No. 19-2064

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CHRISTOPHER DOYLE, LPC, LCPC, individually and on behalf of his clients,
Plaintiff – Appellant,
v.
LAWRENCE J. HOGAN, JR., Governor of the State of Maryland,
in his official capacity;
BRIAN E. FROSH, Attorney General of the State of Maryland,
in his official capacity,
Defendants - Appellees

On Appeal from the United States District Court
for the District of Maryland
In Case No. 1:19-cv-00190-DKC before the Honorable Deborah K. Chasanow

JOINT APPENDIX - VOLUME II

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SB 1028

Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Third Reader

Senate Bill 1028 (Senator Madaleno, *et al.*)

Education, Health, and Environmental Affairs Health and Government Operations

Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)

This bill prohibits specified mental health or child care practitioners from engaging in "conversion therapy" with a minor. A violation of this prohibition is considered unprofessional conduct and must be subject to discipline by the appropriate licensing or certifying board. Additionally, the bill prohibits the use of State funds to (1) conduct or refer an individual to receive conversion therapy; (2) provide health coverage for conversion therapy; or (3) provide a grant to, or contract with, any entity that conducts or refers an individual to receive conversion therapy. The Maryland Department of Health (MDH) must adopt implementing regulations.

Fiscal Summary

State Effect: The bill is not expected to materially affect State finances or operations, as discussed below.

Local Effect: The bill is not expected to materially affect local finances or operations, as discussed below.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Conversion therapy" means a practice or treatment by a mental health or child care practitioner that seeks to change an individual's sexual orientation or gender identity, and includes any effort to change the behavioral expression of an individual's sexual orientation; change gender expression; or eliminate or reduce sexual or

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romantic attractions or feelings toward individuals of the same gender. The definition does not include specified practices, including sexual-orientation neutral interventions to prevent or address unlawful conduct or unsafe sexual practices and that do not seek to change sexual orientation or gender identity.

"Mental health or child care practitioner" means a practitioner licensed or certified by the State Board of Physicians; the State Board of Professional Counselors and Therapists; the State Board of Examiners of Psychologists; the State Board of Social Work Examiners; and the State Board for Certification of Residential Child Care Program Professionals. The definition also includes any other practitioner who is licensed or certified to provide counseling by the practitioner's board.

Current Law/Background: According to a January 2018 report from The Williams Institute at the University of California Los Angeles School of Law, approximately 698,000 lesbian, gay, bisexual, or transgender (LGBT) adults have received conversion therapy in the United States, including about 350,000 LGBT adults who received treatment as adolescents. Additionally, approximately 20,000 LGBT youth (ages 13 to 17) are estimated to receive conversion therapy from a licensed health care professional before the age of 18.

According to The Williams Institute, conversion therapy has been practiced in the United States for over a century. Conversion therapy involves a range of techniques; talk therapy is the most common technique, but other more physical treatments are also used (*e.g.*, aversion treatments). Several professional associations, including the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics, have issued statements opposing the use of conversion therapy.

A federal bill, the Therapeutic Fraud Prevention Act, was introduced in April 2017. The bill prohibits conversion therapy from being provided in exchange for monetary compensation and prohibits associated advertisements.

According to the Movement Advancement Project, as of February 2018, nine states (California, Connecticut, Illinois, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont) and the District of Columbia have banned conversion therapy for minors.

State Fiscal Effect: The Department of Budget and Management advises that the State Employee and Retiree Health and Welfare Benefits Program does not cover conversion therapy services. Medicaid also does not cover these services.

The State Board of Physicians advises that it has not received complaints regarding conversion therapy, but that if such a complaint was received, the board would investigate

the complaint as a possible standard of care violation through the board's disciplinary proceedings (which includes peer review procedures). The State Board of Professional Counselors and Therapists also advises that the board has not received complaints regarding this practice, although it is not specifically prohibited by the Maryland Professional Counselors and Therapists Act or board regulations.

Several health occupations boards, including the State Board of Physicians, the State Board of Professional Counselors and Therapists, the State Board of Examiners of Psychologists, and the State Board of Social Work Examiners, are authorized to impose disciplinary fines in addition to or in lieu of certain disciplinary action. Such fines are remitted to the general fund. Thus, to the extent these health occupations boards receive complaints and impose disciplinary fines against licensees as a result of the bill, general fund revenues may increase minimally. Any additional disciplinary proceedings can likely be handled with existing resources.

MDH can adopt implementing regulations with existing resources.

Local Fiscal Effect: The Maryland Association of County Health Officers advises that local health departments (LHDs) do not provide conversion therapy as it is not a recommended or accepted practice. Thus, the bill does not affect LHD finances or operations.

Small Business Effect: Potential meaningful for mental health or child care practitioners that offer conversion therapy. The bill explicitly prohibits the practice of conversion therapy with minors under State law and subjects specified practitioners to discipline for the practice by the appropriate licensing or certifying board. The bill also prohibits the award of State funds or contracts to entities that provide or refer individuals for such services.

Additional Information

Prior Introductions: None.

Cross File: HB 902 (Delegate Cullison, *et al.*) - Health and Government Operations.

Information Source(s): Maryland Association of County Health Officers; Maryland Commission on Civil Rights; Maryland State Department of Education; Department of Budget and Management; Maryland Department of Health; Department of Juvenile Services; The Williams Institute; The Movement Advancement Project; Department of Legislative Services

Fiscal Note History: First Reader - February 27, 2018
md/jc Third Reader - March 30, 2018

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CONVERSION THERAPY AND LGBT YOUTH

The Williams Institute
UCLA SCHOOL OF LAW

Christy Mallory, Taylor N.T. Brown and Kerith J. Conron

January 2018

EXECUTIVE SUMMARY

Conversion therapy is treatment grounded in the belief that being LGBT is abnormal. It is intended to change the sexual orientation, gender identity, or gender expression of LGBT people.[1] Conversion therapy is practiced by some licensed professionals in the context of providing health care and by some clergy or other spiritual advisors in the context of religious practice.[2] Efforts to change someone's sexual orientation or gender identity are associated with poor mental health,[3] including suicidality.[4] To date, nine states, the District of Columbia, and 32 localities have banned health care professionals from using conversion therapy on youth.

The Williams Institute estimates that:

- 698,000 LGBT adults (ages 18-59)[5] in the U.S. have received conversion therapy, including about 350,000 LGBT adults who received treatment as adolescents.[6]
- 20,000 LGBT youth (ages 13-17) will receive conversion therapy from a licensed health care professional before they reach the age of 18 in the 41 states that currently do not ban the practice.[7]
- 6,000 LGBT youth (ages 13-17) who live in states that ban conversion therapy would have received such therapy from a licensed health care professional before age 18 if their state had not banned the practice.[8]
- 57,000 youth (ages 13-17) across all states will receive conversion therapy from religious or spiritual advisors before they reach the age of 18.[9]

HISTORY

Conversion therapy has been practiced in the U.S. for over a century. Academic literature has documented instances of conversion therapy being used as early as the 1890s and continuing through the present day.[10] Throughout the history of conversion therapy, a range of techniques have been used by both health care professionals and religious figures seeking to change people's sexual orientation or gender identity. Currently, talk therapy is the most commonly used therapy technique.[11] Some practitioners have also used "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."[12] Other practitioners have used non-aversive techniques such as attempting to "change

thought patterns by reframing desires, redirecting thoughts, or using hypnosis."[13]

An estimated 698,000 LGBT adults in the U.S have received conversion therapy either from a licensed professional or a religious advisor or from both at some point in their lives,[14] including about 350,000 LGBT adults who received conversion therapy as adolescents.[15]

CURRENT PERSPECTIVES

Professional Health Associations

A number of prominent national professional health associations—including the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics, among others—have issued public statements opposing the use of conversion therapy because it is harmful and ineffective.[16] Several of these associations have called on Congress and state legislatures to pass laws that ban conversion therapy. For example, the CEO of the American Counseling Association (ACA) submitted testimony to the Illinois House and Senate in support of the state's conversion therapy ban bill in 2015.[17] In addition, ACA members sent 79 letters to the Governor and 84 letters to state legislators in support of the bill.[18] Also, several professional health associations have endorsed the Therapeutic Fraud Prevention Act, a federal bill that would prohibit the practice of conversion therapy, including the National Association of School Psychologists, the American Psychoanalytic Association, the American Counseling Association, and the American Academy of Pediatrics.[19]

Public Opinion

Three recent public opinion polls found majority support for ending the use of conversion therapy on youth. A 2017 Gravis Marketing poll found that 71% of Florida residents believed that the use of conversion therapy on youth should be illegal.[20] A 2016 Gravis Marketing poll similarly found that 64% of Virginia residents believed that the use of conversion therapy on youth should be illegal.[21] Another 2016 poll conducted by the Center for Civil Policy similarly found that 60% of New Mexico respondents supported a legal ban on the use of conversion therapy on youth.[22] Polling also indicates that many people do not think conversion therapy is effective; only 8% of respondents to a 2014 national poll said they thought conversion therapy could change a person's sexual orientation from gay to straight.[23]

CURRENT LAWS

Conversion Therapy by Licensed Health Care Professionals

As of January 2018, nine states and the District of Columbia had passed statutes limiting the use of conversion therapy: California, Connecticut, D.C., Illinois, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont.[24] The laws protect youth under age 18 from receiving conversion therapy from licensed mental health care[25] providers and, in some states, other individuals who perform conversion therapy services in exchange for payment.[26] California was the first state to pass a conversion therapy ban in

2012.[27] Four states—Connecticut, Nevada, New Mexico, and Rhode Island—passed bans in 2017.[28] While more limited in reach than the statutory bans, a gubernatorial executive order in New York prohibits the state's Medicaid program and private health insurers from providing coverage for conversion therapy on youth and prohibits facilities under the State Division of Mental Health from performing conversion therapy on youth.[29] In addition, 32 localities in states without statewide bans have passed bans at the local level,[30] over half (19) of these localities are in Florida.[31]

All of the state statutory bans allow licensing entities to discipline health care providers who use conversion therapy on youth under age 18.[32] Under Connecticut and Illinois laws, the use of conversion therapy on youth is also considered an unfair business practice and the laws allow for enforcement and penalties consistent with other state laws against such practices.[33] In addition, in 2015, a New Jersey court held that providing conversion therapy in exchange for payment constitutes a fraudulent business practice, regardless of whether it is used on youth or adults.[34]

An estimated 20,000 LGBT youth (ages 13-17) will receive conversion therapy from a licensed health care professional before they reach the age of 18 in the 41 states that currently do not ban the practice, unless additional states pass conversion therapy bans.[35] An estimated 6,000 LGBT youth (ages 13-17) who live in states with conversion therapy bans would have received such therapy from a licensed health care professional before age 18 if their state had not banned the practice.[36]

More states are expected to consider conversion therapy bans in 2018.[37] In addition, members of Congress have introduced federal legislation aimed at ending conversion therapy. The Therapeutic Fraud Prevention Act,[38] introduced in both the House and Senate in 2017, would classify conversion therapy provided in exchange for payment as a form of consumer fraud.[39] The law would allow state attorneys general and the Federal Trade Commission to bring enforcement actions against individuals who are providing conversion therapy for payment or advertising such services.[40]

Conversion Therapy by Religious and Spiritual Advisors

The state statutory conversion therapy bans apply to licensed mental health care providers and sometimes to any others who seek to provide conversion therapy in exchange for payment.[41] The laws generally do not apply to religious or spiritual advisors who engage in sexual orientation or gender identity change efforts within their pastoral or religious capacity. In most states with bans (California, D.C., Nevada, New Mexico, Oregon, Rhode Island, and Vermont[42]), this means that any individuals (including licensed professionals) may engage in conversion therapy as long as they are acting as clergy or religious counselors and they do not hold themselves out as acting pursuant to a professional license. In states with bans on providing conversion therapy in exchange for payment (Connecticut, Illinois, and New Jersey[43]), religious or spiritual advisors acting in a pastoral or religious capacity may continue to provide conversion therapy as long as they are not acting pursuant to a professional license and they do not accept payment for their services.

These exclusions for therapy provided by religious or spiritual advisors leave many youth vulnerable to conversion counseling even in states with bans. An estimated 57,000 youth (ages 13-17) across all states will receive conversion therapy from religious or spiritual advisors before they reach the age of 18.[44]

ENDNOTES

[1] JUDITH M. GLASSGOLD ET AL., AM. PSYCH. ASSOC., REPORT OF THE AM. PSYCH. ASSOC. TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 22 (2009).

[2] Susan L. Morrow & A. Lee Beckstead, *Conversion Therapies for Same-Sex Attracted Clients in Religious Conflict: Context, Predisposing Factors, Experiences, and Implications for Therapy*, 32 COUNSELING PSYCHOLOGIST 641, 642 (2004).

[3] *E.g.*, Annesa Flentje, Nicholas C. Heck & Bryan N. Cochran, *Sexual Reorientation Therapy Interventions: Perspectives of Ex-Ex-Gay Individuals*, 17 J. GAY & LESBIAN MENTAL HEALTH 256 (2013); Elizabeth M. Weiss et al., *A Qualitative Study of Ex-Gay and Ex-Ex-Gay Experiences*, 14 J. GAY & LESBIAN MENTAL HEALTH 291 (2010); Ariel Shidlo & Michael Schroeder, *Changing Sexual Orientation: A Consumer's Report*, 33 PROF. PSYCH.: RESEARCH & PRACTICE 249 (2002).

[4] SANDY E. JAMES ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2016).

