay and lesbian kids.

10 But I also know that these therapies have been
11 applied to the gay and lesbian kids as well.

12 Q Do you considered aversive therapies to be
13 unethical?

14 A Yes.

15 Q In all context or specifically in the context
16 of what you define as reparative therapy?

17 A I can't think of anything that we could call
18 therapy that would be associated with painful -- painful
19 treatment.

20 Q In what states are you licensed as a
21 physician?

22 A Massachusetts.

23 Q Any others?

24 A No.

25 Q And in the state of Massachusetts, is there a

1 board or authority, governmental board or authority that
2 controls your licensure?

3 A Yes.

4 Q What is that board?

5 A Massachusetts board of medicine.

6 Q Do you know the makeup of that board in terms
7 of the credentials or qualifications of the board
8 members?

9 A To be on the board? I don't. But I'm pretty
10 certain that some members of the board are not
11 themselves physicians.

12 Q Is it your understanding that some or most of
13 the members would be physicians?

14 A I would think so.

15 Q Does that same board hear any complaints about
16 you or any other physician in the state of Massachusetts
17 for unethical practices?

18 A Yeah. That's -- it's my understanding that
19 they are the first to receive such complaints.

20 Q And would it be your understanding that if a
21 complaint was made to that board about an aversive
22 treatment by a patient, that they would investigate that
23 and take that seriously?

24 A They would, especially because -- and I just
25 found this out. I would have -- that Massachusetts

1 would have been on the forefront of this. But I just
2 found out that prior to this year, in New England, all
3 the states except Massachusetts and Maine had ordinances
4 against reparative therapy or aversive therapy. But
5 this year, both Maine and Massachusetts have joined the
6 other four.

7 Q Okay. Prior to Massachusetts enacting some
8 kind of statewide ban against reparative therapy, would
9 it have been possible to submit a complaint to the
10 Massachusetts board of medicine regarding unethical
11 practices by a physician?

12 A I would imagine so, and then they would have
13 had to run a case-any-case basis to decide.

14 Q Getting back to your engagement in this case,
15 at some point were you given a specific list of tasks or
16 instructions for what was needed from you as an expert
17 witness?

18 A Yes. I have a notebook that's the size of
19 Robert Mueller's that contains numerous other people's
20 depositions and other comments.

21 Q Was all that material provided to you?

22 A Yes.

23 Q By Mr. Williams' firm?

24 A Yes.

25 Q Okay. Does it include a specific list of

1 things for you to complete or services to provide?

2 A No. The only thing -- and it was quite
3 helpful because I had brought down from Boston, a huge
4 amount was directing what areas I would likely need to
5 focus on.

6 Q And that directive, was that regarding
7 specifically your deposition today or the assignment in
8 general?

9 A No. I think my deposition today.

10 Q I see.

11 A And, yeah.

12 Q Now, so far in this case, you have provided a
13 declaration. Do you recall that?

14 A Correct.

15 Q And you're testifying here today. Are there
16 other tasks yet to be completed in connection with your
17 engagement?

18 A I don't think so.

19 Q So --

20 A There's one area that I think you should
21 know --

22 Q Okay. What's that?

23 A -- because I think it will help you. And that
24 is the issue of other physicians who have been
25 associated with, you might call reparative therapy.

1 Are you aware of other physicians in Canada?

2 Q What do you want me to know about physicians
3 in Canada?

4 A Probably the most famous physician who has
5 been responsible for recommending a kind of coercive
6 therapy, i.e., telling parents to -- that if -- to limit
7 the child's toys and clothes, et cetera, to one room in
8 the house and not permit the child to take any of those
9 things outside the house. In a way, I call this a kind
10 of coercive therapy.

11 And he's been head of the -- of the program at
12 the hospital of sick children -- adjacent to the
13 hospital of sick children in Toronto. And he has -- I
14 just blocked on his name. I just blocked on his name.

15 Q You might remember it on a break or something
16 later. That's fine. Just...

17 MR. WILLIAMS: I can't help you,
18 unfortunately, under the rules, so...

19 THE WITNESS: It's blocked.

20 I've known him for 30 years. There are some
21 things he's done that have been commendable with
22 treating adolescents. But in treating children,
23 I've had several patients go to see him and come
24 back very depressed, very -- the child more dug in
25 than ever.

1 BY MR. GANNAM:

2 Q What condition are we talking about?

3 A We're talking about gender dysphoria --

4 Q Okay.

5 A -- in a child who is prepubertal, perhaps
6 11 -- ten- or 11-year-old genetic male, affirming a
7 female identity and having two other -- two brothers who
8 initially were trying to do everything possible to get
9 this child to act in a masculine way like they.

10 But they came -- the family came back from --
11 Ken Zucker is his name. And the brothers went to the
12 parents and saw -- they said, he's totally depressed,
13 he's lying on the couch, he won't do anything. And the
14 parents were about to do what Zucker had recommended
15 which was to give the child a birthday present, a
16 boy-type toy. And the brothers suddenly changed their
17 mind. They said, You can't do this, you've got to give
18 her a girl thing. She'll just dissolve.

19 And then they went forward and treated her
20 like a girl, dressed as a girl. Her progress has been
21 phenomenal. And what happened was Zucker -- I think
22 what actually happened was there are so many parent
23 groups now of kids who have gender issues. They talk to
24 each other. And I believe it was the parents that
25 initially caused a review of his practices. And he

1 actually lost his position.

2 Q Did you participate in any formal review of
3 Dr. Zucker's practices?

4 A No.

5 Q Do you know why he lost his position, apart
6 from what you've heard from others?

7 A I have. It's interesting because I have a
8 bill of particulars of what they -- what the reviewing
9 committee in all of Canada had. And it seemed that it
10 doesn't come to the conclusion of what should be done
11 with him, but it does indicate in what ways he needs to
12 improve the main standards.

13 And it appeared that one of the most
14 problematic area was that he seemed to be operating in a
15 vacuum, that he didn't bring in enough other specialists
16 like social workers and et cetera. And it was quite
17 secretive what he was doing.

18 Now, it's important I tell you this because
19 I've been present at meetings where he speaks. And
20 it's -- there's no -- he doesn't put any criticism or
21 typical debate.

22 And he is often -- if the you read the DSM5,
23 that Diagnosis and statistical manual of psychiatric
24 diseases, or the APA, American Psychological Association
25 standard of care, or the WPATH, the world professional

1 association of transgender care, it's very likely that
2 what has been written as a standard of care of
3 transgender youth was written by him. And so you better
4 be sure you're reading the most up-to-date thing because
5 a lot of the things that he wrote have been erased. And
6 then nobody had the courage to say, we can't have his --
7 because he was basically codifying his approach.

8 Little kids don't necessarily know who they
9 are, so let's not allow them to live in a way they want
10 to. The worst case scenario that maybe they'll turn out
11 gay and that's better than turning out trans.

12 That's how he would speak.

13 Q Did the City of Tampa rely on any of
14 Dr. Zucker's work in connection with passing its
15 ordinance?

16 A I think not.

17 Q Do you know?

18 A I don't know.

19 Q Getting back to your engagement in this case,
20 let's start with your declaration, though. What were
21 you asked to address in your declaration?

22 A I was asked to address my opinion about a
23 therapy that convinces -- attempts to convince children
24 and adolescents to remain in or return to the sex and
25 behavior of the sex at birth.

1 Q And so apart from offering an opinion about
2 that, what else or other specific items were you asked
3 to address in your declaration?

4 A I don't actually recall that I had -- that
5 there was another task.

6 Q And is --

7 A And, in fact, I don't think there was any
8 mention in that for gay and lesbian youth.

9 Q Do you mean that your opinions are limited to
10 children who identify as transgender or gender --

11 A Correct.

12 Q And a note about terminology. I see
13 transgender and the abbreviation TGNC for transgender,
14 gender nonconforming.

15 If I say TGNC, will you understand what I'm
16 talking about?

17 A No.

18 Q So that's not an abbreviation you use?

19 A You know, all of these things can -- everybody
20 has -- I'll give you an example. You might find some
21 literature, even the literature that I helped write the
22 standard of care from the endocrine society says
23 standard of care for treatment of transsexual. Now, I
24 wouldn't write "transsexual" because that's the European
25 term, the broad-brush term for people who feel they're

1 in the wrong body.

2 I remember when transgender meant you felt you
3 were in the wrong body. But you didn't qualify as
4 transsexual unless you had surgery. So I find
5 transgender to be sufficiently inclusive.

6 Q And will you just define what you mean by the
7 word "transgender," then so, that we communicate clearly
8 the rest of the day?

9 A Somebody who believes that their physical body
10 does not conform to this sense of self.

11 Q And under that definition you just gave me, is
12 that an absolute? Or are there degrees of those
13 feelings of not -- of physical body not being congruent
14 with how the person identifies themselves?

15 A That's a good question.

16 MR. MIHET: They're all good questions.

17 MR. GANNAM: Stipulate.

18 THE WITNESS: The point is, by the time they
19 get to me, I tend to see only those who are pretty
20 hardened in their feelings. But I'm not with them
21 all the way.

22 Now, the one group that is not all the way who
23 I have seen, the very frustrating group, that's the
24 group that calls themselves gender queer, and I
25 call them gender fluid.

1 But either way, they don't want to see me.

2 It's the parents that want them to see me because
3 there is no medicinal treatment for them unless
4 they decide one way or the other.

5 BY MR. GANNAM:

6 Q So can you tell me or maybe give me a
7 definition of the condition of a person who identifies
8 as gender queer or what you call gender fluid?

9 A It's a person who doesn't commit to being
10 either male or female. But that may take different --
11 manifest, for example, it could be someone who just sees
12 themselves somewhere in the spectrum and it changes from
13 day-to-day, and someone who sees themselves very much
14 male one day and very much female the next.

15 Q Now, is gender queer or gender fluid itself a
16 gender identity?

17 A It is, but it is as a term.

18 Q What does that mean?

19 A Well, because it gives you -- if you
20 describe -- otherwise you'd have a great difficulty
21 describing this person.

22 But if I say to you, this kid is gender fluid,
23 then you wouldn't have expectations of is the kid going
24 to strike you as a male or female.

25 Q So suppose we were to categorize the different

1 gender identities that at least are recognized in
2 medicine in your field, would it be accurate to say
3 there is male, there is female, and an in-between gender
4 fluid captures everything in between or does it only
5 capture some in between?

6 A No. If it's ill defined and especially
7 moving, a moving target, I would call it a form of
8 gender identity.

9 Q Okay.

10 A The thing I don't know, and I wouldn't be able
11 to tell you -- I don't know if I'll live long enough to
12 find out -- is how do these people end up? Are they on
13 a path towards one or the other or not?

14 Q Now, you said earlier that when a minor would
15 identify as gender fluid or gender queer presents to
16 you, there's not a medical treatment for them. Can you
17 just explain what you mean by that?

18 A Well, if they were certain they were to affirm
19 a male identity, then they would need to be testosterone
20 treated, unless they're making it by themselves.

21 If they affirm a female identity, they would
22 need to be estrogen treated, unless they already are
23 making estrogen themselves.

24 So many of the gender fluid kids take no
25 medications.

1 Q Thank you.

2 Now, getting back to your declaration that you
3 prepared in this case, just so I'm clear, was there ever
4 a document or set of instructions provided to you by
5 Mr. Williams' firm that said, for example, make sure you
6 address these five points or this one point in your
7 declaration?

8 A I think the -- I think that is the case.

9 Q Okay.

10 A Because I really didn't know what was going to
11 transpire here.

12 Q And was that an email or some other kind of
13 document?

14 A It may have been an email. I think it
15 probably -- I mean, it would be too complicated for them
16 to telephone it.

17 Q Certainly you needed something to tell you
18 what --

19 A A template.

20 Q -- you were writing; correct?

21 A Right.

22 Q And as you sit here, do you believe that your
23 declaration addressed what you were asked to write
24 about?

25 A Yes.

1 Q Was there anything you were asked to write
2 about that you declined to write about for one reason or
3 another?

4 A No. But in fact, my first draft was really
5 far too wordy. And what it really was was a kind of
6 autobiography of my life and the terms...

7 Q Is that the word Rob used, "too wordy"? I'm
8 kidding.

9 Did anyone review earlier drafts of your
10 declaration besides this law firm?

11 A No.

12 Q Did you provide earlier drafts of your
13 declaration to anyone outside of this law firm?

14 A No.

15 Q Did you receive input regarding what should be
16 in your declaration from anyone besides this law firm?

17 A No.

18 MR. WILLIAMS: Off the record.

19 (Off the stenographic record.)

20 BY MR. GANNAM:

21 Q So, back to your engagement here. Apart from
22 preparing the declaration and testifying here today, has
23 your engagement involved any other work on your part?

24 A Only reading Tommy Hart's --

25 Q Let me ask you this, what did you do to

1 prepare for today specifically? In other words, your
2 declaration was written and submitted. At some point,
3 did you start preparing for your testimony today?

4 A Okay. I'll make this brief. And this was
5 just yesterday, so this was a last-minute. I read the
6 ordinance.

7 Q The Tampa ordinance?

8 A Yes.

9 Q Okay.

10 A I read my declaration. I read -- I read
11 Dr. Hudson's narrative. And I read -- because I thought
12 it was very well written, Dr. -- is it Glassman?

13 Q Glassgold, maybe?

14 MR. WILLIAMS: Glassgold.

15 THE WITNESS: Glassgold.

16 BY MR. GANNAM:

17 Q Anything else that you read?

18 A No.

19 Q And you said that this was yesterday that this
20 occurred?

21 A Yep.

22 Q And did you meet with anyone to prepare for
23 your testimony today?

24 A Yes. You gave us some extra time. But
25 really, yesterday, we spent time. But that was not so

1 much a personal review. It was more related to the
2 ordinance. And I think that was really it. That is --
3 yeah.

4 Q Who did you meet with yesterday?

5 A It's also possible that yesterday we read
6 the -- Kenneth Zucker, the -- the Kenneth Zucker review,
7 critical review.

8 Q And who did you meet with yesterday?

9 A With Rob, Shannon.

10 Q Anyone else?

11 A I don't think so.

12 Q How long did you meet for?

13 A I would say maybe three or four hours. After
14 we went through the golf stories.

15 Q Did you have any other in-person meetings
16 besides that meeting yesterday to prepare for your
17 deposition today?

18 A No.

19 Q Okay. So we covered documents you reviewed
20 and who you met with. All right.

21 Are you being compensated for your engagement
22 as an expert witness in this case?

23 A I hope so.

24 Q What is your understanding of the arrangement?

25 A I understand that my expenses will be covered

1 coming down here, hotel, and that I would be compensated
2 at what has been referred to as a municipal rate.

3 Q That makes me think lower than what you'd get
4 anywhere else. Does that sound about right?

5 A It is.

6 Q So you testified -- compensated for time spent
7 doing what, exactly?

8 A Preparation, attendance at meeting -- the
9 meeting unrelated to this one, and this deposition
10 meeting.

11 Q And what is the rate that you're being
12 compensated at? Do you know what that is?

13 A I think I know what it is. The non -- the
14 deposition rate I believe is \$250 an hour. And the
15 non-deposition work is half that.

16 Q Are you offered any enhancement or additional
17 compensation based on the outcome of the case?

18 A No.

19 Q And to your understanding, who is paying your
20 compensation?

21 A I assume this law firm is.

22 Q Do you have any written agreement to that
23 effect?

24 A No.

25 Q All right. Let's do this. Should we take

1 a -- let me just get something on the record first, make
2 the best use of our time here. I'm handing you a
3 document that I'm marking as Exhibit 36, which for the
4 record is just a continuation of the numbering of
5 plaintiffs' exhibits.

6 (Exhibit 36 was marked.)

7 BY MR. GANNAM:

8 Q Doctor, what I've handed you is titled
9 "Declaration of Norman Spack, MD," with a case style at
10 the top reading United States District Court for the
11 Middle District of Florida, Tampa Division, Robert L.
12 Vazzo, LMFT, versus City of Tampa, Case No.
13 8:17-cv-02896, et cetera. Do you recognize this
14 document?

15 A Yes.

16 Q Is this the declaration that you prepared for
17 the City of Tampa as an expert witness in this case?

18 A Yes.

19 Q You had an opportunity to review this
20 yesterday; correct?

21 A Yes.

22 Q Is there -- is everything in this declaration
23 still accurate and truthful as we sit here today?

24 A There's one slight error.

25 Q Okay. Please point that out.

1 A On my part. Number nine, I've treated more
2 than 250 transgender children, not 140.

3 Q You're talking about number nine on Roman
4 numeral one on page two?

5 A Yes. The very last line.

6 Q Okay. And that number that reads now says,
7 "I've treated more than 140 transgender children and
8 adolescents." What should the number be?

9 A 250.

10 Q Okay. Do you know why you said 140 before?

11 A I don't know. I was -- I think my mind had
12 wandered to how many people the study had enrolled.

13 Q Other than that change, are there any other
14 changes necessary to make the entire declaration
15 accurate?

16 A Okay.

17 Q Is that --

18 A My CV.

19 Q I'm not sure if my question and your answer
20 matched up. So let me ask, just for the record. Are
21 there any other changes that need to be made to the
22 declaration to make it entirely accurate?

23 A I think not.

24 Q Did anyone assist you in writing the
25 declaration, besides any assistance this law firm may

1 have provided in formatting and things like that?

2 A No.

3 Q So is it fair to say all the content of the
4 written part came from you?

5 A Yes.

6 Q About how much time would you say it took you
7 to write the declaration?

8 A Well, I talked with them after initial. So
9 there was an initial, and then...

10 I would say that total together, I would say
11 it would probably have been about three hours.

12 Q Have you done any additional research or
13 writing in connection with this expert engagement since
14 you submitted this declaration?

15 A No.

16 Q Do you intend to give any opinions in this
17 case that are not reflected in this declaration?

18 A No.

19 MR. MIHET: Good.

20 Just kidding.

21 BY MR. GANNAM:

22 Q And I didn't -- it's probably just a
23 formality, but will you turn to page four of the
24 declaration? The signature appears as Norman Spack. Is
25 that your signature?

1 A No. I can't write that well.

2 Q Is that an electronic signature made on your
3 behalf or that you effected yourself?

4 A No. I believe it's electronic, and it was
5 with my approval.

6 Q Okay. Very good.

7 All right. Why don't we take a break now,
8 maybe just a five-minute comfort break, and try to --
9 are you okay with taking a little bit later lunch today,
10 just so we can cover some --

11 MR. WILLIAMS: I'm okay, as long as Dr. Spack
12 is.

13 THE WITNESS: I'm okay.

14 MR. GANNAM: All right. We'll make this very
15 quick, if that's all right with you. And then
16 we'll come back and get some more testimony.

17 (A brief recess is had from 12:17 p.m. to
18 12:44 p.m.)

19 BY MR. GANNAM:

20 Q Dr. Spack, will you take a look again at your
21 declaration that we marked as Exhibit 36. And on the
22 first page, I just want to look at numbered paragraph
23 two. You see that?

24 A Yep.

25 Q And first sentence says [as read]: I have

1 read the ordinance number 2017-47, an ordinance of the
2 City of Tampa, Florida, relating to conversion therapy
3 on patients who are minors.