[5] 698,000 US LGBT adults ages 18 to 59 are estimated to have received treatment to change their sexual orientation or gender identity [range 572,000 to 857,000]. This figure was calculated by adding estimates for LGB and transgender adults. In order to determine an estimate for the number of LGB adults who have received conversion therapy, we started with the proportion of LGB adults ages 18 to 59 who report having received treatment to change their sexual orientation (6.7%) from the Generations Study, a national probability study of LGB individuals supported by the Eunice Kennedy Shriver National Institute of Child Health & Human Development of the National Institutes of Health under Award Number R01HD078526 (Ilan H. Meyer, PI). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The proportion who received conversion therapy, across three age cohorts (18-25, 34-41, and 52-59), where receipt of conversion therapy did not statistically significantly differ across these age cohorts, is assumed to be consistent for those ages 26 to 33 and 42 to 51 (Williams Institute unpublished analyses). That proportion was then multiplied by the proportion of adults ages 18 to 59 who identify as LGBT (5.29%) in the 2015-2017 Gallup Daily Tracking Survey (Williams Institute unpublished analyses) and the proportion of LGBT individuals ages 18 to 59 who are cisgender (87.7%) among LGBT-identified respondents to the 2014-2015 BRFSS (Williams Institute unpublished analyses), and then applied to the number of adults ages 18 to 59 in the U.S. (180,757,997), according to 2016 population estimates from the 2010 U.S. Census. For total 18-59 population estimates: search American FactFinder, (last visited Dec. 15, 2017) (select advanced search, enter "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016" under topic or table name, and select "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016" 2016 Population Estimates). The same steps were followed with 95% confidence intervals to calculate a range for each estimate.

In order to determine an estimate for the number of transgender adults who have received conversion therapy, we started with the proportion of transgender adults who report that one or more professionals tried to make them identify only with their sex assigned at birth or try to stop them from being transgender (13.0%), as observed in the U.S. Transgender Survey—the largest purposive sample study of transgender adults to date and reported in JAMES ET AL., *supra* note 4. The proportion who received conversion therapy was multiplied by the proportion of adults ages 18 and older who are estimated to be transgender (0.58%) and then applied to the number of adults ages 18 to 59 in the U.S. (180,757,997). This estimate is likely to be somewhat conservative given that slightly larger proportions of the population identify as transgender among younger age cohorts. For transgender population estimates see ANDREW R. FLORES ET AL., THE WILLIAMS INSTITUTE, HOW MANY ADULTS IDENTIFY AS TRANSGENDER IN THE UNITED STATES? (2016).

[6] Among adults who have received conversion therapy, approximately 49.9% of LGB adults in the Generations Study and 51% of transgender adults in the U.S. Trans Survey are estimated to have received treatment at or before the age of 18. These proportions are applied to the number of LGB and transgender adults ages 18 to 59 who are estimated to have received conversion therapy, as described above. Thus, we estimate that 350,000 LGBT adults [range 287,000 to 429,000] received treatment as adolescents. We believe that our estimate of conversion therapy among cisgender LGB adolescents is, if anything, an underestimate because the Generations Study survey asked about age at which last conversion therapy was received versus the age at which conversion therapy first began. It is possible that some youth received conversion therapy that did not end until age 18 or later and that these individuals are missing in our estimates of the percentage of LGB youth who received conversion therapy. This would lead to an underestimate of the number of current LGB youth currently at risk of conversion therapy.

[7] 20,000 LGBT youth ages 13 to 17 [range 13,000 to 32,000] are estimated to live in states without state-wide conversion therapy bans and will receive conversion therapy from a professional before the age of 18. This figure was calculated by adding estimates for LGB and transgender youth. In order to determine an estimate for the number of LGB youth who will receive conversion therapy before age 18, we multiplied the proportion of LGB adults ages 18 to 59 who report having received treatment from a health care professional to change their sexual orientation that began and ended before the age of 18 (1.2%) from the Generations Study (Williams Institute unpublished analyses) by the proportion of youth in grades 9 through 12 who identify as LGB (8.0%) in the 2015 YRBS and by the proportion of LGB young adults ages 18 to 24 who are cisgender (95.7%) among LGB-identified respondents to the 2014-2015 BRFSS

[14] For methodology, see note 5, *supra*.

[15] For methodology, see note 6, *supra*.

[16] American professional organizations that have issued statements opposing the use of conversion therapy on youth include: American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Association for Marriage and Family Therapy, American College of Physicians, American Counseling Association, American Medical Association, American School Health Association, American Psychoanalytic Association, American Psychiatric Association, American Psychological Association, American School Counselor Association, and National Association of Social Workers Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957 (2012); Am. Acad. of Pediatrics, *Homosexuality and Adolescence*, 92 PEDIATRICS 631 (1993); Am. Assoc. for Marriage and Family Therapy, Positions on Couples and Families: Reparative/Conversion Therapy (Mar. 25, 2009), http://www.aamft.org/iMIS15/AAMFT/Content/about_aamft/position_on_couples.aspx; Hilary Daniel & Renee Butkis, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 ANNALS OF INTERNAL MEDICINE 135 (2015); Am. Counseling Assoc., Ethical Issues Related to Conversion or Reparative Therapy (Jan. 16, 2013), https://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy; Am. Med. Assoc., Policies on Lesbian, Gay, Bisexual, Transgender & Queer (LGBTQ) Issues, H-160.991 Health Care Needs of the Homosexual Population, https://www.ama-assn.org/delivering-care/policies-lesbian-gay-bisexual-transgender-queer-lgbtq-issues (last visited Dec. 1, 2017); Am. Psychoanalytic Assoc., Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression (June 2012), *available at* http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender; Am. Psychiatric Assoc.; Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies) (2000); Barry S. Anton, *Proceedings of the Am. Psychological Assoc. for the Legislative Year 2009: Minutes of the Annual Meeting of the Council of Representatives and Minutes of the Meetings of the Board of Directors*, 65 AM. PSYCHOLOGIST 385 (2010); Am. Psychological Assoc., Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (2009); Am. School Counselor Assoc., The Professional School Counselor and LGBTQ Youth (revised 2016), *available at* https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf; Nat'l Assoc. of Social Workers, Nat'l Comm. on Lesbian, Gay, Bisexual, and Transgender Issues, Position Statement: Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons (2015), https://www.socialworkers.org/LinkClick.aspx?fileticket=yH3UsGQQmYI%3d&portalid=0;

[17] Press Release, Am. Counseling Assoc., ACA Advocacy Efforts Assist in Prohibiting 'Conversion Therapy' for Minors in Illinois (Aug. 21, 2015), *available at* https://www.counseling.org/news/news-release-archives/by-year/2015/2015/08/21/aca-advocacy-efforts-assist-in-prohibiting-conversion-therapy-for-minors-in-illinois.

[18] *Id.*

[19] Press Release, U.S. Rep. Ted Lieu, Rep. Lieu Introduces the Therapeutic Fraud Prevention Act of 2017, https://lieu.house.gov/media-center/press-releases/rep-lieu-introduces-therapeutic-fraud-prevention-act-2017.

[20] Doug Kaplan, *Political Climate Forecast for Florida in 2018 Looks Positive for John Morgan, Negative for Gay Conversion Therapy, and Uncertain on the Future of American Involvement in Syria*, ORLANDO POLITICAL OBSERVER, Apr. 3, 2017, http://orlando-politics.com/2017/04/13/political-climate-forecast-for-florida-in-2018-looks-positive-for-john-morgan-negative-for-gay-conversion-therapy-and-uncertain-on-the-future-of-american-involvement-in-syria/.

[21] Gravis Marketing, Virginia Election Poll (May 26, 2017), http://www.gravismarketing.com/polling-and-market-research/virginia-election-poll052016/.

[22] Ctr. for Civil Policy, 2017 Landscape Poll (Jan. 15, 2017), https://civicpolicy.com/2017-landscape-poll/.

[23] Peter Moore, Only 8% of Americans Think Gay Conversion Therapy Works, YOUGOV.COM, June 12, 2014, *available at* https://today.yougov.com/news/2014/06/12/gay-conversion-therapy/.

[24] CAL. BUS. & PROF. CODE § 865 (2017); 2017 Conn. Pub. Acts 5 (Reg. Sess.); D.C. CODE § 7-1231.14 (2017); 405 ILL. COMP. STAT. 48/1 (2017); S.B. 201, 79th Leg., Reg. Sess. (Nev. 2017); N.J. REV. STAT. § 45:1-54 (2016); S.B. 121, 2017 Leg., Reg. Sess. (N.M. 2017); OR. REV. STAT. §§ 675.070; 675.300; 675.336; 675.540; 675.745 (2016); H. 5277, 2017 Gen. Assem., Reg. Sess. (R.I. 2017); VT. STAT. ANN. tit. 18, § 8351; VT. STAT. ANN. tit. 26, §§ 1354(a), 1842(b), 3016, 3210(a), 3271(a), 4042(a), 4062(a), 4132(a).

[25] Some laws apply to other types of health professionals as well. For example, New Mexico's conversion therapy ban applies to nurses and doctors of osteopathic medicine. S.B. 121, 2017 Leg., Reg. Sess. (N.M. 2017)

[26] See note 24, *supra*.

[27] CAL. BUS. & PROF. CODE § 865.

[28] 2017 Conn. Pub. Acts 5 (Reg. Sess.); S.B. 201, 79th Leg., Reg. Sess. (Nev. 2017); S.B. 121, 2017 Leg., Reg. Sess. (N.M. 2017); H. 5277, 2017 Gen. Assem., Reg. Sess. (R.I. 2017).

[29] Press Release, Gov. Andrew M. Cuomo, Governor Cuomo Announces Executive Actions Banning Coverage of Conversion Therapy (Feb. 6, 2016), *available at* https://www.governor.ny.gov/news/governor-cuomo-announces-executive-actions-banning-coverage-conversion-therapy.

[30] In chronological order of passage: Cincinnati, Ohio; Miami Beach, Florida; Seattle, Washington; Wilton Manors, Florida; Miami, Florida; North Bay Village, Florida; West Palm Beach, Florida; Bay Harbor Islands, Florida; Pittsburgh, Pennsylvania; Lake Worth, Florida; Boynton Beach, Florida; El Portal, Florida; Toledo, Ohio; Key West, Florida; Columbus, Ohio; Tampa, Florida; Delray Beach, Florida; Riviera Beach, Florida; Philadelphia, Pennsylvania; Wellington, Florida; Dayton, Ohio; Allentown, Pennsylvania; Greenacres, Florida; Pima County, Arizona; Athens, Ohio; Oakland Park, Florida; Boca Raton, Florida; New York City, New York; Doylestown, Pennsylvania; Reading, Pennsylvania; Palm Beach County, Florida; and Broward County, Florida. Movement Advancement Project, Conversion Therapy Laws, http://www.lgbtmap.org/equality-maps/conversion_therapy (last visited Dec. 4, 2017); North Bay Village, Fla., Ord. No. 2017-004 (enacted Mar. 14, 2017); DELRAY BEACH, FLA., CODE § 133.02 (2017); John McDonald, *Oakland Park Bans Conversion Therapy*, SOUTHFLORIDAGAYNEW.COM, Oct. 19, 2017, http://southfloridagaynews.com/Local/oakland-park-bans-conversion-therapy.html; Brittany Wallman, *Gay-Conversion Therapy Increasingly Outlawed across South Florida*, SUN-SENTINEL.COM, Oct. 13, 2017, http://www.sun-sentinel.com/local/broward/fl-reg-conversion-therapy-ban-20171012-story.html; Skyler Swisher, *Florida County Bans Therapy to Change Kids' Sexual Orientation*, SUN-SENTINEL.COM, Dec. 19, 2017, http://www.sun-sentinel.com/local/palm-beach/fl-reg-conversion-therapy-finalized-20171219-story.html; Ted Scouten, *Broward Bans Forced Conversion Therapy for Gay, Transgender Children*, MIAMI.CBSLOCAL.COM, Jan. 9, 2018, http://miami.cbslocal.com/2018/01/09/conversion-therapy-transgender-gay-children/.

[31] *Id.*

[32] See note 24, *supra*.

[33] 2017 Conn. Pub. Acts 5 (Reg. Sess.); 405 ILL. COMP. STAT. 48/1 (2017).

[34] Ferguson v. JONAH, No. L-5473-12 (N.J. Sup. Ct. Dec. 18, 2015).

[35] For methodology, see note 7.

[36] For methodology, see note 8.

[37] *E.g.* H.B. 717, 2018 Leg., Reg. Sess. (Fla. 2017); S.B. 270, 29th Leg., Reg. Sess. (Haw. 2017).

[38] H.R. 2119, 115th Cong. (2017); S. 928, 115th Cong. (2017).

[39] *Id.*

[40] *Id.*

[41] See note 24, *supra*.

[42] See note 24, *supra*.

[43] See notes 24, 33, and 34, *supra*.

[44] For methodology, see note 9, *supra*.

[45] Am. Psych. Assoc., Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts, http://www.apa.org/about/policy/sexual-orientation.aspx (last visited Dec. 18, 2017).

Homosexuality and Adolescence

Committee on Adolescence

The American Academy of Pediatrics issued its first statement on homosexuality and adolescence in 1983. The past decade has witnessed increased awareness of homosexuality, changing attitudes toward this sexual orientation, and the growing impact of the human immunodeficiency virus (HIV). Therefore, an updated statement on homosexuality and adolescence is timely.

Homosexuality is the persistent sexual and emotional attraction to members of one's own gender and is part of the continuum of sexual expression. Many gay and lesbian youths first become aware of and experience their sexuality during adolescence. Therefore, pediatricians who care for teenagers need to understand the unique medical and psychosocial issues facing homosexually oriented youths (see Table 1 for a definition of terms).

ETIOLOGY AND PREVALENCE

Homosexuality has existed in most societies for as long as recorded descriptions of sexual beliefs and practices have been available. Societal attitudes toward homosexuality have had a decisive impact on the extent to which individuals have hidden or made known their sexual orientation.

In 1973, the American Psychiatric Association reclassified homosexuality as a sexual orientation/expression rather than as a mental disorder.[1] The etiology of homosexuality remains unclear, but the current literature and the vast majority of scholars in this field state that one's sexual orientation is not a choice, that is, individuals no more choose to be homosexual than heterosexual.[2,3] However, the expression of sexual behaviors and lifestyle is a choice for all teenagers regardless of sexual orientation.

During the adolescent years, many youths engage in sexual experimentation. Sexual behavior during this period does not predict future sexual orientation. Gay, lesbian, and heterosexual youths may engage in sexual activities with members of the same or opposite sex. Kinsey et al,[4,5] from their studies in the 1930s and 1940s, reported that 37% of men had at least one homosexual experience resulting in orgasm. From the same cohort, Kinsey reported that 4% of women and 10% of men were exclusively homosexual for at least 3 years of their lives. Sorenson[6] surveyed a group of 16- to 19-year-olds and reported that 6% of females and 17% of males had at least one homosexual experience. While the Kinsey data suggest that 4% of adult men and 2% of adult women are exclusively homosexual in their behavior and fantasies, the current prevalence of homosexual behavior and identity among adolescents remains to be defined.

SPECIAL CONCERNS

Gay and lesbian adolescents share many of the developmental tasks of their heterosexual peers. These include establishing a sexual identity and deciding on sexual behaviors, whether choosing to engage in sexual intercourse or to abstain. Due to the seriousness of sexually transmitted diseases (STDs), abstinence should be promoted as the safest choice for all adolescents. However, not all youths will choose abstinence. The current reality is that a large number of adolescents are sexually active. Therefore, all adolescents should receive sexuality education and have access to health care resources. It is important to provide appropriate anticipatory guidance to all youths regardless of their sexual orientation. Physicians must also be aware of the important medical and psychosocial needs of gay and lesbian youths.[7]

HIV

The epidemic of the HIV infection highlights the urgency of making preventive services and medical care available to all adolescents regardless of sexual orientation or activity. Heterosexual and homosexual transmission of HIV infection is well established. The role of injectable drugs of abuse in HIV transmission is also well known.[3,8] Sex between males accounts for about half of the non–transfusion-associated cases of acquired immunodeficiency syndrome (AIDS) among males between the ages of 13 and 19 years.[8] While not all gay adolescents engage in high-risk sex (or even have sex), their vulnerability to HIV infection is well recognized. The pediatrician should encourage adolescents to practice abstinence. However, many will not heed this important message. Thus, practical, specific advice about condom use and other forms of safer sex should be included in all sexuality education and prevention discussions.

Issue of Trust

Quality care can be facilitated if the pediatrician recognizes the specific challenges and rewards of providing services for gay and lesbian adolescents. This care begins with the establishment of trust, respect, and confidentiality between the pediatrician and the adolescent. Many gay and lesbian youths avoid health care or discussion of their sexual orientation out of fear that their sexual orientation will be

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this policy statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations taking into account individual circumstances, may be appropriate.

TABLE 1. Definitions of Terms

Coming out	The acknowledgment of one's homosexuality and the process of sharing that information with others.
Gender identity	The personal sense of one's integral maleness or femaleness; typically occurs by 3 years of age.
Gender role	The public expression of gender identity; the choices and actions that signal to others a person's maleness or femaleness; one's sex role.
Heterosexist bias	The conceptualization of human experience in strictly heterosexual terms and consequently ignoring, invalidating, or derogating homosexual behaviors and sexual orientation.[19]
Homophobia	The irrational fear or hatred of homosexuality, which may be expressed in stereotyping, stigmatization, or social prejudice[18]; it may also be internalized in the form of self-hatred.
In the closet	Nondisclosure or hiding one's sexual orientation from others.
Sexual orientation	The persistent pattern of physical and/or emotional attraction to members of the same or opposite sex. Included in this are homosexuality (same-gender attractions); bisexuality (attractions to members of both genders); and heterosexuality (opposite-gender attractions). The terms preferred by most homosexuals today are lesbian women or gay men.
Transsexual	An individual who believes himself or herself to be of a gender different from his or her assigned biologic gender (gender identity does not match anatomic gender).
Transvestite	An individual who dresses in the clothing of the opposite gender and derives pleasure from this action. This is not indicative of one's sexual orientation.

disclosed to others. The goal of the provider is not to identify all gay and lesbian youths, but to create comfortable environments in which they may seek help and support for appropriate medical care while reserving the right to disclose their sexual identity when ready. Pediatricians who are not comfortable in this regard should be responsible for seeing that such help is made available to the adolescent from another source.

SPECIAL ASPECTS OF CARE

History

A sexual history that does not presume exclusive heterosexuality should be obtained from all adolescents.[3,9] Confidentiality must be emphasized except in cases in which sexual abuse has occurred. It is vital to identify high-risk behavior (anal or vaginal coitus, oral sex, casual and/or multiple sex partners, substance abuse, and others).

Physical Examination

A thorough and sensitive history provides the groundwork for an accurate physical examination for youths who are sexually experienced.[10] Depending on the patient's sexual practices, a careful examination includes assessment of pubertal staging, skin lesions (including cutaneous manifestations of STDs, bruising, and other signs of trauma), lymphadenopathy (including inguinal), and anal pathology (including discharge, venereal warts, herpetic lesions, fissures, and others). Males need evaluation of the penis (ulcers, discharge, skin lesions), scrotum, and prostate (size, tenderness). Females need assessment of their breasts, external genitalia, vagina, cervix, uterus, and adnexa.

Laboratory Studies

All males engaging in sexual intercourse with other males should be routinely screened for STDs, including gonorrhea, syphilis, chlamydia, and enteric pathogens. The oropharynx, rectum, and urethra should be examined and appropriate cultures obtained when indicated.[3,9]

Immunity to hepatitis B virus should be assessed. Immunization is recommended for all sexually active adolescents and should be provided for all males who are having or anticipate having sex with other males.[11] HIV testing with appropriate consent should be offered; this includes counseling before and after voluntary testing.

Women who have sex exclusively with other women have a low incidence of STDs, but can transmit STDs and potentially HIV if one partner is infected. Since lesbian women who engage in unprotected sex with men face risks of both sexually acquired infections and pregnancy, the pediatrician should offer them realistic birth control information and counseling on STD prevention.

PSYCHOSOCIAL ISSUES

The psychosocial problems of gay and lesbian adolescents are primarily the result of societal stigma, hostility, hatred, and isolation.[12] The gravity of these stresses is underscored by current data that document that gay youths account for up to 30% of all completed adolescent suicides.[13] Approximately 30% of a surveyed group of gay and bisexual males have attempted suicide at least once.[14] Adolescents struggling with issues of sexual preference should be reassured that they will gradually form their own identity[15] and that there is no need for premature labeling of one's sexual orientation.[16] A theoretical model of stages for homosexual identity development composed by Troiden[17] is summarized in Table 2. The health care professional should explore each adolescent's perception of homosexuality, and any youth struggling with sexual orientation issues should be offered appropriate referrals to providers and programs that can affirm the adolescent's intrinsic worth regardless of sexual identity. Providers who are unable to be objective because of religious or other personal convictions should refer patients to those who can.

Gay or lesbian youths often encounter considerable difficulties with their families, schools, and communities.[16,18,19] These youths are severely hindered by societal stigmatization and prejudice, limited knowledge of human sexuality, a need for secrecy, a lack of opportunities for open socialization, and limited communication with healthy role models. Subjected to overt rejection and harassment at the hands of family members, peers, school officials, and others

TABLE 2. Stages of Homosexual Identity Formation*

Sensitization	The feeling of differentness as a prepubertal child or adolescent. The first recognition of attraction to members of the same gender before or during puberty.
Sexual identity confusion	Confusion and turmoil stemming from self-awareness of same-gender attractions. Often this first occurs during adolescence. This confusion usually is not so much due to a questioning of one's feelings as it is to the attempt to reconcile the feelings with negative societal stereotypes. The lack of accurate knowledge about homosexuality, the scarcity of positive gay and lesbian role models, and the absence of an opportunity for open discussion and socialization as a gay or lesbian person contribute to this confusion. During this stage the adolescent develops a coping strategy to deal with social stigma.
Sexual identity assumption	The process of acknowledgment and social and sexual exploration of one's own gay or lesbian identity and consideration of homosexuality as a lifestyle option. This stage typically persists for several years during and after late adolescence.
Integration and commitment	The stage at which a gay or lesbian person incorporates his/her homosexual identity into a positive self-acceptance. This gay or lesbian identity is then increasingly and confidently shared with selected others. Many gays and lesbians may never reach this stage; those who do are typically in adulthood when this acceptance occurs.

* From Troiden.[17]

in the community, they may seek, but not find, understanding and acceptance by parents and others. Parents may react with anger, shock, and/or guilt when learning that their child is gay or lesbian.

Peers may engage in cruel name-calling, ostracize, or even physically abuse the identified individual. School and other community figures may resort to ridicule or open taunting, or they may fail to provide support. Such rejection may lead to isolation, runaway behavior, homelessness, domestic violence, depression, suicide, substance abuse, and school or job failure. Heterosexual and/or homosexual promiscuity may occur, including involvement in prostitution (often in runaway youths) as a means to survive. Pediatricians should be aware of these risks and provide or refer such youths for appropriate counseling.

Disclosure

The gay or lesbian adolescent should be allowed to decide when and to whom to disclose his/her sexual identity. In particular, the issue of informing parents should be carefully explored so that the adolescent is not exposed to violence, harassment, or abandonment. Parents and other family members may derive considerable benefit and gain understanding from organizations such as Parents and Friends of Lesbians and Gays (PFLAG).[3,18]

Concept of Therapy

Confusion about sexual orientation is not unusual during adolescence. Counseling may be helpful for young people who are uncertain about their sexual orientation or for those who are uncertain about how to express their sexuality and might profit from an attempt at clarification through a counseling or psychotherapeutic initiative. Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation. While there is no current literature clarifying whether sexual abuse can induce confusion in one's sexual orientation, those with a history of sexual abuse should always receive counseling with appropriate mental health specialists. Therapy may also be helpful in addressing personal, family, and environmental difficulties that are often concomitants of the emerging expression of homosexuality. Family therapy may also be useful and should always be made available to the entire family when major family difficulties are identified by the pediatrician as parents and siblings cope with the potential added strain of disclosure.

SUMMARY OF PHYSICIAN GUIDELINES

Pediatricians should be aware that some of the youths in their care may be homosexual or have concerns about sexual orientation. Caregivers should provide factual, current, nonjudgmental information in a confidential manner. These youths may present to physicians seeking information about homosexuality, STDs, substance abuse, or various psychosocial difficulties. The pediatrician should ensure that each youth receives a thorough medical history and physical examination (including appropriate laboratory tests), as well as STD (including HIV) counseling and, if necessary, appropriate treatment. The health care professional should also be attentive to various potential psychosocial difficulties and offer counseling or refer for counseling when necessary.

The American Academy of Pediatrics reaffirms the physician's responsibility to provide comprehensive health care and guidance for all adolescents, including gay and lesbian adolescents and those young people struggling with issues of sexual orientation. The deadly consequences of AIDS and adolescent suicide underscore the critical need to address and seek to prevent the major physical and mental health problems that confront gay and lesbian youths in their transition to a healthy adulthood.

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Homosexuality and Adolescence
Pediatrics 1993;92;631

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Homosexuality and Adolescence
Pediatrics 1993;92;631

"Reparative" Therapy

Committee on Psychotherapy by Psychiatrists (COPP) Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)

Approved by the Board of Trustees March 2000

Approved by the Assembly May 2000

Preamble

In December of 1998, the Board of Trustees issued a position statement that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation (Appendix 1). In doing so, the APA joined many other professional organizations that either oppose or are critical of "reparative" therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, The American Counseling Association, and the National Association of Social Workers (1). The following Position Statement expands and elaborates upon the statement issued by the Board of Trustees in order to further address public and professional concerns about therapies designed to change a patient's sexual orientation or sexual identity. It augments rather than replaces the 1998 statement.

Position Statement
In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Although there is little scientific data about the patients who have undergone these treatments, it is still possible to evaluate the theories, which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologies homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

Recommendations:
1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when

claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality; it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determines "reparative" therapy's risks versus its benefits.

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2012 - Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression

The American Psychoanalytic Association affirms the right of all people to their sexual orientation, gender identity and gender expression without interference or coercive interventions attempting to change sexual orientation, gender identity or gender expression.

As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to “convert,” “repair,” change or shift an individual’s sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes.

Adopted June 2012. This position statement replaces APsaA’s December 1999 position statement on reparative therapy

EXHIBIT 11

Pan American Health Organization
Regional Office of the World Health Organization

"CURES" FOR AN ILLNESS THAT DOES NOT EXIST

Purported therapies aimed at changing sexual orientation lack medical justification and are ethically unacceptable

Introduction

Countless human beings live their lives surrounded by rejection, maltreatment, and violence for being perceived as "different." Among them, millions are victims of attitudes of mistrust, disdain and hatred because of their sexual orientation. These expressions of homophobia are based on intolerance resulting from blind fanaticism as well as pseudo-scientific views that regard non-heterosexual and non-procreative sexual behavior as "deviation" or the result of a "developmental defect."

Whatever its origins and manifestations, any form of homophobia has negative effects on the affected people, their families and friends, and society at large. There is an abundance of accounts and testimonies of suffering; feelings of guilt and shame; social exclusion; threats and injuries; and persons who have been brutalized and tortured to the point of causing injuries, permanent scars and even death. As a consequence, homphobia represents a public health problem that needs to be addressed energetically.

While every expression of homophobia is regrettable, harms caused by health professionals as a result of ignorance, prejudice, or intolerance are absolutely unacceptable and must be avoided by all means. Not only is it fundamentally important that every person who uses health services be treated with dignity and respect; it is also critical to prevent the application of theories and models that view homosexuality as a "deviation" or a choice that can be modified through "will power" or supposed "therapeutic support".

In several countries of the Americas, there has been evidence of the continued promotion, through supposed "clinics" or individual "therapists," of services aimed at "curing" non-heterosexual orientation, an approach known as "reparative" or "conversion therapy."[1] Worryingly, these services are often provided not just outside the sphere of public attention but in a clandestine manner. From the perspective of professional ethics and human rights protected by regional and universal treaties and conventions such as the American Convention on Human Rights and its Additional Protocol ("Protocol of San Salvador")[2], they represent unjustifiable practices that should be denounced and subject to corresponding sanctions.