4 Did I read that correctly?

5 A Yep.

6 Q And is that the ordinance that we've discussed
7 up to now in today's deposition?

8 A Yes.

9 Q And you go on to say, the next sentence -- I'm
10 sorry. The continuation of the same sentence. You read
11 [as read]: And in my opinion, the ordinance is based
12 upon the evidence-based medical consensus regarding
13 appropriate treatment of transgender and
14 gender-nonconforming youth and the ordinance is
15 necessary to effectuate the City of Tampa's interest in
16 protecting vulnerable minors from the serious harms
17 caused by conversion therapy.

18 Did I read that correctly?

19 A Yep.

20 Q So just want to be clear for the record. Your
21 opinion is offered only in connection with transgender
22 and gender-nonconforming youth and excludes
23 considerations specifically relating to gay and lesbian
24 and bisexual youth. Would that be fair to say?

25 A That was my understanding.

1 Q Okay. Very good.

2 And when you use the term "conversion therapy"
3 in that sentence, what does that mean?

4 A Some people would call it -- I'm trying to
5 think -- different names for this. But in any case,
6 conversion therapy is a therapeutic approach to try to
7 induce and encourage patients who are minors, in this
8 case, to maintain or revert to their biologic sex, or
9 probably better to say a gender identity consistent with
10 the biologic sex.

11 Q And in that sense, would that -- is that the
12 same definition, essentially, that you gave me earlier
13 for the term "reparative therapy"?

14 A Yes.

15 Q Okay. Now, in the middle of that sentence,
16 appears the term "evidence-based medical consensus."
17 Can you explain what that term means?

18 A Yes. That there are medical writings that --
19 I'm trying to see how it's written. Yeah. There are
20 medical writings that state that the care of transgender
21 and gender-nonconforming youth is best accomplished in
22 methods consistent with the ordinance.

23 Q Now, you've had an opportunity to read the
24 ordinance; correct?

25 A Yeah.

1 Q And is it your belief that what the ordinance
2 prohibits is what you defined earlier as conversion
3 therapy?

4 A I believe so.

5 Q And do you have any understanding or belief as
6 to whether the ordinance prohibits more than what you
7 identified as conversion therapy?

8 A It's possible that the ordinance deals with
9 gay and lesbian youth. But it wasn't my purview.

10 Q Okay. Fair enough.

11 So specifically as it relates to transgender
12 and gender-nonconforming youth, do you have any belief
13 or understanding as to whether the ordinance prohibits
14 something in addition to or beyond what you earlier
15 defined as conversion therapy?

16 A I don't think so.

17 Q So this sentence where you said "the ordinance
18 is based upon the evidence-based medical consensus
19 regarding appropriate treatment of transgender and
20 gender-nonconforming youth," that is to the extent the
21 ordinance prohibits what you identified as conversion
22 therapy. Would that be fair to say?

23 A That's fair.

24 Q Now, did you cite to any of the medical
25 writings that you said this evidence-based medical

1 consensus is based on, in this declaration?

2 A I believe there are a couple of -- it's hard
3 for me to remember which is in what reference. But if
4 you look on page two, there are a number of references
5 in which I was a co-author.

6 Q All right. Are you referring to the footnote
7 denoted by the asterisk on page two?

8 A Yeah. Right.

9 Q Okay. And do all of the documents referenced
10 there have in common that you are an author or at least
11 co-author of the document?

12 A I see that I am.

13 Q Now, if I refer you to the numbered paragraph
14 five on page two where the asterisk appears about
15 halfway through the paragraph, following the sentence
16 [as read]: I have published peer-reviewed articles on
17 the treatment of transgender people with a particular
18 emphasis on gender identity and youth.

19 Do you see that?

20 A Yep.

21 Q So does this footnote asterisk specifically
22 relate to that sentence?

23 A They do.

24 Q Okay. Do these articles or documents
25 identified in that footnote, are those intended to be

1 support for your statement in paragraph two that there
2 is an evidence-based medical consensus regarding
3 appropriate treatment of transgender and
4 gender-nonconforming youth?

5 A Not all of these references.

6 Q Okay.

7 A But I believe that there is -- in at least
8 one, there is reference because when we write, we often
9 not only write about how to, but how not to.

10 Q When you say "when we write," what are you
11 referring to?

12 A When any of my colleagues -- these are all
13 people who are members of the Gender Management Service.
14 And it's interesting that especially around the time
15 that these were written, I just recall conversations
16 about, don't you think we should put something in about
17 what not to do. And to some extent, that was a dart
18 pointed at Dr. Zucker.

19 Q So of the references identified in footnote
20 asterisk, which of them would you offer as support for
21 the statement in paragraph two that the Tampa ordinance
22 is based upon evidence-based medical consensus regarding
23 appropriate treatment of transgender and
24 gender-nonconforming youth?

25 A You know -- all right. I'll give you an

1 example. The first one by Tishelman could well have it.

2 The second, by me, Clinical Crossroads.

3 Laura Edwards-Leeper and myself could have.

4 Q Now, when you say "could," does that mean they
5 do support it or they might?

6 A No. I can't -- I can't recall which ones
7 because it would likely be a sentence or something that,
8 in fact, any of them could.

9 Q So, as you sit here right now, can you
10 identify one of them that does?

11 A I can't be sure. They're several years old.
12 But if anything, that makes it more likely to be
13 included because this is when the gender clinic was --
14 this is reflecting our treatment in the gender clinic.
15 And we were very likely to put something in that
16 reflects -- reflects our feeling about reparative or
17 conversion therapy.

18 Q So as I understand you, you're saying it might
19 or may even likely these articles may include -- strike
20 that question.

21 If I understand you correctly, you're saying
22 these references in the footnote asterisk may address
23 conversion and reparative therapy, but as you sit here
24 right now, you're not sure?

25 A I'm not -- I'm pretty sure they include it.

1 I'm not sure which one.

2 Q And when you say -- do you have that same
3 level of confidence specifically regarding the statement
4 in paragraph two that the ordinance is based upon
5 evidence-based medical consensus regarding appropriate
6 treatment of transgender and gender-nonconforming youth?

7 A I'm sorry. Can you repeat that?

8 MR. GANNAM: Can you read back my question?

9 (The Court Reporter is directed to read back
10 the previous question and/or answer.)

11 THE WITNESS: Yes.

12 BY MR. GANNAM:

13 Q Is there a reason why you didn't include a
14 citation to authorities in paragraph two?

15 A I'm not sure that this -- I'm not sure that
16 it's fair to say that it doesn't include it. It doesn't
17 include that any particular case. But it takes into
18 account our opinion based on evidence-based consensus,
19 which means the articles would have some citation.

20 Q Let me ask you this, do you agree with me that
21 paragraph two on the first page of your declaration
22 itself does not cite to a medical authority either in
23 the text or by footnote or some other reference?

24 A All right. I'm just...

25 MR. WILLIAMS: You're referring to paragraph

1 two on page one of his declaration?

2 MR. GANNAM: Right.

3 THE WITNESS: Well, I thought it would be -- I
4 think this is pretty straightforward. It's one
5 thing for me to say I have read. It's another
6 thing to say I have published. And so the -- it
7 makes a stronger statement when you asterisk
8 something that leads to citations, all of which
9 include my name. Number two doesn't -- would not
10 be considered a medical citation.

11 BY MR. GANNAM:

12 Q Okay. So I think you answered perhaps why
13 paragraph two doesn't include a reference. My question
14 was actually that, do you agree with me that paragraph
15 two does not contain a reference to other medical
16 writings to support any of the propositions in that
17 paragraph?

18 A Right. That is correct. However, when I did
19 not write anything in paragraph two, I knew that there
20 would be references coming in paragraph five.

21 And, in fact, in most medical journals, the
22 references don't even come to the very end of the
23 article. I thought this would be more relevant to have
24 the references close on the same page as a relevant
25 point.

1 Q And just so I'm clear. This declaration does
2 not include any kind of end notes or list of references
3 or bibliography or anything like that; correct?

4 A Right. Because otherwise, you wouldn't have
5 footnotes.

6 Q Okay. So apart from this footnote asterisk
7 that appears on page two referencing a sentence in
8 paragraph five, are there any other lists of references
9 provided in your declaration?

10 A No.

11 Q Numbered paragraph six on page two refers to a
12 clinical practice guideline attached as Exhibit B.

13 Do you see that?

14 A Yes. Okay. There were three things, yeah.

15 Q And if I flip to Exhibit B of your
16 declaration, which is approximately the last third,
17 maybe, of the packet that's in front of you, do I see
18 that guideline that you reference in paragraph six?

19 A Exhibit B?

20 MR. WILLIAMS: This one right here. Let me
21 find it for you real quick.

22 BY MR. GANNAM:

23 Q Yeah. Rob can help you find it real quick.
24 That's not a problem.

25 MR. WILLIAMS: Parenthetically, off the

1 record.

2 (Off the stenographic record.)

3 BY MR. GANNAM:

4 Q All right.

5 A Yes.

6 Q So in Exhibit B, we see that [as read]:

7 Endocrine treatment of transsexual persons, an

8 independent society clinical practice guideline.

9 Did I read that correctly?

10 A Yes.

11 Q And tell me your involvement in preparing this
12 document in Exhibit B.

13 A As a member of the task force, I helped draft
14 and review drafts. We had two full days of meeting in
15 New York. And then the drafts were formulated. We sent
16 our suggestions in. You may not have seen an
17 evidence-based -- if you notice the -- first of all, if
18 you notice where the people came from, this was
19 international.

20 Also, take a look at the circles next to many
21 of the statements. It's interesting because it shows
22 how much we need to know.

23 Q Can you give me a page reference where I can
24 see exactly where you're talking about?

25 A I think a good page for it is 3133. And look

1 down at 4.0.

2 Q All right.

3 A So there are up to -- up to four circles and
4 have a cross inside. And the degree to which -- the
5 degree to which the statement is borne -- meets the
6 title of -- meets the status of evidence basis. Those
7 get the highest number.

8 And there was a person who -- certainly if
9 there's a -- two of them are crossed, and absolutely if
10 there are three or four, that's strong evidence basis.

11 When you see, for example, under 2.0, we
12 suggest deferring surgery until the individual is at
13 least 18 years old. And that was only given one. And
14 that's because we really aren't sure of what we should
15 recommend.

16 Q Let me ask you, before getting into some of
17 those details. You said that you participated in
18 drafting these guidelines; correct?

19 A Right.

20 Q And you participated in the process of
21 reviewing earlier drafts before this final guideline
22 came out?

23 A Yes.

24 Q And as the -- as this guideline exists, or
25 existed when it was published in its final form, were

1 you in agreement with everything in it?

2 A Yes.

3 Q And okay. And did you have an opportunity
4 during the drafting process to address any points that
5 you may not have agreed with or enter influence what was
6 in the final version?

7 A Yes. That's a good question. There was --
8 God, it's been a while.

9 MR. WILLIAMS: Finally, you stumbled into a
10 good question, Roger.

11 THE WITNESS: No. There was -- oh. I
12 disagreed with them and I held back. In 2.0, down
13 to 2.4, it says [as read]: We suggest that
14 pubertal development of the desired opposite sex be
15 initiated at about age 16.

16 I won by having the term "at about age 16," in
17 part because I thought age 15 is often very
18 appropriate.

19 So that's my great contribution, is to get "at
20 about age 16". There may be another something like
21 that.

22 BY MR. GANNAM:

23 Q All right. I can appreciate the distinction.

24 All right. So now let me ask you to look at
25 page 3135. And there's a section on the right column

1 that reads [as read]: Method of development of
2 evidence-based clinical practice guidelines.

3 Do you see that?

4 A 3135?

5 Q Yes.

6 A Yeah, okay.

7 Q And then about halfway down that column, maybe
8 a little farther, there's a sentence that begins "in
9 terms of the strength."

10 Do you see that?

11 A Yep.

12 Q All right. I'm going to read a portion for
13 the record. [as read]: In terms of the strength of the
14 recommendation, strong recommendations use the phrase
15 "we recommend," and the number one, and weak
16 recommendations use the phrase "we suggest," and the
17 number two. Cross-filled circles indicate the quality
18 of the evidence such that one cross denotes a very low
19 quality evidence, and that's a graphical one cross. Two
20 crosses denotes low quality. Three crosses denotes
21 moderate quality. And four crosses denotes high
22 quality.

23 Have I read that correctly so far?

24 A Yep.

25 Q And then it continues [as read]: The task

1 force has confidence that persons who receive care
2 according to the strong recommendations will derive, on
3 average, more good than harm.

4 Did I read that correctly?

5 A Yep.

6 Q So does that sort of summarize what you
7 explained earlier about the significance of the cross
8 symbols and --

9 A Yes.

10 Q -- strength of the recommendations?

11 A Yes.

12 Q So for example now, turning back to on page
13 3133, for example, item 2.1.

14 Do you see that?

15 A Yep.

16 Q It says [as read]: We recommend that
17 adolescents who fulfill eligibility and readiness
18 criteria for gender reassignment initially undergo
19 treatment to suppress pubertal development.

20 Did I read that correctly?

21 A Um-hum.

22 Q And it's assigned a one for strength of
23 recommendation, and one cross for quality of evidence;
24 correct?

25 A Right.

1 Q And so to interpret that, I would say that 2.1
2 has a strong recommendation based on very low quality
3 evidence; correct?

4 A Right. And that's because no one had
5 carried -- carried it through yet. You've got to look
6 at the date of this.

7 Q And based on how that strong recommendation I
8 just read on 3135, that that means the task force had
9 confidence that persons who received care according to
10 that recommendation will derive, on average, more good
11 than harm; correct?

12 A Yep.

13 Q Now, that also means that there's a
14 possibility of some subset of the people who received
15 treatment, according to that recommendation, were
16 experiencing some degree of harm; correct?

17 A It's hard for me to imagine -- are you talking
18 about harm during the course of treatment?

19 Q Well, I'm referring to whatever the
20 explanation is on page 3135 that I read earlier where it
21 says [as read]: The task force has confidence that
22 persons who receive care, according to the strong
23 recommendations, will derive, on average, more good than
24 harm.

25 A Right.

1 Q So what does "harm" mean in that sentence?

2 A I can give you one possible potential harm --

3 Q Okay.

4 A -- that we just didn't know the answer to, but
5 were concerned about.

6 Q Okay.

7 A We were concerned about the fact that if
8 you -- since most significant amount of your bone
9 density is acquired in puberty, that to shut puberty
10 down altogether might slow down bone density. And the
11 potential harm would come later with perhaps more
12 reasonably fractured or end up with meeting a fall
13 causing a hip -- breaking a hip, et cetera.

14 Q So at the time these guidelines came out in
15 2009, is it accurate to say that the -- there was a
16 perceived risk of harm of --

17 MR. WILLIAMS: Lunch is here.

18 BY MR. GANNAM:

19 Q -- the bone and density not developing because
20 you --

21 A We stopped puberty.

22 Q -- you stopped puberty.

23 Would it also be fair to say you couldn't
24 measure with a percentage, for example, how much more
25 likely that was to happen as a result of stopping

1 puberty?

2 A No. And one of the reasons for that is that
3 there was no way to be -- no one's ever done this
4 before. So the issue was if they did have a slowing of
5 bone density, would they show catch-up as soon as they
6 started on estrogen?

7 Q And so when I asked, were you able to assign a
8 percentage of the greater or increased likelihood of
9 this bone density not developing as a result of the
10 treatment, is your answer that, yes, you were able to
11 quantify that, or no, you were not able to quantify
12 that?

13 A We were able to -- there is a method of
14 testing bone mineral density through a DEXA scanner.
15 And that was done all the time through this.

16 Q I'm not sure that's the question I asked. So
17 there is a method to test bone density?

18 A Yes.

19 Q And that has assigned some numerical value?

20 A Yes.

21 Q Okay. My question is, At the commencement of
22 treatment, according to recommendation 2.1, were you
23 able to quantify the increased risk that the bone
24 density would be hindered or stopped as a result of the
25 treatment?

1 A We couldn't -- we couldn't predict.

2 Q Okay.

3 A We couldn't predict.

4 And I should say, it also fit into the
5 question of when to start. Because if you started,
6 let's take a girl, a genetic female, if you started her
7 a little later on pubertal suppression, you might have
8 achieved a higher bone density at the time you start.
9 But there are other contravening issues with starting a
10 girl late because the average girl we see is -- we want
11 to see them at ten to 12, and they're coming in at 14,
12 which means how much can you -- how much womanhood can
13 you take away from them when they're already women.

14 Q So there's a balancing of considerations when
15 you are setting out to stop or cease pubertal
16 development through --

17 A Right.

18 Q -- a medical intervention; correct?

19 A Yes. And I'll tell you one other thing.

20 One of the reasons we felt comfortable for
21 using -- and the Dutch felt comfortable of using this
22 pubertal suppression is because there is a -- we all in
23 endocrinology have dealt with usually girls, and usually
24 without tumors who are in this situation of precocious
25 puberty. That is puberty that starts at three, four,

1 five -- I mean, the whole nine yards. And it used to be
2 an absolute mess because those girls end up looking
3 five, seven years older than they are. And they
4 menstruate at kindergarten. And because their growth
5 plates close early, they end up very short.

6 Now, the drug we use for pubertal suppression
7 has enabled them to go through a normal childhood. The
8 drug is stopped at early puberty age. They go into
9 normal menstrual cycles. They become pregnant when
10 desired. They become mothers. It's one of the great
11 success stories.

12 But to extrapolate what happens to their
13 healthy bones, healthy because they had advancement in
14 their maturation process, has always been the question
15 of, yeah, but these girls we're starting are not
16 advanced bone age, bone to start with.

17 Q Meaning the girls who had not experienced this
18 precarious puberty, as you called it?

19 A Yep.

20 Q Didn't start on the puberty blocking regime?

21 A Right.

22 Q Didn't have that benefit of the extra bone
23 development?

24 A Right. And nobody has ever done this before.

25 Q I see.

1 MR. WILLIAMS: All right. Lunch is here. You
2 guys call the shot on that, since you're asking the
3 questions.

4 MR. GANNAM: Let me just see.

5 (Off the stenographic record.)

6 BY MR. GANNAM:

7 Q Let me get back to page one of the guideline,
8 or it's actually 3132 is the journal page number. At
9 the summary of recommendations, 1.0, do you see that?
10 We're still on Exhibit B. I'm sorry. I didn't mean for
11 you to flip back to the...

12 The first page of the article itself. There
13 you go.

14 Do you see the summary of recommendations at
15 the bottom?

16 A Yep.

17 Q All right. Under diagnostic procedure, 1.1
18 [as read]: We recommend that the diagnosis of gender
19 identity disorder, GID, be made by a mental health
20 professional, MHP.

21 Did I read that correctly?

22 A Yep.

23 Q Now, I think you alluded to this earlier, but
24 let me ask. Is it accurate to say that these guidelines
25 apply to treatment that would occur after a child has

1 already had some contact with a licensed mental health
2 provider and determined that there is gender identity
3 disorder or gender dysphoria or a condition that could
4 be helped by the treatment outlined in this guideline?
5 Is that an accurate statement?

6 A I'm not sure. I mean, the issue is that
7 the -- it could be the -- are you talking about there
8 has to be two people involved?

9 Q Well, maybe you can just explain to me what
10 that means.

11 A Because what I'm trying to say is that any,
12 any mental health professional who is experienced in
13 dealing with gender identity disorders needs to be the
14 person who assesses whether the kid is the real deal.

15 Q Okay. And so just for clarification, then,
16 you don't hold yourself out as a mental health
17 professional, do you?