Homosexuality as a natural and non-pathological variation

Efforts aimed at changing non-heterosexual sexual orientations lack medical justification since homosexuality cannot be considered a pathological condition.[3] There is a professional consensus that homosexuality represents a natural variation of human sexuality without any intrinsically harmful effect on the health of those concerned or those close to them. In none of its individual manifestations does homosexuality constitute a disorder or an illness, and therefore it requires no cure. For this reason homosexuality was removed

from the relevant systems of classification of diseases several decades ago.[4]

The ineffectiveness and harmfulness of "conversion therapies"

Besides the lack of medical indication, there is no scientific evidence for the effectiveness of sexual re-orientation efforts. While some persons manage to limit the expression of their sexual orientation in terms of conduct, the orientation itself generally appears as an integral personal characteristic that cannot be changed. At the same time, testimonies abound about harms to mental and physical health resulting from the repression of a person's sexual orientation. In 2009, the American Psychological Association conducted a review of 83 cases of people who had been subject to "conversion" interventions.[5] Not only was it impossible to demonstrate changes in subjects' sexual orientation, in addition the study found that the intention to change sexual orientation was linked to depression, anxiety, insomnia, feelings of guilt and shame, and even suicidal ideation and behaviors. In light of this evidence, suggesting to patients that they suffer from a "defect" and that they ought to change constitutes a violation of the first principle of medical ethics: "first, do no harm." It affects the right to personal integrity as well as the right to health, especially in its psychological and moral dimensions.

The long history of psychopathologization

For centuries, left-handed persons suffered because the use of the left hand ("sinister" in Latin) was thought to be associated with disaster. These people were regarded as carriers of misfortune and as having a "constitutional defect." Until relatively recently, there were attempts to "treat" and "correct" this supposed defect, causing suffering, humiliation, learning difficulties and difficulties in adapting to daily life in the affected persons.

Reported violations of personal integrity and other human rights

As an aggravating factor, "conversion therapies" have to be considered threats to the right to personal autonomy and to personal integrity. There are several testimonies from adolescents who have been subject to "reparative" interventions against their will, many times at their families' initiative. In some cases, the victims were interned and deprived of their liberty, sometimes to the extent of being kept in isolation during several months.[6] The testimonies provide accounts of degrading treatment, extreme humiliation, physical violence, aversive conditioning through electric shock or emetic substances, and even sexual harassment and attempts of "reparative rape," especially in the case of lesbian women. Such interventions violate the dignity and human rights of the affected persons, independently of the fact that their "therapeutic" effect is nil or even counterproductive. In these cases, the right to health has not been protected as demanded by the regional and international obligations established through the Protocol of San Salvador and the International Covenant on Economic, Social, and Cultural Rights.

Conclusion

Health professionals who offer "reparative therapies" align themselves with social prejudices and reflect a stark ignorance in matters of sexuality and sexual health. Contrary to what many people believe or assume, there is no reason – with the exception of the stigma resulting from those very prejudices – why homosexual persons should be unable to enjoy a full and satisfying life. The task of health professionals is to not cause harm and to offer support to patients to alleviate their complaints and problems, not to make these more severe. A therapist who classifies non-heterosexual patients as "deviant" not only offends them but also contributes to the aggravation of their problems. "Reparative" or "conversion therapies" have no medical indication and represent a severe threat to the health and human rights of the affected persons. They constitute unjustifiable practices that should be denounced and subject to adequate sanctions and penalties.

Recommendations

To governments:

- Homophobic ill-treatment on the part of health professionals or other members of health care teams violates human rights obligations established through universal and regional treaties. Such treatment is unacceptable and should not be tolerated.
- "Reparative" or "conversion therapies" and the clinics offering them should be reported and subject to adequate sanctions.
- Institutions offering such "treatment" at the margin of the health sector should be viewed as infringing the right to health by assuming a role properly pertaining to the health sector and by causing harm to individual and community well-being.[7]
- Victims of homophobic ill-treatment must be treated in accordance with protocols that support them in the recovery of their dignity and self-esteem. This includes providing them treatment for physical and emotional harm and protecting their human rights, especially the right to life, personal integrity, health, and equality before the law.

To academic institutions:

- Public institutions responsible for training health professionals should include courses on human sexuality and sexual health in their curricula, with a particular focus on respect for diversity and the elimination of attitudes of pathologization, rejection, and hate toward non-heterosexual persons. The participation of the latter in teaching activities contributes to the development of positive role models and to the elimination of common stereotypes about non-heterosexual communities and persons.
- The formation of support groups among faculty and within the student community contributes to reducing isolation and promoting solidarity and relationships of friendship and respect between members of these groups. Better still is the formation of sexual diversity alliances that include heterosexual persons.
- Homophobic harassment or maltreatment on the part of members of the faculty or students is unacceptable and should not be tolerated.

To professional associations:

- Professional associations should disseminate documents and resolutions by national and international institutions and agencies that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation.
- Professional associations should adopt clear and defined positions regarding the protection of human dignity and should define necessary actions for the prevention and control of homophobia as a public health problem that negatively impacts the enjoyment of civil, political, economic, social, and cultural rights.
- The application of so-called "reparative" or "conversion therapies" should be considered fraudulent and as violating the basic principles of medical ethics. Individuals or institutions offering these treatments should be subject to adequate sanctions.

To the media:

- The representation of non-heterosexual groups, populations, or individuals in the media should be based on personal respect, avoiding stereotypes or humor based on mockery, ill-treatment, or violations of dignity or individual or collective well-being.
- Homophobia, in any of its manifestations and expressed by any person, should be exposed as a public health problem and a threat to human dignity and human rights.

- The use of positive images of non-heterosexual persons or groups, far from promoting homosexuality (in virtue of the fact that sexual orientation cannot be changed), contributes to creating a more humane and diversity-friendly outlook, dispelling unfounded fears and promoting feelings of solidarity.
- Publicity that incites homophobic intolerance should be denounced for contributing to the aggravation of a public health problem and threats to the right to life, particularly as it contributes to chronic emotional suffering, physical violence, and hate crimes.
- Advertising by "therapists," "care centers," or any other agent offering services aimed at changing sexual orientation should be considered illegal and should be reported to the relevant authorities.

To civil society organizations:

- Civil society organizations can develop mechanisms of civil vigilance to detect violations of the human rights of non-heterosexual persons and report them to the relevant authorities. They can also help to identify and report persons and institutions involved in the administration of so-called "reparative" or "conversion therapies."
- Existing or emerging self-help groups of relatives or friends of non-heterosexual persons can facilitate the connection to health and social services with the goal of protecting the physical and emotional integrity of ill-treated individuals, in addition to reporting abuse and violence.
- Fostering respectful daily interactions between persons of different sexual orientations is enriching for everyone and promotes harmonic, constructive, salutary, and peaceful ways of living together.

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[1] Human Rights Committee (2008). *Concluding Observations on Ecuador (CCPR/C/ECU/CO/5), paragraph 12.* <http://www2.ohchr.org/english/bodies/hrc/docs/co/CCPR.C.ECU.CO.5.doc>
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[2] The human rights that can be affected by these practices include, among others, the right to life, to personal integrity, to privacy, to equality before the law, to personal liberty, to health, and to benefit from scientific progress.

[3] American Psychiatric Association (2000). *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): Position Statement*. <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200001.aspx>
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[6] Taller de Comunicación Mujer (2008). *Pacto Internacional de Derechos Civiles y Políticos: Informe Sombra*. <http://www.tcmujer.org/pdfs/Informe%20Sombra%202009%20LBT.pdf>
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[7] See General Comment No. 14 by the Committee on Economic, Social, and Cultural Rights with regards to the obligation to respect, protect and comply with human rights obligations on the part of States parties to the International Covenant on Economic, Social, and Cultural Rights.

Journal of the American Academy of Child & Adolescent Psychiatry

Volume 51, Issue 9, September 2012, Pages 957-974

AACAP official action

Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents

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https://doi.org/10.1016/j.jaac.2012.07.004

Children and adolescents who are growing up gay, lesbian, bisexual, gender nonconforming, or gender discordant experience unique developmental challenges. They are at risk for certain mental health problems, many of which are significantly correlated with stigma and prejudice. Mental health professionals have an important role to play in fostering healthy development in this population. Influences on sexual orientation, gender nonconformity, and gender discordance, and their developmental relationships to each other, are reviewed. Practice principles and related issues of cultural competence, research needs, and ethics are discussed.

Previous Next

Key Words

EXHIBIT 13.

Scientific studies demonstrating the healthy, adaptive functioning of the great majority of gay and lesbian adults paved the way toward removal of homosexuality as an illness from the *DSM* in 1973.[1] Homosexuality is now recognized as a nonpathological variant of human sexuality. Although the great majority of gay and lesbian individuals have normal mental health, as a group they experience unique stressors and developmental challenges. Perhaps in part as a consequence of these challenges, adult and adolescent members of sexual minorities (defined below) develop depression, anxiety disorders, substance abuse, and suicidality at rates that are elevated in comparison with those in the general population.[2, 3] Thus, psychosocial distress may account for the different rates in depression, hopelessness, and current suicidality seen between gay, lesbian, and bisexual adolescents and their heterosexual peers.[4] Studies in the U.S. and the Netherlands document this problem continuing into adulthood, and show a significant association among stigma, prejudice, discrimination, and poor mental health.[2, 5, 6]

Sexual development comprises biological, psychological, and social aspects of experience. Extensive scientific research, described below, has been conducted on the influence of these factors on sexual orientation and gender in recent years. Much of what has been learned scientifically about sexual orientation and gender development in the last generation has occurred in parallel with societal changes in attitudes toward sexual orientation and gender roles. While bias against sexual minorities is declining in many segments of society, intolerance is still widespread. Children and adolescents are exposed to these negative attitudes and are affected by them. This Practice Parameter is intended to foster clinical competence in those caring for children and adolescents who are growing up to be gay, lesbian, bisexual, gender variant, or transgender, reflecting what is currently known about best clinical practices for these youth.

Methodology

The list of references for this Practice Parameter was developed by online searches of Medline and PsycINFO. A search of PsycINFO articles published since 1806 and Medline articles published from 1950 through April 27, 2010, of key-word terms

"bisexuality," "transgender," "transsexualism," "gender variant," "gender atypical," "gender identity disorder," and "homosexuality, attitudes toward" limited to English language, human subjects, and ages 0–17 years (PsycINFO) or 0–18 years (Medline) produced 7,825 unique and 967 duplicate references.

To take full advantage of the MeSH Subject Headings database, a subsequent search was conducted of articles in the Medline database through May 3, 2010 using MeSH Subject Headings terms "homosexuality," "male homosexuality," "female homosexuality," "bisexuality," "transsexualism," and limiting articles to those written in English and related to human subjects, all child and adolescent ages (0–18 years). This search produced 2,717 references.

Similarly, to take full advantage of the Thesaurus Terms (Descriptors) database, a subsequent search was conducted of articles in the PsycINFO articles through May 14, 2010 using Thesaurus Terms (Descriptors) "sexual orientation," "homosexuality," "male homosexuality," "female homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender identity disorder," and "homosexuality (attitudes toward)" and limiting articles to those written in English and related to human subjects of childhood age (0–12) and adolescent age (13–17). This search produced 1,751 references.

The combined search in Medline MeSH Subject Headings and PsycINFO Thesaurus Terms (Descriptors) databases produced 4,106 unique references and 361 duplicate references. Of the 4,106 unique references, the following were winnowed out: 345 books or book sections; 94 dissertation abstracts; 18 editorials; 13 articles whose focus was primarily historical; 104 theoretical formulation or comment without peer review; 163 case reports or brief series; 32 related primarily to policy or law; 19 related to news; 74 related primarily to research methods; 736 primarily about human immunodeficiency virus (HIV)/acquired immune deficiency sydrome (AIDS) and an additional 404 about early HIV/AIDS or other sexually transmitted illness; one each related to an award, book review, or interview; 168 that dealt primarily with diseases, reproduction, paraphilia or intersex conditions beyond the scope of the Parameter; an additional 8 that fell outside the specified age range; an additional 26 duplicates that were found; and 10 dating from 1960 to 1975 related to aversive or "reparative" techniques intended to change sexual orientation that are inconsistent with current ethical position statements of the American Psychiatric Association.[7] This winnowing process yielded 1,889 references.

Medline eSH terms and PsycINFO Thesaurus terms (Descriptors) were compared to key-word terms of the Medline and PsycINFO databases. This comparison demonstrated 1,113 overlapping references, with 6,712 unique to the key-word search and 2,993 unique to the combined Thesaurus Term (Descriptor) and MeSH searches.

An updated Medline search of articles through March 3, 2011, of the MeSH database using the same Subject Headings and limits used in the previous search produced 138 references. An updated PsycINFO search of articles through March 3, 2011, of the Thesaurus database using the same Terms (Descriptors) and limits used in the previous search produced 107 references.

Throughout the search, the bibliographies of source materials including books,[8], [9], [10] book chapters,[11] and review articles.[12], [13], [14] were consulted for additional references that were not produced by the online searches. Bibliographies of publications by the following experts were also examined to find additional pertinent articles not produced by online searches: Jennifer I. Downey, M.D., Jack Drescher, M.D., Richard C. Friedman, M.D., Gilbert Herdt, Ph.D., Richard Isay, M.D., Ellen Perrin, M.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., Gary Remafedi, M.D., M.P.H., and Kenneth Zucker, Ph.D. Recent studies and discussions at scientific meetings in the past decade were considered for inclusion.

From the list of references assembled in this way, references were selected whose primary focus was mental health related to sexual orientation, gender nonconformity, and gender discordance in children and adolescents. References that were not a literature review, published in peer-reviewed literature, or based on methodologically sound strategies such as use of population-based, controlled, blinded, prospective, or multi-site evidence were eliminated. References were selected that illustrated key points related to clinical practice. When more than one reference illustrated a key point around which there is general consensus, preference was given to those that were more recent, relevant to the U.S. population, most illustrative of key clinical concepts, based upon larger samples, prospective study design, or meta-analysis. When discussing issues around which consensus is not yet established, citations illustrating a representative sample of multiple viewpoints were selected.

Definitions

following definitions reflect current terminology, and are used in this Practice Parameter.

- *Sex*, in the sense of being male or female, refers to a person's anatomical sex. (Although usually considered dichotomously male or female, disorders of sex development can lead to intersex conditions, which are beyond the scope of this Practice Parameter).
- *Gender* refers to the perception of a person's sex on the part of society as male or female.
- *Gender role behavior* refers to activities, interests, use of symbols, styles, or other personal and social attributes that are recognized as masculine or feminine.
- *Gender identity* refers to an individual's personal sense of self as male or female. It usually develops by age 3, is concordant with a person's sex and gender, and remains stable over the lifetime. For a small number of individuals, it can change later in life.
- *Identity* refers to one's abstract sense of self within a cultural and social matrix. This broader meaning (equivalent to ego identity) is distinct from gender identity, and usually consolidated in adolescence.
- *Sexual orientation* refers to the sex of the person to whom an individual is erotically attracted. It comprises several components, including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role.
  - *Homosexual* people are attracted erotically to people of the same sex, and are commonly referred to as gay in the case of males, and gay or lesbian in the case of females.
  - *Heterosexual* people are attracted erotically to people of the other sex.
  - *Bisexual* people are attracted erotically to people of both sexes.
- *Sexual minority* refers to homosexual and bisexual youth and adults.

homosexual people. "Homophobia" is technically not a phobia; like other prejudices, it is characterized by hostility and is thus a misnomer, but the term is used colloquially.[15]

- *Internalized sexual prejudice* (or colloquially, *internalized homophobia)* is a syndrome of self-loathing based upon the adoption of anti-homosexual attitudes by homosexual people themselves.
- *Heterosexism* refers to individual and societal assumptions—sometimes not explicitly recognized—promoting heterosexuality to the disadvantage of other sexual orientations.
- *Childhood gender nonconformity* refers to variation from norms in gender role behavior such as toy preferences, rough-and-tumble play, aggression, or playmate gender. The terms *gender variance* and *gender atypicality* have been used equivalently in the literature.
- *Gender discordance* refers to a discrepancy between anatomical sex and gender identity. The term *gender identity variance* has been used to denote a spectrum of gender-discordant phenomena in the literature.
  - *Transgender* people have a gender identity that is discordant with their anatomical sex.
  - *Transsexuals* are transgender people who make their perceived gender and/or anatomical sex conform with their gender identity through strategies such as dress, grooming, hormone use and/or surgery (known as *sex reassignment*).
- *Gender minority* refers to gender nonconforming and gender-discordant children, adolescents, and adults.

Homosexuality

Homosexuality comprises multiple components, and can refer to several aspects of same-sex attraction, including physiological arousability, erotic fantasy, sexual behavior, psychological identity, or social role. These facets of homosexuality can be congruent or incongruent in any given person.[9, 16] Many men and women with homosexual desire suppress their feelings or behavior, agonize over sexual

heterosexual public identity.

Not surprisingly, rates of homosexuality vary depending upon definition and study method. In one study, adult males reported same-sex experience rates of 2.7% for the past year, 4.9% since age 18 years, and approximately 7–9% since puberty; for women, rates were 1.3%, 4.1%, and approximately 4%, respectively.[16] Homosexuality was correlated with higher education and urban residence. In another study, rates of lifetime same-sex experience were 6.7% for men and 14.2% for women, and 3% of men and 4% of women reported a same-sex partner in the preceding 12 months.[17]

One large sample of predominantly white but geographically and socioeconomically diverse junior and senior high school students found that 10.1% of males and 11.3% of females were “unsure” of their sexual orientation, and 1.5% of males and 1.1% of females said they were “bisexual or predominantly homosexual.” Same-sex attractions were reported by 4.5% of males and 5.7% of females, same-sex fantasies by 2.2% of males and 3.1% of females, and same-sex sexual behavior by 1.6% of males and 0.9% of females. Of youth with homosexual experience, only 27.1% identified themselves as gay, consistent with a struggle with identity and group affiliation.[18]

Influences on Sexual Orientation

There is evidence that biological factors influence sexual orientation.[19] Evidence from a variety of animal and human studies indicate that prenatal neuroendocrine factors, including levels of sex hormones, influence sexual organization of the brain in utero when neuronal patterns are laid down, and activate their sexual function beginning in puberty.

Neuroendocrine Factors

The *neurohormonal theory* of sexual orientation posits that prenatal sex hormone levels influence development of gender role behavior in childhood and sexual orientation in adulthood.[20] However, evidence of the organizing effects of sex hormones in females, and of the degree to which animal studies may be relevant to humans is limited.[21] Although sex hormone levels during fetal brain development may influence childhood gender variance and adult sexual orientation, neither homosexuality nor gender variance is an indication for endocrine, genetic, or any other special medical evaluation.

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There is evidence of a genetic influence on gender role behavior in childhood and sexual orientation in adulthood from family, twin, and molecular studies.[19] One study found that, among gay adult males, 52% of monozygotic co-twins were homosexual, whereas only 22% of dizygotic co-twins and 11% of adoptive brothers were homosexual.[22] Another study found that, among adult lesbians, 48% of monozygotic co-twins, 16% of dizygotic co-twins, and 6% of adoptive sisters were also lesbian.[23] These data suggest a substantial heritable influence on sexual orientation.

Neuroanatomy

Limited evidence suggests that the size of certain neuroanatomical features may correlate with sexual orientation. In males, these may include the third anterior interstitial nucleus of the hypothalamus (INAH-3)[24] and the suprachiasmatic nucleus (SCN).[19] Further research is needed to confirm these results and to establish their significance. When used appropriately, information about biological influences on sexual orientation can be relevant to patients, families, and clinicians. However, such influences do not constitute an illness.

Psychological and Social Factors

Before the shift to empirically based psychiatry following the publication of *DSM-III*, prevailing psychiatric theory ascribed homosexuality to character pathology.[1] However, this view was revised because of a lack of empirical evidence. Although homosexuality is associated with somewhat elevated rates of certain psychiatric disorders such as depression and anxiety, there is no evidence from any controlled scientific study that most gay and lesbian people suffer from character pathology, or from any other mental illness; on the contrary, the vast majority do not.[2, 3] In addition, studies of character profiles and defense mechanisms have found no differences between nonheterosexuals and the general population.[25, 26] Another theory, that male homosexuality resulted from overly close mothers and hostile or distant fathers, was similarly not supported by empirical study of nonclinical populations.[27] Rather, nonclinical groups of gay adults, especially males, appear to have childhood histories of gender nonconformity; their family relationships may be the result rather than the cause of gender nonconformity, and may possibly be subject to a degree of recall bias.[28, 29]

Social learning does not appear to influence sexual orientation at the level of erotic fantasy or physiological arousal, although it can influence identity and social [illegible]

necessary for the development of a homosexual orientation.[9] The effect of parents' sexual orientation on their children's own gender development and sexual orientation has been investigated in longitudinal studies of community samples in the U.S. and the United Kingdom.[30, 31, 32, 33] Parents' sexual orientation had no effect on gender development in general. This was true even though tolerance for gender nonconformity was more common among lesbian parents than among heterosexual ones. Boys raised by lesbian couples demonstrated greater gender role flexibility such as helping with housework, on average, a social strength that was also observed in some heterosexual-parent families, and that appears to be influenced more by parental attitudes than by parental sexual orientation. Regarding sexual orientation in adolescents who were raised by same-sex parents (including same-sex attraction, same-sex relationships, and gay identity), compared with the general population, no differences in sexual attraction are found; the large majority of adolescents raised by lesbian couples identify as heterosexual. However, in the minority of cases, when they do experience same-sex attractions, adolescent girls raised by lesbian parents appear to experience less stigma about acting on those feelings than those raised by heterosexual parents, and are accordingly slightly more likely to identify as bisexual.[33] Data on children raised by gay male couples is relatively lacking, but preliminary evidence appears to be consistent with the findings in children raised by lesbian couples.[30]

Exposure to anti-homosexual attitudes can induce shame and guilt in those growing up gay, leading them to suppress a gay identity or same-sex behavior; conversely, well-adjusted gay or lesbian adults can provide positive role models for youth.[7] There is no rational basis for depriving gay youth of such role models, as stereotyped views of homosexual adults as being more likely to commit sexual abuse of minors is not supported by evidence.[34, 35]

Psychosexual Development and Homosexual Orientation

Children display aspects of sexuality from infancy, and develop sexual feelings almost universally by adolescence or earlier. Although most people are predominantly heterosexual, some develop predominantly same-sex attractions and fantasies in or before adolescence. Most boys, whether heterosexual or homosexual, experience a surge in testosterone levels and sexual feelings in puberty, and almost all begin to masturbate then.[36] Most girls experience more gradually increasing sexual desires. A majority of girls, although a smaller majority than among boys, also begin to

accompanies masturbation, and may crystallize sexual orientation.[37] Whether heterosexual or homosexual, most men experience more frequent interest in sex and fantasies involving explicit sexual imagery, whereas women's sexual fantasies more often involve romantic imagery.[38] Sexual behavior with others typically begins in or after mid-to-late adolescence, although the age of onset of activity, number of partners, and practices vary greatly among individuals.[16]

One possible developmental pathway of male homosexuality proceeds from same-sex erotic fantasy to same-sex experience, then homosexual identity (self-labeling as gay), and finally a homosexual social role (identifying oneself as gay to others).[39] In comparison with those who first identify as gay in adulthood, those who identify as gay in adolescence may be somewhat more likely to self-label as gay before same-sex experience, and to achieve the foregoing gay developmental milestones earlier. This developmental path appears to be more common in recent cohorts than it once was,[40] perhaps reflecting the consolidation of a gay identity earlier in recent generations as the result of the increasing visibility of gay role models for adolescents. Developmental pathways may be more variable in females, whose sexuality is generally more fluid than that of males.[41] Compared with men, women are more likely to experience homosexual as well as heterosexual attraction across the lifespan.[12] This may occur only in youth, may emerge in adulthood, or may be stable through life.[42]

Certainty about sexual orientation and identity—both gay and straight—increases with age, suggesting “an unfolding of sexual identity during adolescence, influenced by sexual experience and demographic factors.”[18] Although it may be difficult to tell which developmental path a particular adolescent is on at a given moment, a consistently homosexual pattern of fantasy, arousal, and attraction suggests a developmental path toward adult homosexuality. Retrospectively, many gay men and lesbians report same-sex erotic attraction from youth onward.[28]

Development of Gender Role Behavior

Boys and girls generally exhibit different patterns of gender role behavior. These are quite distinct from erotic feelings, instead involving such areas as toy preferences, play patterns, social roles, same-sex or opposite-sex peer preferences, gesture, speech, grooming, dress, and whether aggression is expressed physically or through social strategies.[43], [44] For example, most boys are more likely than girls to engage

do so through verbal and social means. When given a choice, most boys are more likely to select conventionally masculine toys such as cars, trains, and adventure or fighting games, whereas most girls more frequently select conventionally feminine toys such as dolls, jewelry, and nurturing games. Most children exhibit a preference in middle childhood for same-sex playmates, or “sex-segregated play.”

Social, psychological, and biological factors, including genetic and environmental ones, interactively influence childhood gender role behavior and gender identity.[45], [46] Sex differences exist at multiple levels of brain organization, and there is evidence of neuroanatomic differences between gender-typical and gender-atypical individuals. At the same time, part of a developing child's cognitive understanding of gender—for example, whether competitiveness and aggression can be feminine, or whether empathic, nurturing activities can be masculine—is related to societal norms.[47] As science has progressed, the complexity of the way in which factors related to gender role behavior such as genes, hormones, and the environment (including the social environment) interact have come to be better appreciated. Psychological experience is presumably reflected in brain structure or function, and each may influence the other. Previous questions about the roles of nature and nurture in causing childhood gender role differences have come to be understood as overly simplistic, and have been replaced by models showing biological and environmental factors influencing one another bidirectionally during critical periods in neurodevelopmental processes that are sometimes modifiable and sometimes fixed.

Gender Nonconformity and Its Developmental Relationship to Homosexuality

Most boys and girls display some variability in gender role behavior. However, some children display toy, play, and peer preferences that are typical of the other gender. They have been referred to as “gender atypical,” “gender variant,” or, increasingly, “gender nonconforming” in scholarly literature. Childhood gender nonconformity often is a developmental precursor of homosexuality in males, and sometimes in females.[48]

Although childhood gender nonconformity does not predict adult homosexuality with certainty, many gay men recall boyhood aversion to rough-and-tumble play, aggressive behavior, and competitive athletics.[49] In females, gender nonconformity (e.g., being a “tomboy”) is sometimes associated with adult homosexual orientation, although less consistently than in males.[50] Many gay people report having felt “different” from others long before the development of erotic feelings as such due to

self-esteem, boys, who may particularly value adherence to gender norms, may be especially distressed.[51]

Although gender nonconforming children may experience discomfort or marked anxiety if forced to participate in gender-typical behaviors, their gender identity is entirely congruent with their sex. They do not express a wish to be, or belief they are, the other sex. On the contrary, gender nonconforming boys in particular may be upset by feelings they are insufficiently masculine, especially in contexts in which gender norms are highly valued.[9]

Adolescence, Sexual Orientation, and Identity Formation

Adolescence normally brings increased sexual and aggressive drives, social role experimentation, and separation and individuation for all youth. For those who are developing as gay, lesbian, bisexual, or transgender, the challenge of establishing one's ego identity—including a sense of one's sexual identity—is uniquely complex. Although most heterosexual youth take social acceptance of their sexual orientation for granted, sexual and gender minority youth usually cannot.[9] They must cope with feeling different, ostracism, and dilemmas about revealing a sexual identity that is discrepant from family and social expectations (“coming out”).[13] These adolescents are at somewhat elevated risk for having suicidal thoughts[52, 53, 54]; however, only a minority actually do, indicating a capacity for resilient coping in most.