18 A No. I wouldn't -- I wouldn't claim -- I'd put
19 my two cents in from talking to the kid. But I would
20 make my -- our psychologists are the ones who do this
21 testing and make the -- a true judgment about these
22 kids.

23 But I don't -- it could be a social worker.
24 It could be a psychiatrist. And somebody who's really
25 invested in this as an endeavor.

1 Q So would it be fair to say you're an
2 endocrinologist, generally speaking?

3 A Right. Yes.

4 Q And so the treatments that are outlined in
5 this guideline --

6 A Right.

7 Q -- are treatments that, generally speaking,
8 would be administered after someone in the mental health
9 field first sees the child?

10 A Right. Yes.

11 Q Okay. But that's not something -- you don't
12 make that initial determination. The mental health
13 professional would make it; correct?

14 A Right.

15 Q And then one more statement. And then we can
16 have some lunch. Also on that same page, 1.2 -- I'm
17 sorry if you closed it up again.

18 A Okay.

19 Q 1.2 reads [as read]: Given the high rate of
20 remission of GID, after the onset of puberty, we
21 recommend against a complete social role change and
22 hormone treatment in prepubertal children with GID.

23 Did I read that correctly?

24 A Yes.

25 Q And that's a strong recommendation based on

1 two crosses or low evidence; correct?

2 A Right. I think this has just come out in a
3 new form.

4 Q Okay. "This," meaning this guideline?

5 A This guideline. And I haven't seen it. I was
6 not on the committee this time. I think that it's
7 probably -- if you're looking for it, it's probably
8 still under Hembree.

9 Q What's the year of the new guideline?

10 A I think it would probably be either this year
11 or last year.

12 Q Let me just ask you this, then, with that
13 clarification. The assumption, given the high rate of
14 remission of GID after the onset of puberty, let me just
15 stop right there. In 2019, is it still true that
16 there's a high rate of remission of GID after the onset
17 of puberty?

18 A I'm sorry. I want to be sure I...

19 Q I'm on page 3132, item 1.2, bottom right of
20 the page. Do you see where it says, "given the --

21 A I do, yeah.

22 Q So if I just stop with that assumption here
23 that given the high rate of remission of GID after the
24 onset of puberty, is it still a case in 2019 as we sit
25 here today, that there is a high rate of remission of

1 GID after the onset of puberty?

2 A The thing I'm having trouble with in the
3 statement is that you can read that statement as, you
4 know, after the onset of puberty, many of these kids
5 won't be transgender anymore. Right? That's not how I
6 read it, but I'm looking at the next section, do you...

7 Oh, okay. I get it. This is for untreated
8 people.

9 Q Okay. Explain that. What do you mean by
10 that?

11 A Okay. So this is a description of kids who
12 may show cross-gender treatment, but that -- but unless
13 they really meet the treatment -- they're looking at
14 kids who have cross-gender behavior, but not so much as
15 to qualify as being transgender.

16 Q I see.

17 A Okay? So they're saying -- it's saying,
18 therefore, hold the fort with prepubertal kids.

19 Q So --

20 A Because --

21 Q Go ahead.

22 A Because that some kids will act in a
23 prepubertal way, act in their birth sex later, but
24 they're not really the same. And so what they're saying
25 here is don't encourage that kid to do a complete social

1 transition as a prepubertal kid because that kid may not
2 turn out. That's one of the -- one of the reasons for
3 waiting until the beginning of puberty before making
4 distinctions about how you present -- how your kid
5 should present.

6 But this may have changed in the
7 recommendations because some of the people who have been
8 involved in the recommendations are stronger believers
9 in letting a kid present themselves whatever way they
10 want.

11 Q And by social transition, do you mean, for
12 example, a biological boy, if he were to socially
13 transition, that means fully identifying as a girl --

14 A Right.

15 Q -- as a gender identity; correct?

16 A Right.

17 Q Okay. And just so I read this correctly, in
18 1.2, we're talking about a group of children who have
19 experienced some gender dysphoria or have been diagnosed
20 as having gender identity disorder but have not
21 identified as the other gender. Would that be a fair --

22 A Well, they haven't -- their degree of
23 identification with the other gender is less.

24 Q And but just reading this here, their degree
25 of identity with the other gender is less, but still

1 enough for them to have been diagnosed with gender
2 identity disorder; correct?

3 A Right.

4 Q Okay. So --

5 A And if there's any reason why you have to have
6 incredibly skillful psychologists and testing
7 psychologists, it's over stuff like this.

8 Q Meaning, you have to have an incredibly
9 skillful --

10 A Someone who can follow this kid and see if the
11 kid conforms to those who really are going to change
12 their gender identity at post puberty and be treated
13 according to the protocol, or we're going to wait it out
14 and see what happens.

15 Q Now, based on that statement, I want to ask a
16 follow-up. Would a non-psychologist, let's say a person
17 with a high school diploma, for example, be able to make
18 that determination that you just described?

19 A No.

20 MR. GANNAM: Let's break for lunch.

21 (A luncheon recess is had from 1:30 p.m. to
22 2:04 p.m.)

23 BY MR. GANNAM:

24 Q All right. Are we back on?

25 All right, Dr. Spack. Going back to your

1 declaration, Exhibit 36, I want to ask you a few more
2 questions about it. Can we look at page three and
3 numbered paragraph seven that begins "multiple
4 professional organizations."

5 Do you see that?

6 A Yep.

7 Q All right. In that paragraph, it says [as
8 read]: Multiple professional organizations have issued
9 evidence-based guidelines and standards of care for
10 treating transgender and nonconforming children and
11 adolescents.

12 Did I read that correctly?

13 Did I read that correctly, Dr. Spack?

14 A Yes.

15 Q Next, you write [as read]: I am familiar with
16 these guidelines and standards which include the World
17 Professional Association for Transgender Health, the
18 American Psychological Association, the American
19 Psychiatric Associate, the American Medical Association,
20 and the Endocrine Society.

21 Did I read that correctly?

22 A Yes.

23 Q Now, these standards and guidelines of care
24 that you have identified in this paragraph, I want to
25 take them one by one. Beginning with the last one, the

1 Endocrine Society guidelines are the guidelines attached
2 to your declaration as Exhibit B; correct?

3 A No.

4 Q No. What are the Endocrine Society
5 guidelines?

6 A Well, it's ten years newer than that.

7 Q What would be the date, then?

8 A November -- it's actually 2018.

9 Q Now, those guidelines are not attached to your
10 declaration; correct?

11 A Right. And I'm sorry about that. I
12 thought -- I didn't realize that they had actually come
13 out.

14 Q The World Professional Association for
15 Transgender Health, is that the same as WPATH?

16 A Correct.

17 Q And do you say WPATH to shorten that? How do
18 you pronounce that?

19 A That's what generally is said.

20 Q WPATH. Okay. I'm going to show you a
21 document that I will mark as Exhibit 37.

22 (Exhibit 37 was marked.)

23 BY MR. GANNAM:

24 Q This document has WPATH on the top left and on
25 the cover it says [as read]: Standards of care for the

1 health of transsexual, transgender, and
2 gender-nonconforming people.

3 Lower right along the edge, it reads "version
4 seven." Did I say that correctly?

5 A Um-hum.

6 Q And when I open to the first page after that
7 cover, I see [as read]: Copyright 2012, World
8 Professional Association for Transgender Health, WPATH.

9 Am I reading that correctly?

10 A You are. And I don't know what the frequency
11 of publication is to be able to -- do you know whether
12 this is most recent issue?

13 Q Well, that was going to be my question for you
14 since you say in your declaration that you're familiar
15 with the guidelines and standards and you identified
16 World Professional Association for Transgender Health.
17 I wanted to ask you, are these the most current WPATH
18 standards of care?

19 A Look, they don't usually come out that
20 frequently.

21 Q Have you seen this version that I marked as
22 Exhibit 37?

23 A I believe I have.

24 MR. MIHET: Dr. Spack, would you be able to
25 speak up just a little bit? I'm having a hard time

1 hearing you.

2 THE WITNESS: All right.

3 MR. MIHET: Thank you.

4 THE WITNESS: All right. Here we go. Page
5 ten.

6 BY MR. GANNAM:

7 Q Okay. Is there something on page ten you
8 wanted me to look at?

9 A Yeah. I'm just looking at...

10 Q Let me do this. I can represent to you that
11 when I go to the WPATH website, this is the latest
12 version available to me, but it's not my testimony that
13 matters. So I just -- my question is, Are you aware of
14 any later version than what is in front of you as
15 Exhibit 37?

16 A I am not.

17 Q What is the significance of WPATH in this
18 field that you practice in?

19 MR. WILLIAMS: You mean the organization?

20 BY MR. GANNAM:

21 Q The organization.

22 A The organization is really mixed. It does not
23 define itself by specialty or skill. It is open to
24 people who are all manner of mental health professionals
25 and as well as endocrinologists, both pediatric and

1 adult. And even some surgeons.

2 Q Is it a membership organization?

3 A Yes.

4 Q Are you a member?

5 A Yes, actually.

6 Q How long have you been a member?

7 A I would say 15 years.

8 Q As you sit here, can you tell me whether this
9 is the version you were referring to in paragraph seven
10 of your declaration?

11 A Yes, I believe it is.

12 Q Are you aware of anything -- strike that.

13 Will you look at page eight of this WPATH,
14 Doctor? In the bottom paragraph, the fourth line down
15 is the word "often."

16 Do you see that?

17 A [As read]: Often with the help of
18 psychotherapy, some individuals integrate their trans-
19 or cross-gender feelings into the gender role they were
20 assigned at birth and do not feel the need to feminize
21 or masculinize.

22 Q Those last three words were "masculinize their
23 body"; correct?

24 A Correct.

25 Q Is that still a true statement in 2019?

1 A Well, knowing who these people are who wrote
2 it, I think that it's a mistake not to define the age
3 that they're talking about.

4 Q All right. What clarification would you add
5 to make that sentence true in your opinion?

6 A Well, I would like it to say either -- and
7 this is the case in both adults and children. See, I
8 read this and I look at this and I see the adults that
9 I've cared for. Just a pure gut feeling, and a little
10 knowledge.

11 The two people who wrote -- the people who
12 wrote, who are in parentheses are all treaters of
13 adults. Bockting...

14 Q Meaning that the citation preceding this
15 sentence that reads [as read]: Bockting & Goldberg,
16 Bockting and Lev?

17 A Yes.

18 Q Is that who you're referring to?

19 A Yes.

20 Q And you know their practices or that they are
21 practitioners?

22 A Yeah.

23 Q Okay.

24 A And this distinguished practitioner. But I
25 don't know that they've ever seen a kid.

1 Q Now, you said, I believe a moment ago, that
2 the statement would be true with respect to children and
3 adults; correct?

4 A No, I didn't say that.

5 Q Okay.

6 A Or if I said it, I didn't mean it that way.

7 What I think that -- I think that they should
8 make clear who they're talking about. And if they're
9 talking about children and adults, say it.

10 MR. WILLIAMS: "They," the authors of this
11 Exhibit 37? Is that what you meant, Doctor?

12 THE WITNESS: Yeah.

13 BY MR. GANNAM:

14 Q Dr. Spack, who wrote these WPATH standards of
15 care? Or do you know?

16 A It'll say on front.

17 Q So on page one --

18 A Page one.

19 Q -- has a listing beginning with the name Eli
20 Coleman; is that correct?

21 A Right.

22 Q Now, your name is not on this list?

23 A No.

24 Q Okay. I see -- okay. I'm not going to count,
25 but I see roughly 20 or so people --

1 A Right.

2 Q -- maybe even 30?

3 A Okay. And I can --

4 MR. WILLIAMS: It goes all the way from
5 Coleman down to Ken Zucker; right? That whole list
6 of people? Is that what you're talking about?

7 THE WITNESS: Right. And out of this, and I
8 know just about everybody here. I see Peggy
9 Cohen-Kettenis. These are following who I would
10 trust with this -- with comments about children or
11 adolescence, would be: Peggy Cohen-Kettenis, Rob
12 Garofalo, Arlene Istar Lev, Heino Meyer-Bahlburg.
13 And I would delete Ken Zucker.

14 BY MR. GANNAM:

15 Q Okay. So understanding that this group of
16 people are listed as the authors here, going back to
17 page eight, the authors state -- let me read the whole
18 paragraph. [As read]: As the field matured, health
19 professionals recognized that while many individuals
20 need both hormone therapy and surgery to alleviate their
21 gender dysphoria, others need only one of these
22 treatment options and some need neither.

23 Did I read that correctly?

24 A Yes.

25 Q And then the next sentence reads [as read]:

1 Often with the help of psychotherapy, some individuals
2 integrate their trans- or cross-gender feelings into the
3 gender role they were assigned at birth and do not feel
4 the need to feminize or masculinize their body.

5 Did I read that correctly?

6 A Yes.

7 Q My question is, Does that statement, beginning
8 with "often with the help of," apply to minors; that is,
9 persons under the age of 18?

10 A I think -- well, depends what you call minors.
11 If I were talking about minors who have just reached
12 puberty, I would say that it does not.

13 It's certainly not with the kind of certitude
14 that is written here that was much more applicable to
15 adults. And I'll tell you why. And that is that the
16 about-to-be -- the early pubertal kid who has major
17 issues about gender identity, as puberty hits, they have
18 a profound panic. My own philosophy about this is that
19 what happens is they've been told that when they got
20 through puberty, they wouldn't feel gender dysphoric
21 anymore. And the fantasy that they're going to turn
22 into the other gender is not realized and they
23 decompensate.

24 But the adults, their bodies are essentially
25 finished. And being finished, they feel they have more

1 choice. Do you know what I mean? My body's finished
2 and, well, am I going to go through all this that's
3 going to not do such a great job of having me look like
4 a woman or like a man. And I've seen it. I mean, I've
5 seen these -- they -- of course, they may be amendable,
6 more amendable to psychotherapy because the
7 psychotherapist is pointing out to them all the issues
8 and problems and challenges and physical and maybe
9 familial and everything else.

10 So I have trouble when I read somebody who
11 writes with this kind of certitude, knowing that the
12 kids I see are in terror.

13 Q Well, let me ask you about --

14 MR. WILLIAMS: What was that last word?
15 Terror?

16 THE WITNESS: Yeah.

17 MR. WILLIAMS: Oh.

18 BY MR. GANNAM:

19 Q This statement on page eight, if it were
20 revised to leave off the first qualifier there "often,"
21 and I just began with the word "some," and I changed it
22 as follows: Some prepubertal children integrate their
23 trans- or cross-gender feelings into the gender role
24 they were assigned at birth and do not feel the need to
25 feminize or masculinize their body.

1 Would that be a true statement?

2 MR. WILLIAMS: Object to the form of the
3 question as an improper hypothetical which assumes
4 speculative facts, frankly.

5 Go ahead and give an answer to the question,
6 if you can, Doctor.

7 THE WITNESS: Well, "some," would apply to
8 anything. But the way this is written is more like
9 "often." And I would never write -- I could accept
10 it writing with "some." But if they -- but I would
11 not accept it being included in "often."

12 BY MR. GANNAM:

13 Q Understood. Let me move on then and look at
14 something a little more specific. Page 11 contains the
15 beginning of a section titled "differences between
16 children and adolescents with gender dysphoria."

17 Do you see that?

18 A Yep.

19 Q First sentence [as read]: An important
20 difference between gender dysphoric children and
21 adolescents is in the proportion for whom dysphoria
22 persists into adulthood. Gender dysphoria during
23 childhood does not inevitably continue into adulthood.

24 Let me stop there. Have I read that
25 correctly?

1 A Yes.

2 Q And do you agree with those two sentences so
3 far?

4 A Yes.

5 Q And just so we're clear, when this uses the
6 term "gender dysphoria," are we to understand that to
7 mean a disagreement or incongruency between the child's
8 biological sex and the child's gender identity or the
9 gender the child believes the child is closer to or
10 matches better?

11 A I think it gets the statement across.

12 Q So let me continue. It says [as read]:
13 Rather, in follow-up studies of prepubertal children,
14 mainly boys, in parentheses, who were referred to
15 clinics for assessment of gender dysphoria, the
16 dysphoria persisted into adulthood for only six to
17 23 percent of children.

18 Did I read that correctly?

19 A Yes.

20 Q And then after the long citation -- or after
21 the citation -- actually, just go down to the sentence
22 begins "newer." It says [as read]: Newer studies, also
23 including girls, showed a 12 to 27 percent persistence
24 rate of gender dysphoria into adulthood.

25 Did I read that correctly?

1 A Yeah.

2 Q Now, this document shows a date of 2012 on it.
3 Are you aware of any studies that alter these numbers
4 that are presented here as the range of boys and girls
5 whose gender dysphoria persists into adulthood?

6 A No. But I'm always -- and I don't disbelieve
7 the basic point here. But I do want to point out that
8 sampling, in other words -- well, I trust
9 Cohen-Kettenis.

10 When I read Zucker, makes me wonder because
11 his patients are coming into a place that says
12 psychiatric clinic.

13 However, let's go -- let's go on because the
14 key thing is what they say about adolescents.

15 Q Right. Well let me read that, then, the next
16 paragraph begins [as read]: In contrast, the
17 persistence of gender dysphoria into adulthood appears
18 to be much higher for adolescents. No formal
19 prospective studies exist.

20 Did I read that correctly?

21 A You did. And I think that this -- pairing
22 these two makes perfect sense.

23 Q "These two" meaning that first paragraph --

24 A That first paragraph.

25 Q -- and the two sentences I just read?

1 A Yes. And it has some obligation. Just the
2 fact that many of these kids won't persist doesn't mean
3 they don't need support or doesn't mean that if they are
4 very much compromised by, if not allowed to live in the
5 opposite role, even if it's temporary, it should be
6 allowed.

7 Q So you're speaking of some ethic of client
8 determination or freedom here?

9 A Right.

10 Q Okay.

11 A And what you see here, and this is really
12 important, why did the Dutch, why do we, why do all the
13 places around the world that are doing pubertal
14 suppression start with the first sign of puberty? And
15 the reason for that is the data show that a kid who
16 holds on to the idea that he's in the wrong or she's in
17 the wrong body at puberty are almost definitely
18 transgender.

19 Q Can I ask for your opinion on the second
20 sentence of that second paragraph that I just read "no
21 formal prospective studies exist." Is that still the
22 case?

23 A I would say that if anybody has that data, it
24 would be the group listed in the bottom. And let me
25 just see.

1 Q The bottom of...

2 A So you see, what they say is that -- now they
3 talk about -- see where it says [as read]: However, in
4 follow-up study with 70 adolescents --

5 Q Right.

6 A -- who were diagnosed with gender dysphoria
7 and given pubertal suppression? All continued with
8 actual sex reassignment. In other words, they were
9 suppressed in puberty, but when they -- they all wanted
10 the hormones consistent with their new gender identity.

11 Q And so there's a citation after that sentence
12 to de Vries, Steensma --

13 A Right.

14 Q -- Doreleijers.

15 A This is the -- you're seeing the names of the
16 Dutch group, de Vries, the psychiatrist is head of the
17 group. Steensma is a endocrinologist. I don't know the
18 next one. Cohen-Kettenis was the former leader of the
19 group. She's now retired.

20 Q So the statement in this 2012 document says
21 "no formal prospective studies exist." And I believe
22 you're saying this Dutch group would be the people to
23 ask if that's still the case?