Increasing social acceptance may encourage gay, lesbian, or bisexual adolescents to come out more frequently and at younger ages. However, some youth who become aware that they have homosexual feelings may be unprepared to cope with possible negative attitudes that they may encounter among their own family or peers.[55]

Clinical Issues in Homosexuality

Effects of Stigma, Peer Rejection, Bias, and Bullying

Despite increasing tolerance, gender and sexual minority youth may experience criticism, ostracism, harassment, bullying, or rejection by peers, family, or others, even in relatively tolerant, cosmopolitan settings.[56] These can be associated with significant social problems, distress, and psychological symptoms.[57] They may be shunned or disparaged when they long for peer acceptance. A poor developmental fit between children's gender nonconformity or sexual orientation and parents' expectations can result in distress for both parent and child.[11]

Even when not personally threatened, homosexual youths may be indirectly or overtly disparaged by family or peers. They may observe other gay people experiencing disrespect, humiliation, lower social status, or fewer civil rights. This experience may create difficulty reconciling the simultaneous developmental needs to form a sexual identity on the one hand and to feel socially acceptable on the other, typically a painful developmental conflict for gay youth.[13] They may identify with others who are emotionally important to them but sexually prejudiced, leading to a syndrome of self-loathing (internalized sexual prejudice, or "internalized homophobia"). This may adversely affect self-esteem, lead to denial of same-sex attractions, cause difficulty identifying with other gay people, and prevent formation of healthy relationships.[8]

Revealing a Homosexual Orientation to Others

Many gay and lesbian youth hide their identity from others.[55] The dilemma over whether to reveal a homosexual orientation—to "come out of the closet" or "come out"—is a unique aspect of the psychological development of sexual and gender minority youth. They must decide whether to hide their sexual orientation (remain "in the closet," or "closeted") or risk rejection. Coming out is usually a highly significant event that may be anticipated with dread. There is no single answer to the question whether a particular gay youth should come out, or to whom. This requires judgment about the youth's maturity and coping, as well as the social context. For some, coming out brings great relief. Others in hostile environments may come out with bravado before it is safe; for them, remaining closeted or in denial may be adaptive.

Gender Identity and Gender Discordance

For the vast majority of people, gender identity is established in toddlerhood, is consistent with biological sex, and remains fixed. This holds true for many children with gender-nonconformity in toy, play, and playmate preferences. However, some children experience not only gender nonconformity, but also discomfort with their biological sex. They derive comfort from being perceived as, or a wish to be, the other sex. The desire leads to discordance between gender identity and phenotypic sex, a core feature of gender identity disorder (GID) as conceptualized in the *DSM-IV*.[58] The diagnosis of GID in children is controversial, and the degree to which *DSM-IV* criteria reflect an illness or social bias against gender nonconformity has been debated.[59, 60]

developmental trajectory, have been described.[61] They differ in regard to whether gender discordance emerges in childhood, adolescence or adulthood; whether the gender discordance is persistent or transient; and whether there is a post-transition homosexual or heterosexual orientation. These heterogeneous developmental trajectories may subsume different causes of gender discordance.

In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2%[62] to 11.9%[63] continuing to experience gender discordance. Rather, 75% become homosexual or bisexual in fantasy and 80% in behavior by age 19; some gender-variant behavior may persist.[63] The desistence of gender discordance may reflect the resolution of a "cognitive confusion factor,"[64] with increasing flexibility as children mature in thinking about gender identity and realize that one can be a boy or girl despite variation from conventional gender roles and norms.

In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood.[65] This gender discordance may lead to life-long efforts to pass socially as the other sex through cross-dressing and grooming, or to seek sex reassignment through hormones or surgery.

Many of the clinical issues pertaining to gay and lesbian youth doubtlessly affect youth with gender discordance as well. In addition, children and especially adolescents with gender discordance have been found to have behavior problems and anxiety.[66], [67] Proposed causes include family and social opprobrium, the discrepancy between psychological and anatomic gender, and maternal and family psychopathology.[65], [68]

Factors Influencing Development of Gender Discordance

Causes of gender discordance may include biological factors.[59] Genetic males with gender discordance tend to have a later birth order, more male siblings, and lower birth weight, suggesting an influence of prenatal events that is poorly understood. Individuals with gender discordance may differ in central nervous system lateralization from the general population. Consistent with this hypothesis, they are more likely to be non-righthanded, to have abnormal EEG findings, and to have lateral otoacoustic processing consistent with their gender identity compared to a non-gender discordant

influence later gender identity, but do not appear to fully determine it.[69] There is evidence that the central bed nucleus of the stria terminalis (BSTc), a hypothalamic structure implicated in sexual behavior, is small in male to female transsexuals, similar to most females.[70]

A hypothesis that inappropriately close maternal and overly distant paternal relationships causes gender discordance in boys was not borne out by empirical study, which found both mothers and fathers to be distant from sons with gender discordance, possibly a result, rather than the cause, of gender discordance.[62] A theory that predisposing biological factors, temperamental anxiety, and parental tolerance for gender nonconformity interact to cause gender discordance has not been empirically tested.[71] A controlled study found increased rates of psychopathology in mothers of boys with gender discordance, but was not designed to assess a causal relationship.[68]

Principles

Principle 1

A comprehensive diagnostic evaluation should include an age-appropriate assessment of psychosexual development for all youths.

The psychiatric evaluation of every patient should take into consideration psychosexual development in a way that is appropriate to developmental level and the clinical situation. Questions about sexual feelings, experiences, and identity or about gender role behavior and gender identity can help clarify any areas of concern related to sexuality. The history should be obtained in a nonjudgmental way, for example without assuming any particular sexual orientation or implying that one is expected. This can be conveyed, for example, by the use of gender-neutral language related to the aim of affection (e.g., asking “is there someone special in your life?” rather than “do you have a boyfriend/girlfriend?”) until the adolescent reveals a particular sexual orientation.

Sexual and gender minority adolescents very frequently face unique developmental challenges, as described above. If an initial screen indicates that issues of sexual orientation, gender nonconformity, or gender identity are of clinical significance, these challenges can be explored in greater depth.

The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth.

Issues of confidentiality are important with all patients; they are particularly so with sexual and gender minority youth, who require a clinical environment in which they can explore their developing orientation and identity. Prior experiences of rejection and hostility may lead them to watch social cues vigilantly to determine whether they can safely reveal their sexual orientation to others without fear of bias or judgment. Any sign of these in a mental health professional may induce shame and undermine the clinical alliance.

Clinicians should bear in mind potential risks to patients of premature disclosure of sexual orientation, such as family rejection or alienation from support systems, which might precipitate a crisis. They should be familiar with standard confidentiality practices for minors, and should protect confidentiality when possible to preserve the clinical alliance. This is particularly true when using media such as electronic health records, in which sensitive information can be easily disseminated. It is often helpful to emphasize reasonable expectations of privacy in the clinical relationship with sexual and gender minority youth—not to express shame, but to permit the exploration of sexual identity free from fear and with a sense of control over disclosure. As the development of sexual identity is variable, it is often desirable to allow youth to set the pace of self-discovery.

Principle 3

Family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity should be explored in the context of the cultural values of the youth, family, and community.

Families of sexual or gender minority youth may consult mental health professionals for a variety of reasons, for example, to ask whether a disclosure of being gay represents a temporary stage, to request support for an adolescent, or to address problems such as bullying, anxiety, or depression. Just as some adults try to alter their sexual orientation,[72] some parents may similarly hope to prevent their children from being gay. Difficulty coping with prejudice and stigma are often the appropriate focus of treatment.

some adopt their children, others explicitly or implicitly disparage or reject them, evoking shame and guilt; some force them to leave home. Although some are surprised by a child's coming out, others are not, and some are supportive. Families may have to fundamentally alter their ideas about a child who comes out, confront misconceptions, and grieve over lost hopes and/or expectations. Most parents experience distress following a child's coming out, frequently experiencing cognitive dissonance or feelings of anxiety, anger, loss, shame, or guilt; despite this, over time the majority become affirming and are not distressed.[73] Children frequently predict their parents' reactions poorly. Ideally, families will support their child as the same person they have known and loved, although doing so may require time.

Youth who are rejected by their parents can experience profound isolation that adversely affects their identity formation, self-esteem, and capacity for intimacy; stigmatized teens are often vulnerable to dropping out of school, homelessness (which may lead to exploitation or heightened sexual risk), substance abuse, depression and suicide.[53] Clinicians should aim to alleviate any irrational feelings of shame and guilt, and preserve empathic and supportive family relationships where possible. They should assess parents' ideas about what constitutes normal, acceptable behavior, their cultural background, and any misconceptions or distorted expectations about homosexuality. These may include fears that their child will have only casual relationships, is fated to contract HIV/AIDS, cannot become a parent if desired, or will be ostracized. Stereotyped views of gay males as engaging only in numerous, indiscriminate sexual encounters are not supported by empirical research except in rare cases.[12] If such behavior is present and cannot be explained as part of normal adolescent sexual drive or identity formation, factors known to be associated with excessive sexuality in youth, such as a history of sexual abuse, family dysfunction, a pattern of conduct problems, or mood disorder such as bipolar disorder or depression, should be considered. Clinicians should screen for all forms of abuse or neglect (as in any evaluation), with careful attention to adverse family reactions to a youth's sexual or gender development. If these are suspected, they should involve child protective services as clinical appropriateness and ethical and legal mandates warrant. Support groups may be helpful for families in distress. In cases of protracted turmoil or family pathology, referrals to family therapy, individual or couples therapy may be appropriate.

relating the values and norms of their ethnic group.[74] Various groups may place different emphasis on ideals of masculinity or femininity, on family loyalty, or on social conformity; some with authoritarian parenting ideals may sanction youth who reject traditional mores.

For gay and lesbian adolescents who are also members of ethnic minorities, the deleterious effect of anti-homosexual bias may be compounded by the effect of racial prejudice. In response to unique pressures to gain group acceptance, they may give particular weight to negative group stereotyping of gay people. Gay and lesbian youth who are also members of ethnic minorities may be less likely than nonminority youth to be involved in gay-related social activities, to be comfortable with others knowing they are gay, or to disclose a gay identity.[75] In caring for youth who are members of both ethnic and sexual minorities, mental health professionals should take into account the unique complexities of identity formation for these groups.

Religion, often a valued aspect of identity, can vary widely regarding tolerance for sexual minorities. Membership in relatively more liberal or conservative religious groups is a significant influence on one's “sexual script,” or social pattern in the expression of sexuality.[16] Some minority denominations hold strong religious injunctions against homosexuality and stricter views about gender roles. As a result, members of certain religious groups can experience special challenges in integrating their sexual identity with family and community values. However, many religious groups are reconciling their traditions with more inclusive values. This remains an area of active social and cultural debate and change. Clinicians should respect the religious values of their patients, and should be aware of ongoing developments in religious thinking that may provide opportunities to integrate the religious and sexual aspects of identity.

Principle 4

Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk.

Bullying

Gay, lesbian, bisexual, and gender nonconforming youth are regularly exposed to hostile peers. Victims of peer harassment experience serious adverse mental health consequences including chronic depression, anxiety, and suicidal thoughts.[76], [77], [78]

harassment. School programs including no-tolerance policies for bullying have proved effective.[79] Family treatment may be useful when sexual and gender minority youth are harassed in their families. Psychotherapy may help to avert or alleviate self-loathing related to identification with the aggressor. Clinicians should consider environmental interventions such as consultation or advocacy with schools, police, or other agencies and institutions advocating enforcement of zero tolerance policies to protect youth who may be victims of harassment or bullying.

Suicide

Rates of suicidal thoughts and suicide attempts among gay, lesbian, and gender-variant youth are elevated in comparison with the general population.[52], [53], [54] The developmental interval following same-sex experience but before self-acceptance as gay may be one of especially elevated risk.[54] Suicidal thoughts, depression, and anxiety are especially elevated among gay males who were gender-variant as children.[80], [81] Family connectedness, adult caring, and school safety are highly significant protective factors against suicidal ideation and attempts.[82]

High-Risk Behaviors

Unique factors promoting risk-taking among gay and lesbian youth include maladaptive coping with peer, social and family ostracism, emotional and physical abuse, and neglect.[83] Fear of rejection may lead some youth to be truant, run away, become homeless, be sexually exploited, or become involved in prostitution. Positive coping skills and intact support systems can act as protective factors. Lesbian youth have higher rates of unintended pregnancy than heterosexual female youth, perhaps due to anxiety about their same-sex attractions and a desire to “fit in,” an assumption birth control is unnecessary, or high-risk behavior rooted in psychological conflict.[84] Clinicians should monitor for these risks or provide anticipatory guidance for them when appropriate.

Substance Abuse

Some adolescents explore a gay identity in venues such as dance clubs and bars where alcohol and drugs are used. These youth may be at heightened risk of substance abuse because of peer pressure and availability of drugs. Lesbian and bisexual girls and boys describing themselves as “mostly heterosexual” (as opposed to unambiguously hetero- or homosexual) are at increased risk for alcohol use.[85] A subgroup of gay youth displays higher rates of use of alcohol and drugs including

and alcohol to achieve a sense of belonging or to relieve painful affects such as shame, guilt, and a lack of confidence associated with their romantic and sexual feelings.