24 A Right.

25 Q But as you sit here, do you know the answer?

1 A And I kind of have a feeling, is that they got
2 so involved in the pubertal suppression that they had no
3 doubt that these kids -- these kids would not have been
4 enrolled in their study if they didn't have the testing
5 that showed they are -- they're transgender. So I don't
6 know why they put it this way.

7 Q But are you aware, personally, of any studies
8 that exist or that came out after this statement that
9 the authors of this document made, which is that no
10 formal prospective studies exist?

11 A No. And part of that is that it's really --
12 it's -- they could be such studies, but you have Zucker
13 who would be one of the authors. And he was so eager to
14 treat that we don't really know what his patients were
15 like before treatment.

16 Q So apart from speculating about Zucker, you're
17 not aware of any --

18 A No.

19 Q -- formal prospective studies; correct?

20 A No.

21 Q Am I correct?

22 A I think so.

23 Q Okay. Thank you.

24 Let's -- the bottom of that page 11, it says
25 "as discussed in section four," do you see that?

1 A Yep.

2 Q It says [as read]: As discussed in section
3 four and by Zucker and Lawrence, 2009, formal
4 epidemiologic studies on gender dysphoria in children,
5 adolescents, and adults are lacking.

6 Do you agree with that statement?

7 A Yes.

8 Q And what does epidemiologic mean?

9 A Population studies.

10 Q Great. I'm going to show you a document I've
11 marked as Exhibit 38.

12 (Exhibit 38 was marked.)

13 BY MR. GANNAM:

14 Q This document is from the American Psychiatric
15 Association. The title is "a guide for working with
16 transgender and gender-nonconforming patients."

17 And what follows is sort of a table of
18 contents. This is from a website. I accessed it from
19 the American Psychiatric Association website. And my
20 question for you is, Is this guide, at least as it's
21 laid out here, the American Psychiatric Association
22 guidelines to which you refer in paragraph seven of your
23 declaration?

24 MR. WILLIAMS: Object to the form because
25 obviously Exhibit 38 is -- I don't know that he can

1 really answer your question, Roger, but...

2 THE WITNESS: So the only question really that
3 you can ask with a document like this is, Does
4 this -- does this table of contents conform to what
5 you would expect of a document on the subject by
6 the American Psychiatric Association.

7 BY MR. GANNAM:

8 Q Let me ask you this question: You refer in
9 numbered paragraph seven on page three of your
10 declaration to various guidelines and standards of which
11 you specifically identified the American Psychiatric
12 Association; correct?

13 A Right.

14 Q So --

15 A But I saw something a lot more than this.

16 Q Okay. And so is this a -- did the document
17 you saw, for example, have the same title as this
18 document, "a guide for working with transgender and
19 gender-nonconforming patients"?

20 A Yes. But you know when it says "view more"?

21 Q Right. Well, let me ask you next, then. Does
22 this listing of contents, understanding this was printed
23 from a website where you could click on each of these
24 things and view more, does this listing of contents
25 correspond to the document that you were referring to in

1 the -- in your declaration?

2 A Yes.

3 Q Okay.

4 A If I were writing this for them, these are
5 the -- these are the headings I would --

6 Q Let me ask you to look at the second to last
7 page of the document that I gave you where it says
8 "about the guide."

9 A About the guide.

10 Q Do you see that?

11 Under "disclaimer," the second paragraph, it
12 says [as read]: Many experts have studied gender and
13 sexuality throughout their careers. This toolkit
14 represents just one view of how to work with TGNC
15 patients, based largely on the WPATH standards of care.
16 Did I read that correctly?

17 A Okay. Yeah.

18 Q Is that consistent with your understanding of
19 the American Psychiatric Association guideline you refer
20 to in your declaration?

21 A It doesn't surprise me at all.

22 Q Okay. Understand, I haven't given you --

23 A No, but...

24 Q -- the entire document to work with. But are
25 you aware of some other document besides what I've given

1 you the title and contents of in this Exhibit 38 by the
2 American Psychiatric Association, that you're referring
3 to in your declaration?

4 A No, I'm not. And I was pleased to see the
5 topics and less pleased to see the text.

6 Q Understood.

7 A It doesn't -- that doesn't surprise me with
8 this organization.

9 Q Going to footnote asterisk in your
10 declaration, you identified in that footnote several
11 documents of which you are the author or co-author;
12 correct?

13 A Yes.

14 Q And you mentioned the first couple of them as
15 possibly containing some information relevant to your --
16 the contents of your declaration, generally speaking; is
17 that correct? Actually, strike that.

18 I'm just going to show you the document. This
19 is marked as Exhibit 39.

20 (Exhibit 39 was marked.)

21 BY MR. GANNAM:

22 Q The title is "management of transgenderism" in
23 a publication from JAMAnetwork.com. It says Norman P.
24 Spack, MD, discussant as the author. Is this the same
25 document identified in footnote asterisk as Spack, NP,

1 clinical crossroads, management of transgenderism, JAMA
2 2013-2019?

3 A Yes.

4 Q Okay. So this is a document you authored;
5 correct?

6 A Yes.

7 Q I wanted to ask you about the bold paragraph
8 at the top right appears to be some kind of abstract or
9 summary. Would that be fair to say?

10 A Yes.

11 Q It talks about gender identity disorder, or in
12 parentheses, transgenderism to begin the paragraph. Did
13 I read that correctly?

14 A Yes.

15 Q It says [as read]: Gender identity disorder
16 (transgenderism) is poorly understood from both
17 mechanistic and clinical standpoints. Awareness of the
18 condition appears to be increasing probably because of
19 greater societal acceptance and available hormonal
20 treatment.

21 Have I read that correctly so far?

22 A Um-hum.

23 Q Then it says [as read]: Therapeutic options
24 include...

25 And it gives a listing of male to female and

1 female to male therapeutic options; is that correct,
2 generally?

3 A Right.

4 Q I'm going to skip down towards the end, the
5 sentence begins "medical therapy." Did I say that
6 correctly? Or do you see that?

7 A Yes.

8 Q Now that sentence says [as read]: Medical
9 therapy for both FTM, defined above as female to male,
10 and MTF, defined above as male to female, can be started
11 in early puberty, although long-term effects are not
12 known.

13 Did I read that correctly?

14 A Yep.

15 Q Now, where it says medical therapy, is that
16 referring generally to the listing of therapeutic
17 options that appeared before it?

18 A Yes.

19 Q And you wrote this -- or this was published in
20 2013. Is the statement "although long-term effects are
21 not known" still a true statement?

22 A Yes.

23 Q All right. I'm going to show you another
24 document now. This, I will label Exhibit 40.

25 (Exhibit 40 was marked.)

1 BY MR. GANNAM:

2 Q Will you take a look at Exhibit 40 for me?

3 The title of this document is "serving transgender
4 youth, challenges, dilemmas, and clinical examples."

5 The main heading says "HHS public access,
6 author manuscript."

7 Below that, it says [as read]: Published in
8 final edited form as professional psychology -- I guess
9 that would be research and practice, 2015.

10 Is this the document identified in your
11 declaration footnote, the first document there, as
12 Tishelman, A. C., Kaufman, R., Edwards-Leeper, L.,
13 Mandel F. H. --

14 A Yes.

15 Q -- Shumer, D. H., and Spack, N. P., 2015?

16 A Yes.

17 Q Yes. Thank you. So this is a document you
18 co-authored; correct?

19 A Correct.

20 Q Will you look at page four, please? The first
21 paragraph, the last sentence begins members of the GeMS
22 team.

23 Do you see that?

24 A Page four?

25 Q Yes.

1 A First paragraph.

2 Q Last sentence of the first paragraph.

3 A Okay.

4 Q First of all, what is GeMS?

5 A Gender Management Service. That is the name
6 of our clinic where we see kids in gender --

7 Q In Boston?

8 A Yeah. Boston Children's.

9 Q All right. So members of -- do you say GeMS?
10 Is that how you pronounce it?

11 A Yeah.

12 Q Okay. So members of the GeMS team have played
13 a role in the development of standards and guidelines,
14 including as a member of the active APA task force to
15 develop guidelines for psychological practice with
16 transgender and gender-nonconforming clients. Did I
17 read that correctly?

18 A Yes.

19 Q Now, did you personally participate on that
20 APA task force?

21 A No.

22 Q Are you aware of that task force and the
23 document that it was bearing?

24 A Yes. And I'll tell you why.

25 Q Okay.

1 A We benefited from -- you can see the names of
2 the Dutch up above who gave us their testing materials
3 to determine gender -- gender identity and gender
4 dysphoria. And we had it translated from the Dutch.
5 But we needed to be able to -- we got permission from
6 the Dutch that the task force was literally translating
7 and establishing something that we could pass around to
8 all these new 70 clinics.

9 Q I see. We'll come back to those APA
10 guidelines. I want to ask you a few more questions
11 about this document.

12 Will you look at page seven?

13 MR. WILLIAMS: Page seven.

14 THE WITNESS: Yep.

15 BY MR. GANNAM:

16 Q Under the heading "medical intervention," do
17 you see that?

18 A Yes.

19 Q The second paragraph under that heading, the
20 last sentence begins with the word "nevertheless."

21 Do you see that?

22 A Okay.

23 Q It says [as read]: Nevertheless, an
24 adolescent who has initiated puberty blockers can decide
25 to terminate the intervention and allow physiological

1 changes to occur as they would have had the medical
2 intervention never been initiated.

3 Did I read that correctly?

4 A Yes.

5 Q Now, just for the record, puberty blockers, is
6 that what we've already discussed as drugs that can be
7 administered to a child to stop the progression of
8 puberty?

9 A Yes.

10 Q And this statement seems to be claiming that
11 puberty blockers can be administered, but then stopped,
12 and then --

13 A It's completely reversible.

14 Q Meaning puberty will begin where it left off,
15 so to speak?

16 A Exactly.

17 Q Okay. Now, is there any study or research
18 pointing to what harms may occur in a person who delays
19 puberty such that they take puberty blockers and then
20 stop puberty blockers and recommence puberty, but at an
21 older age than they otherwise would have or then their
22 peers went through puberty?

23 A It would only be an issue if the -- if they
24 were on them all the way through puberty and stopped
25 them close to a time of desired fertility. Because when

1 you're on them, they're shutting down the whole system.

2 Q What do you mean "the whole system"?

3 A The whole system that leads to
4 spermatogenesis, leading to testosterone production.
5 And in the case -- in our usual case, that genetic male
6 who affirms a female identity, around age 17 and 18, is
7 going to want to have what I call a feminizing
8 genitoplasty. In other words, female external genitals.

9 In the course of doing that, the testes are
10 removed.

11 Q Which is an irreversible --

12 A It's as irreversible as it gets. But the
13 point is, it's -- so the issue for us in this regard is
14 usually moot because the patients are told well ahead of
15 time, if you go this far, they're going to have to do
16 a -- remove the testes.

17 Q So would it be accurate to say the effects of
18 puberty blockers are reversible up to a point in time
19 after which they no longer would be reversible?

20 A Well, they would be -- believe it or not,
21 they -- your ability to generate the hormone that you're
22 blocking will still be there.

23 Q Okay.

24 A Okay? The point is that if someone besides,
25 well, I'm not sure I want to have feminizing

1 genitoplasty, but please keep the blocker going so I
2 don't have to shave and I don't this or that, and then
3 decided at some point wanted to procreate, given a few
4 years, all spermatogenesis would reoccur.

5 Q So in that sense, it's reversible in that
6 those biological processes will kick in again?

7 A Right.

8 Q Okay. Next paragraph on the same page seven
9 reads [as read]: Only with an older adolescent,
10 typically around age 16, are irreversible interventions
11 initiated, and only after psychotherapy and a careful
12 psychological evaluation has taken place.

13 Did I read that correctly?

14 A Yes.

15 Q Can you kind of summarize for me, what are the
16 irreversible interventions that could be initiated
17 around age 16?

18 A So I'm trying to see if they're referring to
19 males or females; right? It looks like they are.

20 So, they're talking about the institution of
21 the actual hormones of the affirmed gender. Okay? And
22 once you do that, you get breasts whether you want them
23 or not. You get body hair, you get larynx. You get
24 lower voice if you get testosterone.

25 Q Did you just describe some examples from both

1 sexes?

2 A From both, yeah.

3 Q Okay.

4 A And so it's going to happen. And that's why
5 we test them before we -- because this is the first time
6 that we, at around age 15, 16, the first time that we do
7 give irreversible treatment.

8 Q So within the standards or guidelines of
9 practice that you operate under, there is a -- a range
10 of ages under 18, you say around 16 here, at which a
11 minor can elect to kind of cross that threshold of
12 irreversible treatment, beginning with cross-sex
13 hormones. Is that --

14 A Yeah. I would say it's 15 to 16.

15 Q Okay.

16 A Would be the case.

17 And 18 is a timing of surgery, if desired.

18 Q Now, is that a -- is 18 an absolute? Or are
19 there situations where persons under the age of 18 may
20 elect and proceed with surgical interventions?

21 A Yes. You raise an interesting point. We used
22 to say 18 because that was a legal age of consent.
23 However, the surgeons have told us that the worst
24 outcomes that they have in feminized genitoplasty where
25 the patients have to use dilation for four or five times

1 a day for a year that we, in the past, were sending
2 girls to the surgeons during the summer before their
3 going off to college, if 18.

4 They tell us that the worst results they have
5 are with them because the first year requires strict
6 adherence to the dilation protocol. They can't do it at
7 school and they don't.

8 Q Can you, just for the record, explain what
9 you're talking about, about the dilation protocol for --

10 A Well, they create a new vagina, and believe it
11 or not, using inverted scrotal tissue.

12 Q This would be in a male to female --

13 A A male to a female.

14 Q -- surgery.

15 A Right.

16 Q Okay.

17 A So that tissue needs to be expanded to be
18 functional, for them to be sexually functional.

19 And it works. But unless the initial dilation
20 after the surgery is required to keep the patent.

21 Q What does that dilation involve? Is it
22 something that would have to be --

23 A It looks a lot like a vibrator really.

24 They may have a series of gradations of size.
25 But they have to do it. If they don't do it, what

1 happens is they go back to the doctor, the spring after
2 their operation, and the doctor finds he can't get the
3 dilator in, in which case, he has to do another surgery
4 to cut a slit in the upper part of the vaginal wall.
5 And it's a mess.

6 So we've kind of shifted and said, Okay, a
7 girl has to be in her mother's territory for the first
8 year after surgery, because the mother can make sure
9 that the girl does the dilatation. Otherwise, the girl
10 goes off to school, is so happy to be free, this or
11 that, and doesn't do it.

12 Q And can you articulate a reason why the -- why
13 a child or adolescent, I guess, who has undergone this
14 surgery might not continue with the dilation? Is it
15 laziness? Is it painful? What is that?

16 A It's laziness. It's the fact that you have to
17 be -- first of all, if you go to college, they have to
18 have a single room. They have to dilate on their bed.
19 You can't share a room with someone doing that.

20 Secondly, their classes are so much farther
21 from their dorm to do four or five dilations a day.
22 It's just physically impossible.

23 Q I see. On page eight --

24 MR. WILLIAMS: We're still on Exhibit 39? 40.

25 MR. GANNAM: 40, actually.

1 BY MR. GANNAM:

2 Q I'll just read the whole paragraph. The
3 second -- or the first full paragraph --

4 A What page?

5 Q Page eight. Begins "a common scenario."

6 A Okay.

7 Q [As read]: A common scenario for GeMS to
8 recommend puberty blockers -- strike that. Let me start
9 over.

10 [As read]: A common scenario is for GeMS to
11 recommend puberty blockers when the youth and/or the
12 parent may feel that it would be best to start cross-sex
13 hormone therapy instead. The delay of puberty, rather
14 than the immediate onset of the puberty of choice,
15 (utilizing cross-sex hormones) is sometimes difficult
16 for the youth or family to accept. This is an area
17 where we currently have little research to guide us and
18 the decision of whether to block puberty or instead move
19 forward with an affirmed gender, i.e., cross-sex
20 hormones, must be weighed carefully.

21 Did I read that correctly?

22 A Yeah.

23 Q Is that still a true statement that this is an
24 area where we currently have little research to guide
25 us?

1 A Because very few people should, would, or
2 should do it this way.

3 And the reason is that, say, you're dealing
4 with a genetic female. And they want to go right
5 forward into a male puberty -- into a male puberty.
6 Okay? If you don't block them while you're doing it,
7 there's going to be menstruating. They have to
8 understand that she's going to be menstruating like a
9 female, she's going to get progressively large breasts
10 that may require a more complex operation. And it's why
11 my way of doing things and most of the people follow me
12 is that I run the blockade medicine all the way until
13 the gonads come out. So therefore, the person who's
14 male to female has no masculinization, but at age 15 is
15 getting feminization. So there's a person who comes out
16 looking perfectly female in the end because they don't
17 have any male characteristics while they're going
18 through a feminine puberty.

19 So, you know, if I had a situation like this,
20 I would say forget it.

21 Q So the statement that "we currently have
22 little research to guide us" refers specifically to that
23 decision of whether to simply block puberty or move
24 ahead with cross-sex hormones?

25 A Yeah. I remember seeing this and I said,

1 well, I understand that you could put it in there
2 because unfortunately, a lot of people can't afford the
3 blocking hormones. And we've got to do something. So
4 this is what we do, is to give them the hormones they
5 desire. They get some of those characteristics. But
6 it's not ideal.

7 Q Now, the last sentence reads [as read]: Aside
8 from the irreversible nature of cross-sex hormone
9 initiation, this intervention has significant
10 ramifications for fertility while puberty blockers do
11 not.

12 Did I read that correctly?

13 A Yes. For example, you have a -- you give
14 excess or masculinizing testosterone levels to a genetic
15 female, you're going to end up making her what we call
16 polycystic ovary disease. She's going to have big cysts
17 in the ovaries. She's going to have trouble conceiving.

18 Ironically, the just shutting down puberty
19 just lift it up when you want to...

20 Q Will you look at page 11, please? The heading
21 reads "the service gaps and evolution of practice."

22 Did I read that correctly?

23 A Yeah.

24 Q Now, this reads [as read]: Watching the
25 clinical services grow is rewarding, especially when

1 they translate into more contented and peaceful lives
2 for youth and their families. Nevertheless,
3 evidence-based practices are aspirational when a new
4 field emerges with no guiding clinical precedent.
5 Controversies among providers in the mental health and
6 medical fields are abundant.

7 Did I read that correctly?

8 A Yes.

9 Q Okay. Now, the next sentence reads [as read]:
10 Drescher & Byne, 2012, and Stein, 2012, provide
11 excellent discussions of issues of consensus versus
12 continued controversies. These include differing
13 assumptions regarding whether early intervention with
14 gender variant youth can encourage the assistance, and
15 whether that is an appropriate practice.

16 Did I read that correctly?

17 A Yep.

18 Q It continues [as read]: Other areas of debate
19 include the age at which children or adolescents should
20 be encouraged or permitted to socially transition,
21 whether cross-sex hormones and surgery should be offered
22 to youth, and if so, at what age, whether parental
23 consent be required for these medical interventions, and
24 whether mental health involvement be required including
25 psychological evaluation prior to each stage of medical

1 intervention.

2 Did I read that correctly?

3 A Yes.

4 Q [As read]: These issues are complex and
5 providers in the field continue to be at odds in their
6 efforts to work in the best interest of the youth they
7 serve.

8 Did I read that correctly?

9 A Yes.

10 Q And this is a 2015 document. Is it still the
11 case that these complex issues of disagreement continue?

12 A Yes. But, you know, I would like to make one
13 point. This is why we're a team. This is why every
14 patient is discussed before they're in the clinic
15 they're going to come in at, and everyone has a role
16 about how the patient feels about this and helps to make
17 these complex decisions.

18 There are also a reason why we're here today,
19 in part, because of alternative ways of going at this
20 issue, albeit it somewhat of an early issue. Who knows.
21 This is what I -- I can worry about this because I think
22 in time we can get the right answers to it.

23 But I can't worry for my patients who's seeing
24 somebody who may have a theological basis for how
25 they're going to treat the patient, or where I worry

1 whether the person who is benefiting the most is the
2 patient or the clinician. And these are tough-enough
3 issues, even when you have all the tools.

4 The people on my team can handle these
5 decisions with this stuff.

6 Q The next paragraph begins "an important
7 priority."

8 Do you see that?

9 A Yep.

10 Q [As read]: An important priority. Going
11 forward is to develop research to enhance our
12 understanding of what typifies this population of
13 children and their developmental course and patterns and
14 to examine the long-term outcomes of treatment.

15 Did I read that correctly?

16 A Yes.

17 Q [As read]: The field needs to better
18 comprehend which children are most likely to have a
19 lifelong and persistent identification with a different
20 gender than the one they were assigned versus those who
21 cease to self identify as transgender over the course of
22 time.

23 Did I read that correctly?

24 A Yes.

25 Q [As read]: Although some information is

1 available -- there's a parenthetical with several
2 sources listed -- much more research in this area is
3 needed.

4 Did I read that correctly?

5 A Yes.

6 Q Is that still a true statement, that much more
7 research in this area is needed?

8 A Yes. But what you're reading is the marching
9 orders of why we would grant.

10 Q Okay. You're talking about the \$6 million NIH
11 grant that was awarded?

12 A Right.

13 Q All right. I'm going to show you a document
14 I've marked as Exhibit 41.

15 (Exhibit 41 was marked.)

16 BY MR. GANNAM:

17 Q All right. This document is titled "practice
18 parameter on gay, lesbian, or bisexual sexual
19 orientation, gender nonconformity, and gender
20 discordance in children and adolescence."

21 At the top is a filing header from this
22 lawsuit reading case 8:17-cv-02896, document 24-4, filed
23 January 12, 2018.

24 And I'll represent to you that this is a
25 document filed in this lawsuit by the City of Tampa as

1 one of the documents referenced in its ordinance. Have
2 you seen this document before?

3 A No. Who is the author?

4 Q The American Academy of Child & Adolescent
5 Psychiatry, AACAP.

6 A Without listing any --

7 Q I'm sorry?

8 A Without listing any particular individuals?
9 This is like a -- this is a -- is this like a, say,
10 statement by...

11 Q Well, if you look on page 971 towards -- 971
12 using the page numbering at the bottom of the pages.

13 MR. WILLIAMS: Excuse me. Just a second so I
14 can catch up. Okay.

15 BY MR. GANNAM:

16 Q You see where it says "parameter limitations"?

17 A Okay.

18 Q And then below that is a box, a gray box,
19 "this practice parameter was developed by"?

20 A Okay. It's like attachments.

21 Q Correct. So are you familiar with this
22 document?

23 A No.

24 Q You're not? Okay. Fair enough. I'll move
25 on, then. All right. Now I'm going to show you a

1 document previously marked as Exhibit 33 when we had the
2 deposition of Dr. Glassgold. And it's an APA document,
3 "guidelines for psychological practice with transgender
4 and gender-nonconforming people."

5 (Off the stenographic record.)

6 MR. WILLIAMS: I can't tell. Is that the '09
7 document?

8 MR. GANNAM: This is the 2015 APA document.

9 MR. WILLIAMS: Oh, the 2015. Okay.

10 MR. GANNAM: For the record, it was filed in
11 this case at document 135-1.

12 (Exhibit 33 was marked in a previous
13 deposition.)

14 BY MR. GANNAM:

15 Q Now, do you recall when I asked you about your
16 article that referred to GeMS team members participating
17 on the APA task force on the development of guidelines
18 for psychological practice with transgender and
19 gender-nonconforming people?

20 A So you're looking at number 33?

21 Q Yeah. Let me ask you -- let me back up.

22 Will you look at document 40 again, which is
23 your article and the HHS public access page. And go to
24 page four of Exhibit 40. And on page four, the first
25 paragraph, last sentence --

1 MR. WILLIAMS: Page four?

2 MR. GANNAM: -- of page four of document 40.

3 MR. WILLIAMS: Oh, this one. Okay.

4 BY MR. GANNAM:

5 Q I think you're on the right document.

6 The last sentence of the first paragraph reads
7 "members of the GeMS team."

8 Do you see that?

9 A I'm sorry, what page?

10 MR. GANNAM: May I point to it, Rob?

11 MR. WILLIAMS: Sure.

12 BY MR. GANNAM:

13 Q We're on page four. And this, "members of the
14 GeMS team."

15 Do you see that?

16 A Okay.

17 Q It reads [as read]: Members of the GeMS team
18 have played a role in the development of standards and
19 guidelines, including as a member of the active APA task
20 force to develop guidelines for psychological practice
21 with transgender and gender-nonconforming clients.

22 Did I read that correctly?

23 Dr. Spack, did I read that correctly?

24 A Yep.

25 Q Now, this document that I handed you just a

1 moment ago marked Exhibit 33, is that the document being
2 referred to that your GeMS team played a part in?

3 A Yes.

4 Q I didn't hear if you answered or not.

5 A Yes.

6 Q Oh, okay. Are you familiar with these APA
7 guidelines?

8 A I have seen them, yes.

9 Q Okay. Have you had an opportunity to develop
10 any opinions as to their accuracy?

11 Let me stop there.

12 A Well, if I looked at this, I looked at it
13 casually. I'm not a great fan of the APA.

14 Q Okay. Fair enough. Let me just ask you some
15 specific questions about it, then.

16 Will you look at, using the page numbering at
17 the bottom of the pages, page 842 of the document.

18 MR. WILLIAMS: You're talking about that?

19 BY MR. GANNAM:

20 Q Yeah. Exhibit 33.

21 A Okay. Okay.

22 Q On page 842, the first full paragraph begins
23 with "a clear distinction."

24 Do you see that?

25 A Um-hum.

1 MR. WILLIAMS: Are you going to read that into
2 the record, Roger, since I don't have a copy? It
3 might be helpful for me to follow that.

4 MR. GANNAM: Yeah. I'll read the whole
5 paragraph.

6 MR. WILLIAMS: Thank you.

7 BY MR. GANNAM:

8 Q Are you with me on the page, Dr. Spack?

9 A (No verbal response.)

10 Q Is that a yes? Sorry. Just for the record.
11 Did you say yes, Dr. Spack?

12 A Yes.

13 Q Okay. Thank you. [As read]: A clear
14 distinction between care of TGNC and gender-questioning
15 children and adolescents exists in the literature. Due
16 to the evidence that not all children persist in a TGNC
17 identity into adolescence or adulthood, and because no
18 approach to working with TGNC children has been
19 adequately, empirically validated, consensus does not
20 exist regarding best practice with prepubertal children.

21 Did I read that correctly?

22 A Yep.

23 Q Now, I'm going to break that down into a
24 couple of pieces and ask you about it. First, where it
25 says TGNC, you understand that in this document, that

1 means transgender and gender nonconforming?

2 A Um-hum.

3 Q Okay. Great.

4 MR. WILLIAMS: You have to say yes.

5 THE WITNESS: Yeah. Yeah.

6 BY MR. GANNAM:

7 Q All right. So that's a yes?

8 A Yeah.

9 MR. WILLIAMS: For her benefit.

10 THE WITNESS: Yes.

11 MR. MIHET: And try to keep your speech up, if
12 you can. I'm still having a hard time hearing you
13 across the table.

14 MR. WILLIAMS: What did you say?

15 BY MR. GANNAM:

16 Q So it says [as read]: Due to the evidence
17 that not all children persist in a TGNC identity into
18 adolescence or adulthood...

19 So first, do you agree with that premise that
20 not all children persist with a TGNC identity? Do you
21 agree with that, Dr. Spack?

22 A Yep.

23 Q The next premise is [as read]: And because no
24 approach to working with TGNC children has been
25 adequately, empirically validated...

1 Do you agree with that premise, that no
2 approach to working with TGNC children has been
3 adequately, empirically validated?

4 A Yes.

5 Q Then the final statement is [as read]:
6 Consensus does not exist regarding best practice with
7 prepubertal children.

8 Do you agree with that conclusion that
9 consensus does not exist regarding best practice with
10 prepubertal children?

11 A I think it's poorly written because I don't
12 think that they're indicating what kind of practice
13 they're referring to. They should indicate -- we,
14 somebody, they, should indicate should we encourage
15 children to assume a social role, even if temperate.

16 Q Sorry, could you say that again?

17 A Well, it's not giving you a choice -- any idea
18 of what would be a potential way of dealing with
19 prepubertal children.

20 Q Okay. Well let me -- let me -- okay. So
21 apart from that criticism of the statement, is it
22 nonetheless a true statement that there is not a
23 consensus regarding the best practice with prepubertal
24 children?

25 A I would say the answer to that is yes. And

1 part of the reason our clinicians, like Zucker, who have
2 confused the physicians who would take care of these
3 children.

4 Q So it identifies, then, two distinct
5 approaches. If we skip down a sentence, it begins "two
6 distinct approaches."

7 Do you see that?

8 A Um-hum.

9 Q Is that a yes?

10 A (No verbal response.)

11 Q I'm sorry. I need you to say --

12 A Yeah.

13 Q I know it can be cumbersome.

14 But [as read]: Two distinct approaches exist
15 to address gender identity concerns in children.

16 Then after the citation it says [as read]:
17 With some authors subdividing one of the approaches to
18 suggest three.

19 Now, the next paragraph begins [as read]: One
20 approach encourages an affirmation and acceptance of
21 children's expressed gender identity.

22 Did I read that correctly?

23 A Yes.

24 Q And, in fact, in the middle of that paragraph,
25 it even refers to one of your articles; correct?

1 A Yes.

2 Q Okay. Now, the next paragraph says [as read]:
3 In the second approach, children are encouraged to
4 embrace their given bodies and to align with their
5 assigned gender roles. This includes endorsing and
6 supporting behaviors and attitudes that align with the
7 child's sex assigned at birth prior to the onset of
8 puberty.

9 Did I read that correctly?

10 A Yes.

11 Q Are you in agreement with the general
12 proposition that there are two approaches to prepubertal
13 children, one being to encourage and affirm the express
14 gender identity, and the other approach to encourage
15 children to embrace their given bodies that align with
16 their biological sex?

17 A Absolutely.

18 Q Okay. I want to ask you to look at page 843,
19 using the page numbers at the bottom. Have you found
20 page 843?

21 A Yes.

22 Q On the right column, in the last paragraph, it
23 begins "psychologists may encourage."

24 Do you see that?

25 A Yes.

1 Q If I skip down one, two, three sentences to
2 the sentence that begins with the word "emphasizing"?

3 A Yes.

4 Q You see that. Great. I'll read it. [As
5 read]: Emphasizing to parents the importance of
6 allowing their child the freedom to return to a gender
7 identity that aligns with sex assigned at birth or
8 another gender identity at any point cannot be
9 overstated, particularly given the research that
10 suggests that not all young gender-nonconforming
11 children will ultimately express a gender identity
12 different from that assigned at birth.

13 Did I read that correctly?

14 A Yes.

15 Q Do you agree with this admonishment or this
16 advice in this document?

17 A Yes.

18 Q Okay.

19 MR. WILLIAMS: Can we take a break real quick?

20 MR. GANNAM: Yes, we may.

21 (A brief recess is had from 3:18 p.m. to 3:30
22 p.m.)

23 BY MR. GANNAM:

24 Q Dr. Spack, can I ask you to go back to your
25 declaration, which is Exhibit 36?

1 A Okay. Whereabouts?

2 Q And page three, which is the section Roman
3 numeral two, "analysis and opinions." Are you there?

4 A Yes.

5 Q All right. Will you look at numbered
6 paragraph one? It reads -- are you at that paragraph?

7 A Yeah. "I have reviewed."

8 Q It says [as read]: I have reviewed the
9 declaration submitted by Dr. Bernard Hudson. From that
10 review, it is my professional opinion that the
11 declaration significantly misstates current medical
12 knowledge and practice regarding the standard of care
13 and treatment for transgender and gender-nonconforming
14 children and adolescents.

15 Did I read that correctly?

16 A Yes.

17 Q Does this paragraph mean that you disagree
18 with everything Dr. Hudson said in his declaration?

19 A No.

20 Q In your declaration, apart from this paragraph
21 one, do you identify any specific part of Dr. Hudson's
22 declaration that you disagree with?

23 A Do you have his declaration?

24 Q I'm asking if, in your declaration, after this
25 paragraph one --

1 A Oh, oh, oh, okay.

2 Q -- do you specifically identify any part of
3 his declaration that you disagree with?

4 A There's no significant evidence that any type
5 of therapy or treatment can change a person's gender
6 identity.

7 Q Where are you reading? Are you reading --

8 A Number four.

9 Q Okay. Number four reads [as read]: There is
10 no scientific evidence that any type of therapy or
11 treatment can change a person's gender identity. And
12 attempts to do so put patients at risk of serious harms,
13 including suicidality and depression.

14 Did I read that correctly?

15 A Yes, you did.

16 Q Now, are you telling me that that paragraph
17 disagrees with something in Dr. Hudson's declaration?

18 A Yes. He does not refer to the risks
19 associated with trying to shoehorn somebody into a
20 gender identity.

21 Q Now, in paragraph four when you say there's no
22 scientific evidence that any type of therapy or
23 treatment -- let me stop there.

24 Are you referring to what you earlier defined
25 as conversion therapy?

1 A Yes, but -- yes.

2 Q Okay. So when you talk here about -- well, it
3 says [as read]: Attempts to do so put patients at risk
4 of serious harms, including suicidality and depression.

5 Did I read that correctly?

6 A Yes.

7 Q Now, you testified earlier that you're not a
8 mental health professional. But I wanted to ask you if
9 you know, is there some risk of harm, including
10 suicidality and depression that can result from
11 psychotherapy in general?

12 A That's true, but this is a particularly
13 vulnerable population.

14 Q Okay. So you do agree it's true that
15 psychotherapy in general can present some risk of harm
16 of suicidality and depression to patients?

17 A Yes.

18 Yes.

19 Q Now, can you quantify for me what increased
20 risk, if any, from what you defined as conversion
21 therapy for suicidality and depression exists?

22 A Well, it may not be particularly scientific,
23 but the first -- the first association I had with
24 conversion therapy, and actually was the only one so
25 far -- I'll tell you what happened.

1 This was a 18-year-old female who affirmed a
2 male identity. The parents were very active in their
3 Catholic church and tended to go along with some of the
4 sign waving that the MassResistance organization was
5 holding up in front of -- the objection of that
6 organization to gay and lesbian teachers being allowed
7 to teach in the schools.

8 I actually found this kid to be a fairly
9 jovial person. I actually didn't consider him at high
10 risk. His parents felt that he should have a go of
11 therapy with a person who believed very much in
12 conversion therapy and was also tied very much to this
13 particularly right wing Catholic group that had made a
14 fair bit of noise in Massachusetts.

15 Q That's MassResistance?

16 A MassResistance.

17 Q Okay.

18 A Hadn't seen him in a while. And I spoke to
19 his parents. I said, How is he doing. Mom said, Well,
20 I think he's developed a drug problem. Are you getting
21 any help for that? We're going to try.

22 The next thing I heard, that he had still seen
23 the therapist who was working on trying to convert him
24 back to female. And the next thing I knew, I got a call
25 from the parents that he had overdosed on heroin and

1 died.

2 Now, this is a complex situation, obviously.
3 Any heroin death can often be mis -- taking too much or
4 too strong a dose. And I understood that.

5 But I met with the parents and they were
6 beside themselves. And they particularly put blame on
7 themselves for forcing an issue and finding a person who
8 would be their agent in that.

9 So I have a particularly -- I really liked
10 this kid. This kid was a great hockey player and played
11 with boys. I was a hockey player. And ironically, or
12 maybe perhaps expectedly, the parents abandoned the
13 MassResistance type -- abandoned that church altogether.
14 They came to every lecture I ever gave in Greater
15 Boston. They became the most active people to meet with
16 new, newly diagnosed transgender kids. It was just
17 quite amazing as to what happened. But just, what can I
18 say? It was something that's very, very hard to forget.

19 Q As the parent of an 18 year old, I can't
20 imagine. So obviously, that would be a situation that
21 is sad on many, many levels. Can you say, as you sit
22 here, that the drug overdose was caused by what you call
23 the conversion therapy this young person received?

24 A I can't. I can't. All I can say is this:
25 The initiation of drug treatment -- of drug taking --

1 this kid wasn't taking anything before -- was coincident
2 with -- the actual overdose with heroin, I never ascribe
3 the overdose to a voluntary suicide. Just can't.

4 Q Right.

5 A There's too many variables.

6 Q And so scientifically speaking, of course,
7 coincident does not mean causal, obviously?

8 A Of course.

9 Q Now, do you know anything about this person
10 that the parents chose as therapist? Was this person
11 licensed or a religious leader? Or do you know anything
12 about the person?

13 A I think the person came -- was recommended
14 through the church and through -- whether the person
15 was -- well, that's all I know.

16 Q Okay. Now, I understood -- you don't know
17 whether the person was a licensed therapist; is that
18 correct?

19 A No.

20 Q No, you do not know?

21 A No, I do not know.

22 Q Okay. Now, I got the impression from the way
23 you explained what happened that this was also somewhat
24 to some extent coercive where the parents sort of sent
25 their son or -- you told me this was a --

1 A Female to male.

2 Q Okay. So the parents sent their child, who
3 was 18 to this person, whoever it was.

4 A Right.

5 Q Well, I mean, obviously I can see why that
6 account and their experience would put a bad taste in
7 your mouth. But going back to the more scientific
8 question, which is, can you put a percentage or quantify
9 the increased risk to a person of suicidality or
10 depression, or any poor mental health outcome, from
11 conversion therapy as compared to psychotherapy, in
12 general?

13 A The only thing is that he started using heroin
14 after he first met the therapist. And he continued to
15 use heroin for weeks until he took the overdose. And so
16 there was a part of me that was feeling -- he told that
17 therapist he was taking heroin -- why, you know, why
18 didn't -- why didn't he get the kind of referral that
19 you would expect.

20 Q I can see why you would have those questions.

21 MR. GANNAM: Can you read back my question to
22 him, please?

23 (The Court Reporter is directed to read back
24 the previous question and/or answer.)

25 THE WITNESS: I can't say.

1 BY MR. GANNAM:

2 Q You can't say?

3 A The only thing I can say is that whoever he
4 saw was seeing a kid who was relatively new to any --
5 any drug. And this was heroin. And this person made no
6 appropriate move.

7 Q So apart from that particular situation, are
8 you telling me that you can't quantify or put a
9 percentage on the increased risk from conversion
10 therapy?

11 A Correct.

12 Q Now, what led me to that question was an
13 earlier question about what specifically your
14 declaration points to in Dr. Hudson's declaration that
15 you disagree with.