HIV/AIDS and Other Sexually Transmitted Illnesses

Adolescents are at risk for acquiring sexually transmitted illnesses included HIV infection through sexual risk taking, especially those who feel invulnerable or fatalistic, or who lack mature judgment, self-confidence, or the mature interpersonal skills needed to negotiate safe sexual experiences. Programs aimed at reducing adolescent sexual risk taking that are successful not only increase information about how HIV and sexually transmitted diseases are acquired and prevented, but also provide emotionally relevant and practical help in having safe sexual experiences that are developmentally relevant to youth.[86] Adolescent gay males may be at particular risk of acquiring HIV sexually because of its high prevalence among men who have sex with men. Factors such as substance abuse or internalized homophobia associated with shame, guilt, or low self-esteem may interfere with an individual's motivation to use knowledge effectively about how to protect oneself from acquiring HIV infection. If present, these issues should be addressed clinically. Special HIV-prevention programs have been developed for and tested in gay youth and have demonstrated promising results.[87, 88]

Principle 5

Clinicians should aim to foster healthy psychosexual development in sexual and gender minority youth and to protect the individual's full capacity for integrated identity formation and adaptive functioning.

Protecting the opportunity to achieve full developmental potential is an important clinical goal in working with sexual and gender minority youth. The psychological acceptability of homosexual feelings to an individual and his or her family, and the individual's capacity to incorporate them into healthy relationships, can change with therapeutic intervention, and are an appropriate focus of clinical attention.[9] Clinicians should strive to support healthy development and honest self-discovery as youth navigate family, peer, and social environments that may be hostile. Family rejection and bullying are often the proper focus of psychiatric treatment rather than current or future sexual orientation.

attention. When they do, it may be most useful to explore what this issue means to the adolescent and significant persons in his/her life. It may be preferable to indicate that it is too early to know an adolescent's sexual orientation rather than to refer to such feelings as a “phase,” which may have connotations of disapproval.

When working clinically with youth whose sexual orientation or gender identity is uncertain, protecting the opportunity for healthy development without prematurely foreclosing any developmental possibility is an important goal. Clinicians should evaluate and support each child's ability to integrate awareness of his or her sexual orientation into his or her sexual identity while developing age-appropriate capacities in the areas of emotional stability, behavior, relationships, academic functioning, and progress toward an adult capacity for work, play, and love.

The availability of role models for sexual and gender minority youth varies greatly. The increasing visibility of gay people in society may decrease the isolation and loneliness of some gay youth, but others may be confronted with information that forces self-labeling before they are able to cope with irrational bias and feeling different. Some have access to positive role models or opportunities to form an affirming sexual identity among family, friends, the media, or through school programs such as gay–straight alliances. Urban environments or the Internet may give youth access to positive role models and experiences, but may also carry risks that require adult supervision.

Principle 6

Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.

There is no established evidence that change in a predominant, enduring homosexual pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter homosexuality.[89] Psychiatric efforts to alter sexual orientation through “reparative therapy” in adults have found little or no change in sexual orientation, while causing significant risk of harm to self-esteem.[7] A study of efforts to do so in adults[71] has been criticized for failure to adequately consider risks

suicidality and for failure to support appropriate coping with prejudice and stigma.[90]

There is no empirical evidence that adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness, and caring, which are important protective factors against suicidal ideation and attempts.[82] As bullies typically identify their targets on the basis of adult attitudes and cues,[76] adult efforts to prevent homosexuality by discouraging gender variant traits in “pre-homosexual children” may risk fomenting bullying. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.[7, 91]

Principle 7

Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.

A majority of children display gender role behavior that adult caregivers regard as departing from gender role norms in toy preferences at least some of the time (demonstrating a difference between that which is culturally expected and that which is actually statistically normal).[92] However, a smaller group of children demonstrate a consistent difference in gender role behavior from social norms. In different children, this may be true to varying degrees. In some, it may involve only a few areas—for example, an aversion to rough-and-tumble sports in boys, or tomboyishness in girls. In others, it may involve several areas, including dress, speech, and use of social styles and mannerisms. It is important to distinguish those who display only variation in gender role behavior (gender nonconformity, which is not a *DSM* diagnosis) from those who also display a gender identity discordant from their socially assigned birth gender and biological sex (gender discordance, reflected in the *DSM-IV* diagnosis Gender Identity Disorder when accompanied by marked gender nonconformity).[93]

A clinical interview using *DSM* criteria is the gold standard for making a *DSM* diagnosis. In some cases of gender role variance, there may be clinical difficulty distinguishing between gender nonconformity and gender discordance—for example, there may be clearly marked gender nonconforming behavior, but ambiguous cross-

present, addition to using clinical interviews, they can consider using structured instruments such as the Gender Identity Interview for Children,[94] the Gender Identity Questionnaire for Children,[95] and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults.[96] In using such instruments, clinicians should bear in mind that the American Psychiatric Association's Gender Identity Disorder subworkgroup for *DSM-5* is currently debating areas of controversy in the diagnostic criteria for GID, including whether and how the explicit verbalization of gender discordant wishes should be included as a criterion, given the difficulty children may have expressing such wishes in nonaccepting environments.[93]

Disorders of sex development are an important differential diagnosis in gender discordant children and adolescents, for which endocrinological treatment may be indicated.[97] When the clinical history suggests that a somatic intersex condition may be present, clinicians should consider consultation with a pediatric endocrinologist or other specialist familiar with these conditions.

Children

Different clinical approaches have been advocated for childhood gender discordance. Proposed goals of treatment include reducing the desire to be the other sex, decreasing social ostracism, and reducing psychiatric comorbidity.[14] There have been no randomized controlled trials of any treatment. Early treatments for gender discordance developed in the 1970s included behavioral paradigms[98]; their long-term risks and benefits have not been followed up in controlled trials, and have been rejected on ethical grounds as having an inappropriately punitive and coercive basis.[99] Psychodynamically based psychotherapy for gender discordance in boys has been proposed based on a psychodynamic hypothesis that gender discordance is a defense in fantasy against profound, early separation anxiety[71]; like other treatment strategies, this has not been empirically tested in controlled trials.

Recent treatment strategies based upon uncontrolled case series have been described that focus on parent guidance and peer group interaction. One seeks to hasten desistence of gender discordance in boys through eclectic interventions such as behavioral and milieu techniques, parent guidance and school consultation aimed at encouraging positive relationships with father and male peers, gender-typical skills, and increased maternal support for male role-taking and independence.[100] Another approach encourages tolerance of gender discordance, while setting limits on

community harassment.[10] Desistence of gender discordance has been described in both treatment approaches, as it is in untreated children.

As an ethical guide to treatment, "the clinician has an obligation to inform parents about the state of the empiric database,"[14] including information about both effectiveness and potential risks. As children may experience imperatives to shape their communications about gender discordant wishes in response to social norms, a true change in gender discordance must be distinguished from simply teaching children to hide or suppress their feelings. Similarly, the possible risk that children may be traumatized by disapproval of their gender discordance must be considered. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth,[57] the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects.

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

There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender-discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so. Social gender assignment appears to exert partial influence on the gender identity of infants with disorders of sex development.[69] At the same time, countervailing biological factors may override social gender assignment and contribute significantly to gender discordance in many cases. Therefore, the possibility that sending a child to school in his/her desired gender may consolidate gender discordance or expose the child to bullying should be weighed against risks of not doing so, such as distress, social isolation, depression, or suicide due to lack of social support. Further research is needed to guide clinical decision making in this area.

adolescence or adulthood.[102] Sometimes it emerges in parallel with puberty and secondary sex characteristics, causing distress leading to a developmental crisis. Transgender adolescents and adults often wish to bring their biological sex into conformity with their gender identity through strategies that include hormones, gender correction surgery, or both, and may use illicitly obtained sex hormones or other medications with hormonal activity to this end. They may be at risk from side effects of unsupervised medication or sex hormone use.

One goal of treatment for adolescents in whom a desire to be the other sex is persistent is to help them make developmentally appropriate decisions about sex reassignment, with the aim of reducing risks of reassignment and managing associated comorbidity.[14] In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent. Transgender youth may face special risks associated with hormone misuse, such as short- and long-term side effects, improper dosing, impure or counterfeit medications, and infection from shared syringes.

For situations in which deferral of sex-reassignment decisions until adulthood is not clinically feasible, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues that reversibly delay the development of secondary sexual characteristics.[102] The goals of such treatment are to avoid distress caused by unwanted secondary sexual characteristics, to minimize the later need for surgery to reverse them, and to delay the need for treatment decisions until maturity allows the adolescent to participate in providing informed consent regarding transition to living as the other sex. Prospective, case-controlled study of such treatment to delay puberty has shown some beneficial effects on behavioral and emotional problems, depressive symptoms, and general functioning (although not on anxiety or anger), and appears to be well tolerated acutely.[103] In addition, gender discordance is associated with lower rates of mental health problems when it is treated in adolescence than when it is treated in adulthood.[104] Therefore, such treatment may be in the best interest of the adolescent when all factors, including reducing psychiatric comorbidity and the risk of harm from illicit hormone abuse, are considered.

trajectories of gender-discordant adolescents have been described.[105], [106], [107] In one approach, puberty suppression is considered beginning at age 12, cross-sex hormone treatment is considered beginning at age 16, and gender reassignment surgery at age 18.[105] Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and treatment of associated mental health problems. In another approach based on stage of physical development rather than age, pubertal suppression has been described at Tanner stage 2 in adolescents with persistent GID; risks requiring management include effects on growth, future fertility, uterine bleeding, and options for subsequent genital surgery and cross-sex hormone use.[107] For families of transgender adolescents, a therapeutic group approach has been described that encourages parental acceptance.[108] This approach may help to mitigate psychopathology and other deleterious effects of environmental nonacceptance. Further research is needed to definitively establish the effectiveness and acceptability of these treatment approaches.

Principle 8

Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care providers, advocating for the unique needs of sexual and gender minority youth and their families.

Evaluating youths' school, community, and culture—essential in any psychiatric evaluation—is particularly important for sexual and gender minority youth. Clinicians should seek information about the sexual beliefs, attitudes, and experiences of these social systems, and whether they are supportive or hostile in the patient's perception and in reality. Clinicians should not assume that all parties involved in a youth's social system know about his or her sexual identity. They should review with the youth what information can be shared with whom, and elicit concerns regarding specific caregivers. If appropriate, the clinician can consider interventions to enhance support, with the youth's knowledge and assent.

As consultants, mental health professionals can help to raise awareness of issues affecting sexual and gender minority youth in schools and communities, and advise programs that support them. Clinicians can consider advocating for policies and legislation supporting nondiscrimination against and equality for sexual and gender

and in libraries.

Principle 9

Mental health professionals should be aware of community and professional resources relevant to sexual and gender minority youth.

Many community-based organizations and programs provide sexual and gender minority students with supportive, empowering experiences safe from stigma and discrimination (e.g., the Harvey Milk School at the Hetrick Martin Institute, www.hmi.org; Gay Straight Alliances, www.gsanetwork.org).

There are many books and Internet resources for youth and families on issues such as discovering whether one is gay or lesbian. Clinicians should consider exploring what youth and families read, and help them to identify useful resources. Organizations such as Parents, Friends, and Families of Lesbians and Gays (PFLAG, www.pflag.org) and the Gay, Lesbian and Straight Education Network (GLSEN) provide support and resources for families, youth, and educators. These organizations have programs in a number of communities. Clinicians can obtain information through professional channels such as the AACAP Sexual Orientation and Gender Identity Issues Committee (www.aacap.org), the American Psychiatric Association (www.psych.org), the Lesbian and Gay Child and Adolescent Psychiatric Association (www.lagcapa.org), and the Association for Gay and Lesbian Psychiatrists (www.aglp.org).

The Model Standards Project, published by the Child Welfare League of America, is a practice tool related to the needs of LGBT youth in foster care or juvenile justice systems available at www.cwla.org.[109] The *Standards of Care for Gender Identity Disorders*, including psychiatric and medical care, are published by the World Professional Association for Transgender Health (www.wpath.org).[110]

Parameter Limitations

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the

family, the diagnostic and treatment options available, and other available resources.

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This Practice Parameter was developed by Stewart L. Adelson, M.D. and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI): Heather J. Walter, M.D., M.P.H., and Oscar G. Bukstein, M.D., M.P.H., Co-Chairs, and Christopher Bellonci, M.D., R. Scott Benson, M.D., Allan Chrisman, M.D., Tiffany R. Farchione, M.D., John Hamilton, M.D., Helene Keable, M.D., Joan Kinlan, M.D., Nicole Quiterio, M.D., Ulrich Schoettle, M.D., Matthew Siegel, M.D., and Saundra Stock, M.D. AACAP liaison: Jennifer Medicus.

AACAP Practice Parameters are developed by the AACAP CQI in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP website. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

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oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented Parameter.

The primary intended audience for the AACAP Practice Parameters is child and adolescent psychiatrists; however, the information contained therein may also be useful for other mental health clinicians.

The authors acknowledge the following experts for their contributions to this Parameter: Members of the AACAP Sexual Orientation and Gender Identity Issues Committee: Sarah E. Herbert, M.D., M.S.W., Chair, and Beth Belkin, M.D., Ph.D., Ledro R. Justice, M.D., Scott Leibowitz, M.D., William Martin, M.D., Edgardo J. Menvielle, M.D., Yiu Kee Warren Ng, M.D., R. Kaan Ozbayrak, M.D., Richard R. Pleak, M.D. (former Chair), Joel J. Stoddard, M.D., William M. Womack, M.D., and other topic experts: Deborah Carter, M.D., Jennifer I. Downey, M.D., James Farrow, M.D., Richard C. Friedman, M.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., and Cynthia Telingator, M.D.

This Practice Parameter was reviewed at the Member Forum at the AACAP Annual Meeting in October 2010.

From September 2011 to February 2012, this Parameter was reviewed by a Consensus Group convened by the CQI. Consensus Group members and their constituent groups were as follows: Heather J.Walter, M.D., M.P.H., chair, Christopher Bellonci, M.D., shepherd, and Helene Keable, M.D. and Saundra Stock, M.D., members (CQI); Gerald Dabbs, M.D. and Cynthia Telingator, M.D. (Topic Experts); Theodore Petti, M.D. and Kathleen Trello-Rishel, M.D. (AACAP Assembly of Regional Organizations); and Kathleen Kelley, M.D. and Melvin Oatis, M.D. (AACAP Council).