16 Is there anything else in your declaration
17 identifying a disagreement with Dr. Hudson's
18 declaration?

19 A I will say one thing about -- or maybe I said
20 this before. As I reread Hudson's declaration, I had
21 the feeling -- I had the feeling that Dr. Hudson might
22 be an appropriate therapist for some of my adult
23 patients. That the way he came -- he comes across, a
24 sensitive person, that even though some of his approach,
25 perhaps, in conversion type would be totally

1 inappropriate for children and adolescents, it might be
2 very useful in someone over 30 who literally needs to be
3 shaken up a bit but with a tenderness.

4 Q Do you, in your declaration, identify anything
5 that -- any treatment that would be inappropriate for a
6 minor, based on Dr. Hudson's declaration?

7 A Well, I do make the points that subjecting
8 minors to conversion therapy deviates from the standard
9 of care for treating transgender and
10 gender-nonconforming children in adolescence.

11 And I think that's the topic sentence for my
12 issues with Dr. Hudson and the age group that I talk
13 about.

14 Q Is there anything else in your declaration
15 that points to a -- something specific in Dr. Hudson's
16 declaration that you disagree with or found
17 inappropriate?

18 A No scientific evidence in any type of therapy
19 or treatment can change a person's gender identity.
20 Attempts to do so put patients at risk of serious harm,
21 including suicidality and depression.

22 Q That was paragraph four; correct?

23 A Right. And number seven, I won't read them
24 all, but I listed the multiple professional
25 organizations that have issued evidence-based guidelines

1 and standards of care for treating transgender and
2 gender-nonconforming children in adolescence. By
3 inference, I say that these -- none of these guidelines
4 include conversion treatment.

5 Q All right. Have you now told me everything in
6 your declaration that addresses anything in Dr. Hudson's
7 declaration that you disagree with or found
8 inappropriate?

9 MR. WILLIAMS: You're talking about the entire
10 declaration one through six of part A and seven
11 through eight of -- actually seven through nine of
12 part B?

13 MR. GANNAM: I'm sorry?

14 MR. WILLIAMS: I want to make sure that I
15 understand the question.

16 MR. GANNAM: Will you read my question back?

17 (The Court Reporter is directed to read back
18 the previous question and/or answer.)

19 THE WITNESS: Perhaps you'd read number nine?

20 MR. WILLIAMS: Let her do this, Doctor. And
21 let me ask.

22 MR. GANNAM: All right. Let me start with
23 that question.

24 MR. WILLIAMS: Well, let me ask you a
25 question, because his reference to Dr. Hudson is

1 specifically in paragraph Roman numeral 2A1. And
2 my question is are you referring to just the six --
3 two through six thereafter or are you talking about
4 B as well or anything before that? You said "in
5 your declaration."

6 MR. GANNAM: All right. I'll ask --

7 MR. WILLIAMS: I want to make sure that I'm
8 understanding.

9 MR. GANNAM: I'll ask the question. And if
10 there's an objection, then make it. And we'll see
11 if he can answer me.

12 MR. WILLIAMS: Okay. Fair enough.

13 BY MR. GANNAM:

14 Q Dr. Spack.

15 A Yes.

16 Q Have you now told me everything in your
17 declaration that addresses a disagreement with
18 Dr. Hudson's declaration or something in his declaration
19 that you found inappropriate?

20 A Well, this may be redundant, but it is my
21 concluding point, number nine. [As read]: There's no
22 evidence-based support for treatments that attempt to
23 change a young person's gender identity or gender
24 expression. Conversion therapy deviates from the
25 standards of care and guidelines promulgated for the

1 psychological and medical treatment of gender diverse
2 adolescence.

3 MR. WILLIAMS: My objection, which I didn't
4 get a chance to lodge, is the declaration speaks
5 for itself. And I think the court can make its own
6 conclusions as to what all this means. So I think
7 it's unfair to the witness to ask him that kind of
8 a question. He's answered the question. And then
9 we'll go from there; okay?

10 BY MR. GANNAM:

11 Q Your attorney said you've answered the
12 question. I want to let you have the last word on that.
13 Have you now told me everything in your declaration that
14 addresses anything you disagree with in Dr. Hudson's
15 declaration or anything you found inappropriate in his
16 declaration?

17 A I'm satisfied that my opinions have been
18 heard.

19 Q All right. Let me take a break with my
20 colleague for a moment and we will reconvene.

21 (A brief recess is had from 3:52 p.m. to 4:00
22 p.m.)

23 BY MR. GANNAM:

24 Q Just to clean up our record a little bit, I'm
25 going to show you what was previously marked as

1 Exhibit 4. This is the Tampa ordinance 2017-47.

2 MR. WILLIAMS: Do I have a copy of that?

3 MR. GANNAM: We marked it as 4 during one of
4 the earliest depositions.

5 MR. WILLIAMS: Right. Right. Give me a
6 second.

7 BY MR. GANNAM:

8 Q Dr. Spack, is this in fact the ordinance that
9 we've been talking about --

10 A Yes.

11 Q -- in this case?

12 Great. And have you had a chance to read this
13 ordinance before?

14 A I did, yes.

15 Q Okay. And does your reading it include all
16 those various "whereas" clauses leading up the text of
17 the ordinance?

18 A I never saw so many whereases in my life.

19 Q Great. All right. I have no further
20 questions.

21 CROSS EXAMINATION

22 BY MR. WILLIAMS:

23 Q All right. Dr. Spack, I just want to clarify
24 some things in my mind. Mr. Gannam went over your
25 declaration, which is Exhibit 36 to your deposition that

1 you signed on June 12th, 2019. And you have that in
2 front of you there, don't you?

3 A Yes.

4 Q He also talked about the 2015 guidelines. Do
5 you remember that part of his --

6 A Yes.

7 Q -- question?

8 2015 APA guidelines, I think.

9 MR. GANNAM: You want to give the Exhibit
10 number, just for the record?

11 MR. WILLIAMS: Yeah. You're better at that
12 than I am. I didn't have a copy of that.

13 MR. GANNAM: 33.

14 MR. WILLIAMS: May I borrow your copy?

15 MR. GANNAM: Why don't you borrow his copy
16 because all the pictures I drew of you in the
17 margin on this one.

18 MR. WILLIAMS: I'm sure they're pretty
19 pictures.

20 BY MR. WILLIAMS:

21 Q If you don't mind, I'll borrow that.

22 So Exhibit 33 is the American Psychological
23 Association 2015 guidelines.

24 Now, Doctor, with those -- with your
25 declaration in mind and the APA guidelines in mind,

1 first of all, let me ask you, you've now been through
2 the better part of the day under Mr. Gannam's
3 grilling -- questioning.

4 MR. MIHET: Skillful.

5 MR. WILLIAMS: Skillful. Yes. Skillful and
6 adroit.

7 BY MR. WILLIAMS:

8 Q But grilling, nevertheless. Has anything that
9 Mr. Gannam has introduced to you today caused you to
10 change in your mind -- well, any of your statements in
11 your declaration?

12 MR. GANNAM: Objection, leading.

13 You can answer.

14 THE WITNESS: There was -- I'm not sure if
15 it's in here or -- there was a place where the two
16 options.

17 BY MR. WILLIAMS:

18 Q Yeah. I'm talking about -- I think you talked
19 about in connection with this. But are the statements
20 that you made in your declaration signed in June still
21 valid statements, as far as you know?

22 A Yes.

23 MR. GANNAM: I just want to object, asked and
24 answered.

25 BY MR. WILLIAMS:

1 Q Now, you just mentioned the two options. And
2 I remember that. And Mr. Gannam asked you -- I think
3 the question was, talked about two options. What
4 options did you understand him to be talking to you
5 about -- asking you about?

6 A It relate -- I don't even remember which
7 document it was. But it --

8 Q I believe it was connected with 33.

9 MR. GANNAM: Objection, leading.

10 MR. WILLIAMS: That's true.

11 THE WITNESS: And the issue was whether or not
12 in response to the statement of two approaches to
13 the treatment of children who had gender dysphoria,
14 whether I had -- whether I had said they were equal
15 or not.

16 MR. GANNAM: I didn't ask that question, so...

17 BY MR. WILLIAMS:

18 Q Well, I'll ask it. Are they equal?

19 A Not necessarily. And the reason is that --
20 well, could I just look at it again?

21 Q Sure. Here's the '15 -- or '15 guidelines.
22 Here's your declaration.

23 MR. GANNAM: I just want to object to the
24 record of leading the witness to a document.

25 MR. MIHET: For the record, Attorney Minter is

1 now flipping through the exhibit and has opened it
2 to a particular paragraph and pointed the witness
3 to it.

4 MR. MINTER: Yes. The same paragraph that he
5 was questioned about earlier.

6 MR. WILLIAMS: And to save time, I might add.
7 It's after 4:00.

8 THE WITNESS: Okay. I believe it was related
9 to guideline eight on page 841 of the American
10 Psychological Association.

11 And I'll read it. This is longer than I
12 thought. Can I ask a question?

13 BY MR. WILLIAMS:

14 Q No, you can't. You can take whatever time you
15 need to.

16 A [As read]: Many children develop stability in
17 the gender identity between ages three and four,
18 although gender consistency, which is recognition that
19 gender remains the same across situations, often does
20 not occur until ages four to seven. Children who
21 demonstrate gender nonconformity in preschool and early
22 elementary school may not follow this trajectory.

23 This comes from Zucker.

24 [As read]: Existing research suggests that 12
25 to 50 percent of all children diagnosed with gender

1 dysphoria may persist in their identification with a
2 gender different than sex assigned at birth into late
3 adolescence and young adulthood.

4 The point here is that what Zucker says
5 shouldn't be regarded as equivalent or shouldn't be
6 regarded as the Bible from Sinai.

7 And I say this because he not only says things
8 like this in 15 -- you know, like 15 personal references
9 in a paragraph, but what he has said has been regarded
10 as truth for a very long time, even in the pediatric
11 endocrine community and in the pediatric psychological
12 community. And if his solution or recommendation is put
13 at equal weight with another, my only recommendation is
14 look very carefully at the other because it's very
15 likely to be more correct. And it's also very likely
16 that when it was raised as a question or a -- or a
17 letter to the editor or whatever, criticizing Zucker, it
18 would have been shouted down. It's really a classic
19 example of what -- of what happens when scientific -- a
20 scientific approach becomes political.

21 Q Of the two choices, is one of them then the
22 Zucker approach? Is that what you're saying?

23 A There is one Zucker approach here.

24 Q And is that the standard of care today, now?

25 A No more.

1 Q What is the standard of care? How would you
2 identify that?

3 A Well --

4 Q The other approach?

5 A Yes. There are two standards of care about
6 how to deal with the prepubertal kid who acts in a
7 cross-gender way.

8 Zucker's approach was to isolate the child,
9 limit the child to their own room, and not permit the
10 child to play with any toys or anything reflecting their
11 cross-gender feelings in another room in the house, as
12 if -- what Zucker was trying to do was accept the
13 possibility the kid may be gay, but try to keep the kid
14 from being transgender.

15 The other example is the best example by Diane
16 Ehrensaft of the University of California or San
17 Francisco, whose attitude is follow the child's lead,
18 you will have a happy child and you won't be making the
19 child transgender in so doing because many kids change
20 anyway. But you can make yourself a really miserable
21 child if you follow Ken Zucker's approach.

22 Q Which of those two is now the standard of
23 care?

24 A I think Ehrensaft is.

25 MR. GANNAM: Just I'm going to object to

1 assumes facts not in evidence.

2 MR. WILLIAMS: All right. I think I've
3 covered those. Okay. Good enough. That's all I
4 have.

5 MR. GANNAM: All right. Just for the record,
6 I'll move to strike the cross-examination as beyond
7 the scope of direct. And we have no follow-up.

8 MR. WILLIAMS: I move to strike your motion to
9 strike.

10 MR. MIHET: And also as leading the witness,
11 coaching, and improperly getting the witness to
12 change their sworn testimony.

13 MR. WILLIAMS: I take offense to all the above
14 objections because that's not what happened at all.
15 All right. We're done?

16 Doctor, you have the right to read your
17 transcript. I'm sure it will be transcribed. And
18 I will -- if you want me to, I will send you, or
19 the court reporter will send you a copy of your
20 transcript. You have the right to read it, make
21 any changes you want to, or whatever, or you can
22 waive that. My advice is never waive that right.
23 That's what I tell everybody, so...

24 MR. MIHET: We disagree that the witness has
25 the right to make any changes that he wants to.

1 MR. WILLIAMS: Good God, how can you disagree
2 with that. Hold on, Harry. I want to put you to a
3 real test here.

4 (Off the stenographic record.)

5 COURT REPORTER: So Mr. Williams, you're
6 getting a copy of the transcript, then?

7 MR. WILLIAMS: I'm sure they're going to order
8 it and I'll take a copy. I'm assuming. Maybe I
9 shouldn't assume. You guys going to order it?

10 MR. MIHET: Yes.

11 MR. WILLIAMS: That's what I thought.

12 (The reading and signing of the deposition is
13 not waived.)

14 (At 4:13 p.m. the deposition was concluded.)
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CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, the undersigned authority, certify that NORMAN
SPACK, M.D. personally appeared before me and was duly
sworn.

WITNESS my hand this 15th day of August, 2019.



DAWN A. HILLIER, RMR, CRR, CLR
Notary Public - State of Florida
My Commission No.: GG 259309
Expires: 12-15-2022

CERTIFICATE

STATE OF FLORIDA)

COUNTY OF HILLSBOROUGH)

I, DAWN A. HILLIER, RMR, CRR, CLR certify that I was authorized to and did stenographically report the deposition of NORMAN SPACK, M.D.; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 15th day of August, 2019.



DAWN A. HILLIER, RMR, CRR, CLR

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.	)	
	)	

**PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND
MOTION TO EXCLUDE CERTAIN OPINIONS OF DEFENDANT'S EXPERT
AND INCORPORATED MEMORANDUM OF LAW**

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,¹ pursuant to Local Rule 3.01 and the Court's Case Management and Scheduling Order (D.183), and on the grounds stated in the Memorandum of Law incorporated hereinbelow, move the Court as follows:

1. For judgment as a matter of law under Rule 56, Fed. R. Civ. P., on all their claims against Defendant, the City of Tampa, Florida ("Tampa" or the "City"), in accordance with their prayer for relief in their First Amended Verified Complaint (Dkt. 78), there being no genuine dispute as to any material fact; and
2. To exclude certain opinions of the City's expert Judith M. Glassgold, Psy.D under Rule 702, Fed. R. Evid. (*See infra* Mem. Law pt. I.B.1.c.)

¹ Plaintiff DAVID H. PICKUP, LMFT does not take part in this filing. *See* Plaintiffs' Certification of Conference to Narrow Issues for Summary Judgment (Dkt. 188).

MEMORANDUM OF LAW

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INTRODUCTION

Much factual and legal ground has been covered in the briefing and proceedings around Plaintiffs' Motion for Preliminary Injunction (Dkt. 85), which remains pending before the Court, including Plaintiffs' Consolidated Response in Opposition to Defendant, City of Tampa's Objections to Magistrate's Reports and Recommendations (Dkt. 160), and the Magistrate's Report and Recommendation (Dkt. 149) concluding Plaintiffs' preliminary injunction motion should be granted, in part. Rather than unnecessarily duplicate the substantial materials already before the Court, Plaintiffs herein focus primarily on certain interactions of their thoroughly briefed legal positions with the undisputed facts in the record, showing that Plaintiffs are entitled to judgment as a matter of law.

Plaintiffs' legal positions, as supplemented herein, are set forth in the following filings, which are incorporated herein by this reference pursuant to Rule 10(c), Fed. R. Civ. P.:

Dkt. Document

- 85 Plaintiffs' Motion for Preliminary Injunction with Incorporated Memorandum of Law (Plaintiffs' "**MPI**")
- 114 Plaintiffs' Response in Opposition to Defendants' Motions to Dismiss and Plaintiffs' Reply in Support of Their Renewed Motion for Preliminary Injunction (Plaintiffs' "**MTD Response/MPI Reply**")
- 138 Transcript of Preliminary Injunction Hearing ("**PI Hearing**")
- 145 Plaintiffs' Post-Hearing Memorandum of Law in Support of Motion for Preliminary Injunction (Plaintiffs' "**Post-Hearing MPI Memorandum**")
- 147 Plaintiffs' Objections to Amicus Curiae Equality Florida's Supplemental Amicus Brief (Plaintiffs' "**Objections to Supplemental Amicus Brief**")
- 160 Plaintiffs' Consolidated Response in Opposition to Defendant, City of Tampa's Objections to Magistrate's Reports and Recommendations (Plaintiffs' "**R&R Objection Response**")

The following additional filings are also referenced herein:

Dkt. Document

- 149 Report and Recommendation (“**MPI R&R**”)
- 155 Defendant, City of Tampa’s, Objections to Magistrate’s Report and Recommendation on Motion to Dismiss (“**MTD Objections**”)
- 156 Defendant, City of Tampa’s, Objections to Magistrate’s Report and Recommendation Regarding Plaintiff’s Motion for Preliminary Injunction (“**MPI Objections**”)
- 193 Plaintiffs’ Statement of Undisputed Facts in Support of Motion for Summary Judgment (Plaintiffs’ “**SUF**”)

SUMMARY JUDGMENT STANDARD

“The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56.

ARGUMENT

I. PLAINTIFFS ARE ENTITLED TO JUDGMENT AS A MATTER OF LAW ON THEIR CONSTITUTIONAL CLAIMS.

A. Binding Precedent Forecloses the City’s Effort to Evade Strict Scrutiny by Relabeling Vazzo’s Speech as ‘Conduct’ or ‘Professional Speech.’

1. Defendants’ Relabeling Fails as a Matter of Law.

As shown in Plaintiffs’ prior briefing, the Supreme Court’s *NIFLA* decision is only the latest of a line of cases prohibiting the government from simply relabeling the speech of professionals as a pretext to restrict their speech with less scrutiny. (See, e.g., *R&R Obj. Resp.* 21–23 (citing, *inter alia*, *Nat’l Inst. for Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371–72 (2018) (hereinafter, “*NIFLA*”); *MTD Resp./MTD Reply* 2–9.) *NIFLA* affirmed the “stringent standard” of *Reed v. Town of Gilbert*, 135 S. Ct. 2218 (2015), mandating strict scrutiny for all

content-based restrictions on speech, and condemned the invidious discrimination inherent in bans on the speech of licensed professionals. 138 S. Ct. at 2371 (“As a general matter, such laws ‘are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests.’”).

The *NIFLA* Court expressly rejected the erroneous conclusion that content-based regulations of so-called “professional speech” do not receive strict scrutiny, **abrogating by name the two principal legal authorities upon which the Tampa ordinance was expressly based—***King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014), and *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014):

Some Courts of Appeals have recognized “professional speech” as a separate category of speech that is subject to different rules. *See, e.g., [King; Pickup]* So defined, these courts except professional speech from the rule that content-based regulations of speech are subject to strict scrutiny.

But this Court has not recognized “professional speech” as a separate category of speech. Speech is not unprotected merely because it is uttered by “professionals.”

NIFLA, 138 S. Ct. at 2371-72 (emphasis added). (*Cf.* SUF ¶ 8.) The *NIFLA* Court further admonished that allowing the government to lessen First Amendment protections for professionals by reclassifying their speech would eviscerate the protections afforded to doctors, lawyers, nurses, mental health professionals, and many others: “[T]hat gives the States unfettered power to reduce a group’s First Amendment rights by simply imposing a licensing requirement. **States cannot choose the protection that speech receives under the First Amendment**, as that would give them a powerful tool to impose invidious discrimination on disfavored subjects.” 138 S. Ct. at 2372.

Even before *NIFLA*, the Eleventh Circuit’s en banc decision in *Wollschlaeger v. Florida* rejected regulation of speech by relabeling because “**characterizing speech as conduct is a**

dubious constitutional enterprise.” 848 F.3d 1293, 1309 (11th Cir. 2017) (emphasis added). “Speech is speech, and it must be analyzed as such for purposes of the First Amendment.” *Id.* at 1307 (citation and internal quotation marks omitted). Thus, whether the City tries to obtain rational basis review by labeling Vazzo’s speech ‘conduct’ (see, e.g., MTD Objs. 3–4; MPI Objs. 5–10), or tries to obtain some kind of intermediate scrutiny by labeling Vazzo’s counseling ‘professional speech’ (see, e.g., SUF ¶ 8), binding precedent requires this Court to reject the City’s labeling game.

Still earlier, almost a decade before *NIFLA*, the Supreme Court solidified the fully protected status of professionals’ speech in *Holder v. Humanitarian Law Project*, 561 U.S. 1 (2010). The *Holder* plaintiffs, including a former judge and a physician, brought a First Amendment challenge to a federal statute prohibiting the provision of “‘material support or resources’” to foreign terrorist organizations. 561 U.S. at 7–8, 10. The plaintiffs wanted to provide support for the non-terroristic activities of two such organizations, “the PKK and LTTE, in the form of . . . legal training, and political advocacy” 561 U.S. at 10. The Court rejected the plaintiffs’ claim that the statute banned pure political speech because plaintiffs remained free to speak and write about the PKK and LTTE, and to advocate for them. *Id.* at 25–26. The Court also rejected, however, the government’s argument that the statute prohibited only “conduct, not speech,” “and only incidentally burdens expression.” 561 U.S. at 26. The Court reasoned,

[the statute] regulates speech on the basis of its content. **Plaintiffs want to speak** to the PKK and LTTE, **and whether they may do so under [the statute] depends on what they say.** If plaintiffs’ speech to those groups imparts a “specific skill” or communicates advice derived from “specialized knowledge” . . . then it is barred.

Id. at 27 (emphasis added).

The government in *Holder* (evocative of Tampa here) nevertheless argued that intermediate scrutiny should apply to the Court’s First Amendment review of the statute “because it *generally*

functions as a regulation of conduct.” *Id.* at 27. The Supreme Court rejected that argument, too, because even though the statute “may be described as directed at conduct, . . . as applied to plaintiffs the conduct triggering coverage under the statute consists of communicating a message.”

Id. at 28. In concluding that strict scrutiny applied, the Court reasoned,

The First Amendment issue before us is more refined than either plaintiffs or the Government would have it. It is not whether the Government may prohibit pure political speech, or may prohibit material support in the form of conduct. It is instead **whether the Government may prohibit what plaintiffs want to do**—provide material support to the PKK and LTTE **in the form of speech**.

Id. at 28.

On the issue of whether strict scrutiny applies, the *Holder* Court’s analysis is controlling because the facts are analogous.² First, the issue here can be framed nearly identically to the issue in *Holder*: whether Tampa may prohibit what Vazzo wants to do—provide sexual and gender identity counseling “in the form of speech.” Second, as in *Holder*, Vazzo wants to use his speech to impart skills requested by his minor clients (reducing or eliminating unwanted same-sex attractions or gender conflicts) or communicate advice derived from his specialized knowledge. Third, as in *Holder*, the Tampa ordinance ostensibly allows Vazzo to write and speak about SOCE, and to advocate its benefits (*see, e.g.*, MTD Objs. 3–4; MPI Objs. 9, 11); but that is irrelevant, as in *Holder*, to the question before this Court (whether Tampa may prohibit what Doyle wants to do). As correctly observed by the Magistrate, the ordinance **prohibits Plaintiff counselors from**

² On the issue of whether the content-based regulation **satisfied** strict scrutiny, the *Holder* analysis is not controlling here because, unlike Tampa, the government in *Holder* narrowly tailored its statute based on **empirical** consideration of the harms sought to be avoided by enacting the statute. *See* 561 U.S. at 29 (“Whether foreign terrorist organizations meaningfully segregate support of their legitimate activities from support of terrorism is an empirical question.”). (*See infra* pt. I.B.1.)

“using ‘speech to help clients understand and identify their anxiety or confusion regarding their attractions, or identity and then help the client formulate the method of counseling that will most benefit that particular client,’” and consequently, prohibits Plaintiff New Hearts Outreach from referring minor clients to the counselor Plaintiffs. (MTD R&R 3–4 (emphasis added) (quoting FAVC ¶ 65); MPI R&R 3 (same).) Thus, under the binding precedent of *Holder*, Tampa cannot avoid strict scrutiny by relabeling Vazzo’s speech as ‘conduct.’

2. The ‘Treatment’ Label from *Otto v. Boca Raton* Also Fails as a Matter of Law.

This Court should also reject the alternative labeling of speech as “treatment” in the Southern District of Florida’s order in *Otto v. Boca Raton*, 353 F. Supp. 3d 1237 (S.D. Fla. 2019) (denying preliminary injunction against city and county “conversion therapy” bans). (Cf. MPI Objs. 5–10 (“[T]he only speech barred by the Ordinance is ‘the manner of delivering the treatment.’” (quoting *Otto*, 353 F. Supp. 3d at 1256).) In *Otto*, the district court disregarded *NIFLA*’s admonition against applying “different rules” to speech “uttered by ‘professionals,’” 138 S. Ct. at 2371–72, and labored to recast the counselor-plaintiffs’ speech as “treatment” speech (*i.e.*, not really speech) with diminished First Amendment protection. 353 F. Supp. 3d at 1255–58. Thus, the *Otto* court downgraded the counselors’ speech based on the “function” of the speech:

This case presents facts in which speech is not always expressive, and thus warrants less scrutiny. Cf. [*United States v.*] *O’Brien*, 391 U.S. 367 (1968). Plaintiffs’ words serve a function; their words constitute an act of therapy with their minor clients, which makes Plaintiffs’ speech different from the protected dialogues in *Wollschlaeger* and *NIFLA*, and from highly protected, political speech in the metaphoric or literal “public square.”

353 F. Supp. 3d at 1257. In *Holder*, however, the Supreme Court rejected this very rationale, holding, “*O’Brien* does not provide the applicable standard for reviewing a content-based regulation of speech.” 561 U.S. at 28.

Thus, the *Holder* analysis (*supra* pt. I.A.1) exposes the *Otto* court’s error, and precludes any legitimate reliance on the *Otto* findings and conclusions. “The Government is wrong that the only thing actually at issue in this litigation is conduct” 561 U.S. at 27. “[Vazzo] wants to speak to [his minor clients], and whether [he] may do so under [the ordinance] depends on what [he] say[s].” *Id.* If Vazzo’s speech “imparts a ‘specific skill’ or communicates advice derived from ‘specialized knowledge’—for example, [strategies to reduce or eliminate unwanted same-sex attractions, or for gaining comfort with biological sex]—then it is barred.” *See id.* “On the other hand, [Vazzo’s] speech is not barred if it imparts only general or unspecialized knowledge”—for example, that another professional can communicate such strategies to the client and that the client should seek out that other professional. *See id.*

Holder, thus, eviscerates the City’s rationalization that the ordinance does not regulate speech because it ostensibly allows Vazzo to talk **about** and **recommend** “conversion therapy.” (MPI Objs. 5–10.) Under *Holder*, Tampa’s seeming benevolence in tossing Vazzo the table scraps of “general or unspecialized” speech cannot excuse the City’s censoring what Vazzo wants to say to help his clients.

The City Cannot Satisfy Its Strict Scrutiny Burden Because It Cannot Show Either a Compelling Interest Supporting the Ordinance or that the Ordinance Is the Least Restrictive Means.

1. **The Undisputed Absence of Empirical Evidence of Harm from “Conversion Therapy” Precludes Any Compelling Interest Justifying the Ordinance.**
 - a. **This Court Owes No Deference to the City’s Unfounded Legislative Judgments in the First Amendment Context.**

As shown in Plaintiffs’ MPI and subsequent briefing, the City is not entitled to deference in making speech-restrictive determinations. (*See, e.g.*, MTD Resp./MPI Reply 16–21.) Rather,

under strict scrutiny, the government must support a content-based speech restriction with empirical or other concrete evidence of genuine, identifiable harm, not merely the anecdotes, conjecture, and supposition of proponents. (MTD Resp./MPI Reply 16–21.) The City has utterly failed to identify empirical or concrete evidence of genuine harm justifying the ordinance, and therefore cannot satisfy the compelling interest prong of strict scrutiny.

This absence of empirical evidence of harm, now beyond dispute, is an insurmountable obstacle to the City’s narrow tailoring burdens. As shown in Plaintiffs’ MPI briefing, it is not Plaintiffs’ burden to prove the effectiveness Vazzo’s talk therapy, or of “conversion therapy” or SOCE in general; rather, it is the City’s burden to show empirical or concrete evidence of harm justifying Tampa’s ordinance. (MTD Resp./MPI Reply 16; R&R Objs. Resp. 25–26.) Whatever **general** interest Tampa may rightfully proclaim in the health and safety of minors in the City, Tampa has no legitimate—let alone compelling—interest in protecting minors from the merely speculative narrative of harm crafted into position statements and uncritically adopted by the City Council. (MPI 13–17; MTD Resp./MPI Reply 16–21.)

In the binding *Wollschlaeger* decision, holding that provisions of a Florida statute prohibiting physicians’ speech about gun ownership did not satisfy even intermediate scrutiny, the en banc Eleventh Circuit explained that purported governmental interests “[a]t an abstract level of generality” are not enough to justify “restrict[ing] the speech of doctors and medical professionals on a certain subject.” 848 F.3d at 1316. Thus, Florida’s undoubted “substantial interest” in “regulat[ing] the medical profession in order to protect the public” was nonetheless not specific enough to justify a speech restriction on professionals where there was no evidence of a harm to be remedied beyond “six anecdotes.” 848 F.3d at 1316. The legislative record of Tampa’s

ordinance is no better. (SUF ¶ 10–41.) Accordingly, Defendants cannot satisfy the interest prong of their narrow tailoring burden.

b. The APA Report Stands Uncontradicted in Exposing the Absence of Any Empirical Evidence of Harm from “Conversion Therapy.”

In Plaintiffs’ SUF and prior briefing, they painstakingly expose the recurring, unequivocal admissions of the 2009 APA Report—ostensibly a principal authority supporting Tampa’s ordinance—that there is no empirical evidence of harm from “conversion therapy.” (SUF ¶¶ 11–14; R&R Objs. Resp. 7–18.) Tampa has never rebutted this absence of empirical evidence of harm, perhaps best summarized in this single passage from the APA Report:

[T]here is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. **Thus, we cannot conclude how likely it is that harm will occur from SOCE.**

(APA Rep. 42 (emphasis added).) Nor has the City rebutted any of the subsequent authorities affirming the APA Report’s conclusions, and revealing the even greater evidence void on gender identity issues in minors. (SUF ¶ 11 (quoting SAMHSA Report PageID 568 (“**No new studies have been published that would change the conclusions reached in the APA Taskforce’s 2009 review.**” (emphasis added)), PageID 569 (“**[N]o research demonstrating the harms of conversion therapy with gender minority youth has been published . . .**” (emphasis added))), SUF ¶ 19 (quoting AACAP Statement PageID 521 (“**There have been no randomized controlled trials of any treatment. . .**” (emphasis added)), PageID 522 (“**Given the lack of empirical evidence . . . further research is needed** on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention . . .” (emphasis

added))), SUF ¶ 21 (quoting APA TGNC Guidelines PageID 2759 (“[B]ecause **no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist**” (emphasis added))).) To be sure, the City cannot rebut its own admission that Tampa had no way to quantify the purported risk of harm the ordinance claims to be posed by “conversion therapy.” (SUF ¶ 14 (quoting ordinance sponsor, Councilman Guido Maniscalco, “No, **nobody knows.**” (emphasis added))).)

Even the later research cited in the Declaration of the City’s expert Dr. Glassgold fails to add any evidence to the empirical record that could rebut the above conclusions of the APA Report, SAMHSA Report, AACAP Statement, or APA TGNC Guidelines, up to and including the most recent study Dr. Glassgold cited, published in 2018 by Ryan, et al. (Dkt. 142-3 Page ID 3234 (“[C]ausal claims cannot be made.” (emphasis added)). (Glassgold 134:18–155:5, 175:15–180:18; Ex. 28 (Dkt. 192-3) ¶ 17 at 7–8, 8 n.7, Ex. B; Exs. 29–32 (Dkts. 192-4 to 192-7).)

c. Dr. Glassgold’s ‘Unequivocal’ Opinion Contradicts All Research and Should Be Excluded.

Given the unequivocally lacking empirical evidence to support any causal claims of harm from SOCE or “conversion therapy,” as shown above, including from authorities co-authored by Dr. Glassgold, coordinated by Dr. Glassgold, and cited by Dr. Glassgold, Dr. Glassgold cannot justify her opinion that states the exact opposite: “[C]urrent scientific evidence, including those cited in the [ordinance] findings, confirm unequivocally that conversion therapy (CT) in any form is ineffective and harmful.” (Glassgold Decl. (Dkt. 192-3) ¶ 14; cf. APA Rep. 90 (“[R]esearch on SOCE . . . has not answered basic questions of whether it is safe or effective and for whom” (emphasis added)).) That is, Dr. Glassgold cannot explain, by any measure of reason or logic, why her opinion for the Court in this litigation is antithetical to the conclusions of the APA Report she co-authored, the SAMHSA report she coordinated, and the other studies she cited in her own

declaration. (Glassgold 182:18–188:2.) The same is true for all of Dr. Glassgold’s opinions ascribing “significant” risk to SOCE or “conversion therapy” (e.g., Glassgold Decl. (Dkt. 192-3) ¶¶ 16, 36, 39, 42, 45, 47, 48, 50, 51, 76, 77) given that “**research studies provide no clear indication of the prevalence of harmful outcomes . . .**” (APA Rep. 42; SUF ¶¶ 11–14, 19–21, 36–40.) To say Dr. Glassgold overplayed her hand is an understatement. This Court should exclude her unsupportable opinions.

The Eleventh Circuit explained the district court’s gatekeeping rule under Federal Rule of Evidence 702:

In *Daubert*, the Supreme Court explained that trial courts must act as **gatekeepers tasked with screening out speculative, unreliable expert testimony**. . . . Later, in *Kumho*, the Court explained that the gatekeeping function governs all expert testimony based on scientific technical, or other specialized knowledge, not just scientific testimony. The Court also stressed that the factors identified in *Daubert* do *not* constitute a definitive checklist or test. . . . Furthermore, *Kumho* emphasized that the goal of **gatekeeping is to ensure that an expert employs in the courtroom the same level of intellectual rigor** that characterizes the practice of an expert in the relevant field.

Adams v. Lab. Corp. of Am., 760 F.3d 1322, 1327 (11th Cir. 2014) (emphasis added) (internal quotation marks and citations omitted).

The Supreme Court earlier held in *Gen. Elec. Co. v. Joiner*:

“nothing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data **only by the ipse dixit of the expert**. A court may conclude that **there is simply too great an analytical gap between the data and the opinion proffered.**”

522 U.S. 136, 146 (1997) (emphasis added). At issue in *Joiner* was a district court’s exclusion of the plaintiff’s experts, having concluded that the studies cited by the experts did not support their opinions. *Id.* at 139–140. The Supreme Court concluded, “it was within the District Court’s

discretion to conclude that the studies upon which the experts relied were not sufficient, whether individually or in combination, to support their conclusions” *Id.* at 146–47.

These binding precedents require this Court to reject all unreliable, intellectually unrigorous *ipse dixit* testimony of an expert witnesses which is not supported by the authorities cited by the witness. The identified opinions of Dr. Glassgold must be excluded under this standard. The analytical gap between all the authorities identified by the ordinance and Dr. Glassgold—that the empirical evidence supports no conclusions about SOCE efficacy or safety—and Dr. Glassgold’s litigation opinion—that “current scientific evidence, including those cited in the [ordinance] findings, confirm unequivocally that conversion therapy (CT) in any form is ineffective and harmful”—is far too great for this Court to take the opinion seriously. *See Joiner*, 522 U.S. at 146.

2. Even if the City Could Establish a Compelling Interest, the Ordinance Is Not Narrowly Tailored Because It Is Not the Least Restrictive Means to Address the Supposed Harms of “Conversion Therapy.”

a. Defendants’ Narrow Tailoring Burden Requires Concrete Evidence Demonstrating Why Less Restrictive Alternatives Would Be Unworkable.

As shown in Plaintiffs’ MPI briefing (MPI 17–19; MTD Resp./MPI Reply 21–27), Tampa’s content-based speech ban must be the least restrictive means to satisfy narrow tailoring, under the most exacting scrutiny. Thus, even if the City could establish a sufficiently compelling interest (it cannot), the City must also show Tampa “**seriously** undertook to address the problem with less intrusive tools readily available to it.” *McCullen v. Coakley*, 134 S. Ct. 2518, 2539 (2014) (emphasis added). The City “would have to show either that **substantially less-restrictive alternatives were tried and failed**, or that the **alternatives were closely examined and ruled out for good reason.**” *Bruni v. City of Pittsburgh*, 824 F.3d 353, 370 (3d Cir. 2016); *see also*

Reynolds v. Middleton, 779 F.3d 222, 229 (4th Cir. 2015) (requiring “government to present **actual evidence** supporting its assertion that a restriction on speech does not burden substantially more speech than necessary; **argument unsupported by the evidence will not suffice to carry the government’s burden**”); *id.* at 231 (“As the Court explained in *McCullen* . . . **the burden of proving narrow tailoring requires the [government] to prove that it actually tried other methods to address the problem.**”); *Libertarian Party of Va. v. Judd*, 718 F.3d 308, 318 (4th Cir. 2013) (holding government failed narrow tailoring under strict scrutiny where it “produced **no concrete evidence** of persuasive force explaining why the plaintiffs’ proposed solution, manifestly less restrictive of their First Amendment rights, would be unworkable or impracticable.”) (All bold emphases added.).

b. The City Cannot Show Tampa Seriously Considered Any Less Restrictive Alternative to Its Total Speech Ban.

The City fails narrow tailoring primarily because Tampa did not seriously (or at all) consider any less restrictive alternative to its total speech ban. The ordinance’s legislative record contains no evidence that the City Council considered any alternative to the ordinance’s speech restrictions. (SUF ¶ 41 (quoting ordinance sponsor, Maniscalco 100:14-102:9 (“We never debated anything else because we specifically wanted the complete ban.”))).) Thus, the City does not come close to proving Tampa seriously considered any less restrictive alternative to the ordinance, or rule out any alternative for good reason. *See Bruni*, 824 F.3d at 370.

3. The Ordinance Cannot Pass Narrow Tailoring Because It Is Practically Unenforceable by City Code Officials.

The City also fails narrow tailoring because the ordinance cannot, as a practical matter, be enforced to remedy any purported harms the City claims to have in view. As the Supreme Court taught in *McCullen*, the First Amendment “demand[s] a close fit between ends and means.” 134

S. Ct. at 2534. The inability to enforce the ordinance through its code officials forecloses the required fit between the ordinance and the City’s purported interest in enacting it.

Tampa’s code officials are objectively ill-equipped to investigate and make determinations about appropriate mental health therapeutic practices. The City’s code enforcement officials tasked with enforcing the ordinance need only a high school diploma or equivalent for the position, and receive no training in marriage and family therapy or mental health counseling. (SUF ¶ 42.) Code officials must know what the ordinance prohibits in order to enforce it, and to fulfill their responsibilities to issue notices of violation. (SUF ¶ 42.) But the officials are not trained to distinguish “conversion therapy” from other therapy, or qualified to tell the difference between “sexual orientation” and “gender identity,” or how to know, for example, whether a child experiencing gender confusion has transitioned to a cross-gender identity or is still exploring the possibility. (SUF ¶ 42.) Tampa code officials do not enforce any other ordinances regulating the therapies offered by mental health professionals, and have no experience or expertise in enforcing such regulations. (SUF ¶ 43.)

Moreover, there is no evidence of any trained or qualified professional upstream from code enforcement personnel to preside over a final determination, such as a board of professional standards, or even a single reviewing professional with appropriate training or licensure. Tampa code officials are instructed to refer all potential “conversion therapy” cases to the City’s legal department for handling. (SUF ¶ 44.) The City’s lawyer responsible for overseeing “conversion therapy” enforcement, however, cannot define the term “gender identity” as used in the ordinance, and would look to the dictionary to interpret the ordinance. (SUF ¶ 44.) The ultimate trier of ordinance violations is a City-appointed special master, but the City does not know whether any special master on its roster is a licensed mental health practitioner, and the City has no plans to

appoint a special master with those credentials. (SUF ¶ 44.) Such a fatally flawed process could never satisfy the constitutional “fit” requirement of narrow tailoring.

To be sure, the testimony of the City’s expert Dr. Spack illustrates the utter incompatibility of code enforcers with the regulation of mental health professionals. According to Dr. Spack, there is a “frustrating group” he sees “that calls themselves gender queer,” and he calls them “gender fluid”:

It's a person who doesn't commit to being either male or female. But that may take different -- manifest, for example, it could be someone who just sees themselves somewhere in the spectrum and it changes from day-to-day, and someone who sees themselves very much male one day and very much female the next.

. . . .

The thing I don't know, and I wouldn't be able to tell you -- I don't know if I'll live long enough to find out -- is how do these people end up? Are they on a path towards one or the other or not?

(Spack 38:6–40:13 (emphasis added).) When asked whether “gender fluid” could be categorized as a gender identity, Dr. Spack answered, “If it’s ill defined and especially moving, a moving target, I would call it a form of gender identity.” (Spack 39:25–40:8.) If Dr. Spack could not easily determine the gender identity of a “gender fluid” person, or whether “they [are] on a path towards one or the other or not,” then no Tampa code official is qualified to make that determination for purposes of determining whether a change of gender identity is being attempted.

As another illustration, the guidelines on gender identity issues lauded by Dr. Spack recommend against transition for prepubertal children who exhibit “cross-gender behavior, but not so much as to qualify as being transgender,” and Dr. Spack testified that the determination of whether the child qualifies as being transgender must be made by “incredibly skillful psychologists” and not non-psychologists without education beyond high school:

Q Would a non-psychologist, let's say a person with a high school diploma, for example, be able to make that determination that you described?

A No.

(Spack 75:15–19 (emphasis added); SUF ¶ 37, 38.)

The ordinance, however, allows unlimited affirmation of this contra-indicated transition, while prohibiting counseling to help the child embrace or align with his or her biological sex if such alignment is construed as a change or attempted change of gender identity. The glaringly obvious problem, then, is that no Tampa code official or upstream adjudicator is qualified to make that determination. Moreover, the ordinance endorses affirmation of contra-indicated transition in the direction of cross-gender identity, but prohibits affirmation in the other direction—towards biological gender identity—even though that is a recognized approach to alleviating gender dysphoria. (Spack 116:25–123:17, Ex. 33 (Dkt. 192-8).)

B. Tampa Intended and Interprets the Ordinance to Prohibit Speech of a Particular Viewpoint.

Not only does the ordinance text betray the City's intent to censor speech, it also betrays the City's intent to censor a particular viewpoint. As found by the Magistrate,

the City adopted Ordinance 2017-47 because the City disagreed with the viewpoint mental health counselors express during SOCE counseling. (See also Doc. 24-1, p. 6) (prohibiting counseling aimed at “chang[ing] . . . gender identity, or gender expression” while allowing counseling “that provides support and assistance to a person undergoing gender transition”)

(MPI R&R 30 (citing ordinance text); *see also* MPI 7–11; MTD Resp./MPI Reply 11–13; R&R Objs. Resp. 32–38.) The City's enforcement attorney confirmed the ordinance punishes a counselor's viewpoint that affirms a client's goal to change sexual orientation or gender identity. (SUF ¶ 9.) The Magistrate correctly discerned that, given the ordinance's expressly allowing the affirmation of a client's “transition” (change) from the client's biological gender, the City's

interpretation otherwise disallowing the affirmation of a client's change of gender identity means that the counseling viewpoint affirming transition-change (away from biological gender) is allowed, while the counseling viewpoint affirming return-change (to biological gender) is prohibited.

A viewpoint-based restriction on private speech has never been upheld by the Supreme Court or any court. Indeed, a finding of viewpoint discrimination is dispositive. *See Sorrell v. IMS Health*, 131 S. Ct. 2653, 2667 (2011). “It is axiomatic that the government may not regulate speech based on its substantive content or the message it conveys.” *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 828 (1995). “When the government targets not subject matter, but particular views taken by speakers on a subject, the violation of the First Amendment is all the more blatant.” *Id.* at 829. In fact, **viewpoint-based regulations are always unconstitutional**. *See, e.g., Lamb’s Chapel v. Ctr. Moriches Union Free Sch. Dist.*, 508 U.S. 384, 394 (1993) (“the First Amendment forbids the government to regulate speech in ways that favor some viewpoints or ideas at the expense of others”) (quoting *City Council of L.A. v. Taxpayers for Vincent*, 466 U.S. 789, 804 (1984)); *Cornelius v. NAACP Legal Def. & Educ. Fund, Inc.*, 473 U.S. 788, 806 (1985) (“the government violates the First Amendment when it denies access to a speaker solely to suppress the point of view he espouses”); *see also Searcy v. Harris*, 888 F.2d 1314, 1324 (11th Cir. 1989) (the government “may not discriminate between speakers who will speak on the topic merely because it disagrees with their views”), *id.* at 1325 (“**The prohibition against viewpoint discrimination is firmly embedded in first amendment analysis.**” (emphasis added)); Elena Kagan, *Private Speech, Public Purpose: The Role of Governmental Motive in First Amendment Doctrine*, 63 U. Chi. L. Rev. 413, 444 (“the Court almost always rigorously reviews and then invalidates regulations based on viewpoint”).

The ordinance is a textbook example of viewpoint discrimination. On its face, the ordinance purports to allow licensed therapists to discuss the subject of sexual orientation, but explicitly prohibits a particular viewpoint on that subject, namely that unwanted same-sex attraction can be reduced or eliminated to the benefit of the client, if the client so desires. The ordinance defines “conversion therapy” in such a way that it is clear that the City is targeting only one viewpoint, *i.e.*, SOCE that seeks to “eliminate or reduce sexual or romantic attractions or feelings **toward individuals of the same gender or sex.**” (Ordinance PageID 348 (emphasis added).) Similarly, the ordinance encourages counselors to affirm and facilitate same-sex attractions when minor clients are questioning such feelings, but prohibits counselors from affirming minor clients’ desires and goals to change unwanted same-sex attractions, even when the minor clients themselves request and seek that outcome. (*Id.*)

The ordinance also purports to prohibit licensed counselors from engaging in any practice that seeks to change behaviors, gender identity, or gender expression. (*Id.*) But the plain text of the ordinance demonstrates that it only prohibits such counseling for minor clients who wish to reduce or eliminate behaviors, identity, or expressions that differ from their biological sex. (*Id.*) That this is true cannot be questioned because the ordinance specifically exempts counseling that “provides support and assistance to a person undergoing gender transition.” (*Id.*). To undergo “gender transition,” one has to be—at minimum—seeking to change from one gender to the other. **Change is the definition of transition.** See Dictionary.com Unabridged, <https://www.dictionary.com/browse/transition?s=t> (last visited Aug. 26, 2019) (“movement, passage, or **change** from one position, state, stage, subject, concept, etc., to another; **change**” (emphasis added).) So, under the ordinance, if a minor client wants to undergo irreversible hormone therapy or surgery to alter his appearance or genitalia, the City has no problem with a counselor providing counseling to assist

in **that** change. (See, e.g., SAMHSA Rep. PageID 557.) But, if a minor client merely wants to speak with a counselor about unwanted feelings concerning her gender identity or expression, the counselor is absolutely prohibited from engaging in such counseling if it aids the minor in reducing unwanted cross-gender identity, behaviors, or expressions. There can be no question that this is viewpoint discrimination.

The Supreme Court and several other courts have invalidated regulations of professional speech as unconstitutional viewpoint discrimination. See *Sorrell*, 131 S. Ct. 2653 (2011); *Legal Servs. Corp. v. Valazquez*, 531 U.S. 533 (2001); *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002). In these cases, the courts recognized the axiomatic truth that the government is not permitted to impose its viewpoint on speakers, even professional speakers subject to licensing requirements and regulation.

In *Velazquez*, the Court addressed a federal funding limitation on legal aid attorneys that operated in the same viewpoint-based manner as the Ordinances. *Velazquez*, 531 U.S. at 537–38. The law provided that attorneys could not receive funds if they challenged welfare laws. The Court invalidated the law as viewpoint discriminatory, because it had the effect of prohibiting “advice or argumentation that existing welfare laws are unconstitutional or unlawful,” and thereby excluded certain “vital theories and ideas” from the lawyers’ representation. *Id.* at 547–49.

In *Conant*, the Ninth Circuit invalidated a federal policy that punished physicians for communicating with their patients about the benefits or options of marijuana as a potential treatment. *Conant*, 309 F.3d at 633. The Ninth Circuit noted that the doctor-patient relationship is entitled to robust First Amendment protection:

An integral component of the practice of medicine is the communication between a doctor and a patient. **Physicians must be able to speak frankly and openly to patients.** That need has been

recognized by courts through the application of the common law doctor-patient privilege.

Id. at 636 (emphasis added). Far from being a First Amendment orphan, such professional speech “may be entitled to the strongest protection our Constitution has to offer.” *Id.* at 637 (quoting *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995)). The ban impermissibly regulated physician speech based on viewpoint:

The government’s policy in this case seeks to punish physicians on the basis of the content of doctor-patient communications. Only doctor-patient conversations that include discussions of the medical use of marijuana trigger the policy. Moreover, the **policy does not merely prohibit the discussion of marijuana; it condemns expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient.** Such condemnation of particular views is especially troubling in the First Amendment context.

Id. at 637–38 (emphasis added). The court rejected as inadequate the government’s justification that the policy prevented clients from engaging in harmful behavior, and permanently enjoined enforcement of the policy. *Id.* at 638–39.

The ordinance here operates almost identically to the federal policy enjoined in *Conant*. Just as the policy in *Conant* prohibited physicians from speaking about the benefits of marijuana to a suffering patient, so does the ordinance prohibit counselors from speaking about the potential for reduction or elimination of unwanted same-sex attractions, or desires to “transition to another gender” (or de-transition to biological sex) that might benefit a client distressed by the unwanted desires. In both cases, the laws express a preference for the message the government approves and disdain attached to punishment for the viewpoint the government abhors. As was true of the law in *Conant*, the ordinance here should be invalidated as unconstitutional viewpoint discrimination.

It is not enough that the ordinance purports to protect a therapist’s right to recommend or refer clients out for SOCE. (Ordinance PageID 347.) In reality, as soon as a therapist informs a

client that the talk therapy recommended by the therapist as beneficial and good is nonetheless illegal, the credibility of the therapist's viewpoint is immediately undermined, to the injury of the therapist's reputation and, more importantly, the therapeutic alliance. To be sure, this undermining of the therapist's viewpoint is intended, and intentionally discriminatory.

C. PLAINTIFFS ARE ENTITLED TO JUDGMENT AS A MATTER OF LAW ON THEIR PRIOR RESTRAINT, VAGUENESS, AND OVERBREADTH CLAIMS.

Plaintiffs are entitled to judgment as a matter of law on their vagueness, overbreadth, and prior restraint claims on the legal grounds presented in their MPI at 20–22 and R&R Objs. Resp. at 38, and as concluded by the Magistrate in the MPI R&R at 30–32.

II. PLAINTIFFS ARE ENTITLED TO JUDGMENT AS A MATTER OF LAW ON THEIR IMPLIED PREEMPTION CLAIM.

As shown in Plaintiffs' MPI briefing, the Tampa ordinance is *ultra vires* and void *ab initio* as legislation on a subject matter impliedly preempted to the State of Florida. (MPI 22–24; MTD Resp./MPI Reply 40–43.) The proper inquiry is whether the State has “preempted **a particular subject area**,” not one individual form of counseling. *Sarasota Alliance For Fair Elections, Inc. v. Browning*, 28 So.3d 880, 886 (Fla. 2010) (emphasis added)). Here, the State of Florida's regulatory scheme, which covers all licensed medical and mental health professionals in the State, is pervasive and evidences an intent to be the sole regulator of these licensed professionals in the State. Tampa's ordinance unlawfully invades Florida's pervasive regulatory scheme.

Florida Statutes Chapter 456 sets forth the general provisions related to the regulation and licensure of health professions and occupations. Specifically, in Fla. Stat. § 456.003(2)(b) the Legislature identified the absence of local regulation as a justification for the State to authorize the **State** Department of Health to establish boards and regulatory bodies to ensure that such professions are regulated to protect the health, safety and welfare of the public:

(2) The Legislature further believes that such **professions shall be regulated** only for the preservation of the health, safety, and welfare of the public **under the police powers of the state**. Such professions shall be regulated when:

....

(b) **The public is not effectively protected by other means, including, but not limited to**, other state statutes, **local ordinances**, or federal legislation.

Fla. Stat. § 456.003. This statement of legislative intent justifies the state's entry into, and occupation of, the field of health professional regulation, because no preexisting local ordinances were there to protect the public. It does not invite Florida cities to subsequently enter the field with their own regulations.

Chapter 491 more specifically regulates professionals in clinical social work, marriage and family therapy, and mental health counseling. For example, **§ 491.003 defines** the “practice of marriage and family therapy,” **identifies** who “[m]arriage and family therapy may be rendered to,” and **restricts** the “use of specific methods, techniques, or modalities within the practice of marriage and family therapy . . . to marriage and family therapists appropriately trained in the use of such methods, techniques, or modalities.” Fla. Stat. § 491.003(8). The section similarly regulates the practices of clinical social work and mental health counseling.

Section 491.004 creates within the State Department of Health the **Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling** (the “State Board”) composed of nine members, **six of which must be licensed professionals in the three practice fields**. Fla. Stat. § 491.004(1), (2). The section also grants rulemaking authority to the Board to implement Chapter 491. Fla. Stat. § 491.004(5).

Section 491.005 imposes **licensure requirements** for clinical social work, marriage and family therapy, and mental health counseling professionals, **including requirements for**

education, experience, passage of a “theory and practice examination,” and “knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.” Fla. Stat. § 491.005(1), (3), (4).

Section 491.009 specifies **grounds for discipline** of licensed clinical social work, marriage and family therapy, and mental health counseling professionals, including “**False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed,**” and “**Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance,**” including the undertaking of activities for which the licensee, registered intern, or certificateholder is not qualified by training or experience.” Fla. Stat. § 491.009(1)(d), (r).

Florida Administrative Code Subtitle 64B4 contains the rules implemented by the State Board to implement Fla. Stat. Ch. 491. For example, § 64B4-3.003 specifies the respective “**theory and practice**” licensure examinations to be administered to social work, marriage and family therapy, and mental health counseling professionals, such as the “**examination developed by the Examination Advisory Committee of the Association of Marital and Family Therapy Regulatory Board (AMFTRB)**” for marriage and family therapists. F.A.C. § 64B4-3.003(2)(c).

Section 64B4-5.001 provides for the **determination of violations and imposition of discipline** on the grounds provided by Fla. Stat. § 491.009, such as “False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed,” and “Failing to meet the MINIMUM standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee is not qualified by

training or experience.” F.A.C. § 64B4-5.001(1)(d), (s). Such **determinations of violations and imposition of discipline** against licensed social work, marriage and family therapy, and mental health counseling professionals are made **by the State Board, six members of which are licensed professionals** in the respective fields.

Section 64B4-3.0035 additionally specifies how the three types of professionals “shall demonstrate knowledge of the laws and rules for licensure:”

(1) An applicant shall complete an approved course consisting of a minimum of eight (8) hours which shall include the following subject areas:

(a) **Chapter 456, Part II, F.S.**, (Regulation of Professions and Occupations, General Provisions)

(b) **Chapter 90.503, F.S.**, (Psychotherapist-Patient Privilege)

(c) **Chapter 394, F.S.**, (Part I Florida Mental Health Act)

(d) **Chapter 397, F.S.**

(e) **Chapters 415 and 39, F.S.**, (Protection from Abuse, Neglect and Exploitation)

(f) **Chapter 491, F.S.**, (Clinical, Counseling and Psychotherapy Services)

(g) **Chapter 64B4, F.A.C.**, (Rules of the Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling)

(2) **The laws and rules course must provide integration of the above subject areas into the competencies required for clinical practice and must include interactive discussion of clinical case examples applying the laws and rules that govern the appropriate clinical practice.**

No local ordinances are mentioned in the extensive requirements for knowledge of the laws and rules, because there is no room for local ordinances in the state statutory scheme.

The foregoing regulation of licensed health providers in general, and licensed mental health providers specifically, including education, experience, licensure, practice, and discipline, administered by a state board of licensed professionals, is pervasive, and implies an intent by the Florida Legislature to occupy the field to the exclusion of local regulation.

III. PLAINTIFFS SATISFY ALL FACTORS FOR PERMANENT INJUNCTIVE RELIEF.

In the Eleventh Circuit, “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 County Sch. Dist.*, 872 F.3d 1209, 1229 (11th Cir. 2017). As shown in Plaintiffs’ MPI briefing, Plaintiffs satisfy these factors. (MPI 24–25; MTD Resp./MPI Reply 27–30; R&R Objs. Resp. 41–43.)

CONCLUSION

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

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CERTIFICATE OF SERVICE

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

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

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.	)	
	)	

**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,¹ 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).

¹ 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.² (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

² 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).³) 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).⁴

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

³ 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”).)

⁴ 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).⁵)

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.

⁵ 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.

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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.

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VAZZO, *etc., et al.* v. CITY OF TAMPA, FLORIDA

CERTIFICATE OF SERVICE

I hereby certify that, on this February 28, 2020, a copy of the foregoing Plaintiffs–Appellees’ Supplemental Appendix, Volumes I—IV, was electronically filed through the Court’s ECF system, and that I also provided a copy by e-mail to the following:

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