This Practice Parameter was approved by the AACAP Council on May 31, 2012.

This Practice Parameter is available on the Internet (www.aacap.org).

Disclosure: Oscar Bukstein, M.D., M.P.H., co-chair, has received support from the National Institute of Mental Health (NIMH), the National Institute of Child Health and Human Development (NICHD), and Shire. He has received royalties from Routledge Press. Stewart L. Adelson, M.D., and Heather J. Walter, M.D., M.P.H., co-chair, report no biomedical financial interests or potential conflicts of interest. Disclosures of potential conflicts of interest for all other individuals named above are provided on the AACAP website on the Practice Parameters page.

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View Abstract

Published on *AASECT:: American Association of Sexuality Educators, Counselors and Therapists* (https://www.aasect.org)

Position on Reparative Therapy

AASECT

Position on Reparative Therapy

The American Association of Sexuality Educators, Counselors and Therapists (AASECT) takes the position that having a non-heterosexual sexual orientation, that being transgender and that being gender non-conforming, are not mental disorders. We oppose any "reparative" or conversion therapy that seeks to "change" or "fix" a person's sexual orientation, gender identity or gender expression. AASECT does not believe that non-heterosexual sexual orientation or being transgender or gender non-conforming is something that needs to be "fixed" or "changed."

The rationale behind this position is the following:

- Reparative therapy (for minors, in particular) is often forced or non-consensual.
- Reparative therapy has been proven harmful to minors.
- There is no scientific evidence supporting the success of these interventions.
- Reparative therapy is grounded in the idea that non-heterosexual orientation, transgender gender identity and gender non-conforming expressions are "disordered."
- Reparative therapy has been shown to be a negative predictor of psychotherapeutic benefit.

We define reparative or conversion therapy as:

- services or interventions purporting to "cure" any sexual orientation that is non-heterosexual or gender identity/expression that falls under a transgender umbrella.

- services that seek to change non-heterosexual orientation because of the assumption that homosexuality or bisexuality are mental disorders.

- services that seek to change transgender gender identities/expressions because of the assumption that being transgender is a mental disorder.

Our position is consistent with our professional colleagues, including but not limited to: the American Medical Association, the American Psychoanalytic Association, the National Association of Social Workers, the American Academy of Pediatrics, the American School Counselor Association, the American Mental Health Counselors Association, the American Bar Association, the American College of Physicians and the Canadian Psychological Association.

EXHIBIT 14

*Revised 2.9.2017

Source URL: https://www.aasect.org/position-reparative-therapy

AMERICAN SCHOOL COUNSELOR ASSOCIATION

The Professional School Counselor and LGBTQ Youth

(Adopted 1995, Revised 2000, 2005, 2007, 2013, 2014)

American School Counselor Association (ASCA) Position

Professional school counselors promote equal opportunity and respect for all individuals regardless of sexual orientation, gender identity or gender expression. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, personal/social and career development of all students.

The Rationale

Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth often experience challenges to their academic and personal/social development related to a negative school climate. Students report feeling unsafe in school due to their sexual orientation, perceived orientation, gender identity or gender expression and report experiencing homophobic remarks, harassment and bullying (GLSEN, 2011). LGBTQ individuals often face multiple risk factors that may place them at greater risk for suicidal behavior (SPRC, 2008). Professional school counselors realize these issues impact healthy student development and psychological well-being.

The Professional School Counselor's Role

The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful (APA, 2009). School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools. School counselors:

- assist students with feelings about their sexual orientation and gender identity as well as the identity of others in an accepting and nonjudgmental manner
- advocate for equitable educational and extracurricular opportunities for all students regardless of sexual orientation, gender identity or gender expression
- promote policies that denounce the use of offensive language, harassment, and bullying that lead to a hostile school environment
- address absenteeism, lowered educational aspirations and academic achievement, and low psychological well-being as a result of victimization and feeling unsafe at school (GLSEN, 2012)
- provide a safe space for LGBTQ students and allies such as Gay and Straight Alliance Clubs
- promote sensitivity and acceptance of diversity among all students and staff to include LGBTQ students and diverse family systems
- advocate for the rights of families to access and participate in their student's education and school activities without discrimination (GLSEN, 2001)
- support an inclusive curriculum at all grade levels
- model language that is inclusive of sexual orientation and gender identity
- advocate for adoption of school policies that address discrimination and promote safe and supportive school environments (Robinson & Espelage, 2012)
- promote violence-prevention programs to create a safe school environment
- encourage staff training on inclusive practices, creating an affirming school environment, accurate information and risk factors for LGBTQ students (Russell, et.al. 2010)
- identify LGBTQ community resources for students and families

EXHIBIT 15

Summary
Professional school counselors promote affirmation, respect and equal opportunity for all individuals regardless of sexual orientation, gender identity, or gender expression. Professional school counselors promote awareness of and education on issues related to LGBTQ students and encourage a safe and affirming school environment. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, career and personal/social development of all students.

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Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians

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Abstract

In this position paper, the American College of Physicians examines the health disparities experienced by the lesbian, gay, bisexual, and transgender (LGBT) community and makes a series of recommendations to achieve equity for LGBT individuals in the health care system. These recommendations include enhancing physician understanding of how to provide culturally and clinically competent care for LGBT individuals, addressing environmental and social factors that can affect their mental and physical well-being, and supporting further research into understanding their unique health needs.

The lesbian, gay, bisexual, and transgender (LGBT) community is diverse, comprising persons from various races, ethnicities, and socioeconomic backgrounds; however, LGBT persons face a common set of challenges within the health care system. These challenges range from access to health care coverage and culturally competent care to state and federal policies that reinforce social stigma,

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LGBT community and the challenges they face in accessing care. Although great strides have been taken in reducing health disparities in the LGBT community, much more needs to be done to achieve equity for LGBT persons in the health care system.

Although members of the LGBT community face similar health concerns as the general population, certain disparities are reported at a higher rate among LGBT persons than the heterosexual population (1). These disparities experienced by LGBT persons may be compounded if they are also part of a racial or ethnic minority (1). Of note, LGBT persons are more likely to identify themselves as being in poor health than heterosexual individuals, and different segments of the LGBT population have individual health risks and needs. For example, gay and bisexual men are at increased risk for certain sexually transmitted infections and account for more than half of all persons living with HIV or AIDS in the United States (1); lesbian women are less likely to have mammography or Papanicolaou test screening for cancer (2); lesbian and bisexual women are more likely to be overweight or obese (3); and lesbian, gay, and bisexual persons are more likely to become disabled at a younger age than heterosexual individuals (4).

Various state or federal laws may affect the quality of life of LGBT persons and can affect their physical and mental health. Same-sex marriage bans may cause psychological distress (5), prohibitive hospital visitation policies may prevent a same-sex parent from seeing a minor while the child is ill or participating in medical decision making for the child, and exclusions on transgender health care in private and public health plans may cause a transgender patient to seek treatment options through illegal channels (6). These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse (7).

Addressing these disparities will require changes in the way LGBT persons and their families are regarded in society and by the health care system. Policies that are discriminatory toward the LGBT community, or are no longer supported by empirical research, continue to reinforce the environmental and social factors that can affect the mental and physical well-being of LGBT persons. The American College of Physicians (ACP) has a long-standing commitment to improving the health of all Americans and opposes any form of discrimination in the delivery of health care services. ACP is dedicated to eliminating disparities in the quality of or access to health care and is committed to working toward fully understanding the unique needs of the LGBT community and eliminating health disparities for LGBT persons.

This Executive Summary provides a synopsis of the full position paper, which is available in Appendix.

Methods

The ACP Health and Public Policy Committee, which is charged with addressing issues affecting the health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed numerous studies, reports, and surveys on LGBT health care and related health policy. The committee also reviewed information on how state and federal policies may affect the physical and mental health of the LGBT population. Draft recommendations were reviewed by the ACP Board of Regents, Board of Governors, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and recommendations were reviewed by the ACP Board of Regents and approved on 27 April 2015.

The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper (Appendix).

A glossary of LGBT terminology used throughout this paper can be found at https://lgbt.ucsf.edu/glossary-terms.

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Conclusion

The ACP recognizes that reducing health disparities in the LGBT population will take concerted efforts not only by those in the medical community but also from society as a whole. Training future physicians to be culturally and clinically competent in LGBT health care, working with practicing physicians to increase their understanding of the LGBT population and their health needs, advocating for practical health policies supported by empirical research, and working to eliminate laws that discriminate against the LGBT community and their families are all important steps to reducing and ultimately eliminating the health disparities

Appendix: Lesbian, Gay, Bisexual, and Transgender Health Disparities: A Policy Position Paper From The American College of Physicians

Understanding the LGBT Community

The LGBT community is a highly diverse and multifaceted group of persons encompassing all cultures, ethnicities, and walks of life. Under the LGBT umbrella, each individual group faces unique cultural and health-related needs but shares common challenges, such as social stigma, discrimination, and disparities in health care, that unite them.

Research into LGBT health has been expanding as the community has become more visible and outspoken about engaging the health care system in developing a knowledge base on the distinctive challenges and health disparities they face. However, gaps in the medical community's understanding of the overall makeup of the LGBT community and the environmental and social factors that may influence the needs of those persons present an obstacle to addressing challenges in a meaningful way. In 2011, the Institute of Medicine issued a report outlining a research agenda targeting several areas that could affect how the health care system approaches LGBT health, including demographics, social influences, disparities and inequalities, intervention that includes increasing access to care and addressing physical or mental conditions, and transgender-specific needs. The report also recommended the inclusion of the LGBT community in national health surveys and emphasized a need for scientific rigor and a respectful environment when gathering data (8).

One important obstacle to identifying health issues within the LGBT population is a lack of reliable data and the exclusion of sexual and gender minorities' identification on federal health surveys. Recent efforts have been made to gather population data on persons who identify as lesbian, gay, bisexual, or transgender and those who

couples that identified as being married. Before that, the 2000 U.S. Census changed the relationship status of same-sex partners identifying as being the spouse of the head of household to an "unmarried partner" because there were no states in which same-sex marriage was legal. In the 1990 U.S. Census, if a same-sex couple identified themselves as married, the sex of 1 of the respondents was automatically changed to the opposite sex and the couple was enumerated as an opposite-sex married couple (9). The Patient Protection and Affordable Care Act allows the Department of Health and Human Services (HHS) to collect "additional demographic data to further improve our understanding of health disparities," and in 2013, the National Health Interview Survey—an annual study of health care access, use, and behaviors—included sexual orientation as part of its data collection system (10). Recent estimates put the number of persons who identify as lesbian, gay, bisexual, or transgender at more than 9 million or approximately 3.4% of the U.S. population, which some analysts believe may be an underestimate (1). Individuals who may have same-sex attractions or experiences but do not self-identify as LGBT may still fall into the category of sexual minorities and face health disparities associated with LGBT persons.

Access to Care in the LGBT Population

The LGBT community has often been overlooked when discussing health care disparities and continues to face barriers to equitable care. Barriers to care are multidimensional and include stigma and discrimination, poverty, lack of education, racial or ethnic minority status, and other psychological health determinants (11). Studies show that persons who identify as LGBT have greater economic disadvantages and are more vulnerable to poverty than those who do not. Using available information from national surveys, the Williams Institute reports higher overall poverty rates for persons identifying under the LGBT umbrella than heterosexual persons and higher rates of poverty in same-sex couples than heterosexual couples (7.6% vs. 5.7%) (12).

Research shows that LGBT adults and their children are more likely to be uninsured by public or private insurance and that they and their family members continue to face difficulties in gaining access to care and face a higher risk for health disparities than the general population (2). Most Americans gain health insurance coverage through their employer; data are limited but suggest LGBT persons face higher unemployment rates than non-LGBT persons. A 2009 survey in California found a 14% unemployment rate among LGBT adult workers compared with 10% among non-LGBT adults (13).

The Affordable Care Act sought to increase access to care for low-income Americans by expanding Medicaid programs to all persons at or below 133% of the federal poverty level, providing financial subsidies to help those making between 100% and 400% of the federal poverty level purchase insurance on the federal and state marketplace exchanges, and including nondiscrimination protections in health plans sold on the exchanges. Although estimates suggested that the number of uninsured LGBT persons would be reduced as a result of Medicaid expansion, only about half of states have chosen to expand their Medicaid programs, which greatly diminishes its effect. This increases the number of LGBT persons who may fall into what has been dubbed the "coverage gap," in which persons may earn too much to qualify for their state's Medicaid program but too little to qualify for subsidies (14).

Transgender individuals face additional challenges in gaining access to care. Not only are they more likely to be uninsured than the general population, they are more likely to be uninsured than lesbian, gay, or bisexual persons (1). They also face high out-of-pocket costs for transgender-specific medical care if they lack insurance or their insurance coverage does not cover transgender health care. According to the American Congress of Obstetricians and Gynecologists, transgender youth who receive inadequate treatment are at an increased risk for engaging in self-mutilation or using illicit venues to obtain certain treatments; research shows more than 50% of

Mental and Physical Health Disparities

Existing research into the health of the LGBT population has found some health disparities that disproportionately affect the LGBT population. In 2000, the first federally funded research study on the health of LGBT persons assessed 5 major areas of concern for lesbian, gay, and bisexual persons (the report noted that transgender health concerns warranted an independent evaluation): cancer, family planning, HIV and AIDS, immunization and infectious diseases, and mental health (15). Research has shown that lesbian women are less likely to get preventive cancer screenings; lesbian and bisexual women are more likely to be overweight or obese (16); gay men are at higher risk for HIV and other sexually transmitted infections; and LGBT populations have the highest rates of tobacco, alcohol, and other drug use (17). Lesbian, gay, and bisexual persons are approximately 2.5 times more likely to have a mental health disorder than heterosexual men and women (18).

Transgender persons are also at a higher lifetime risk for suicide attempt and show higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than nontransgender persons (19). A 2011 survey of transgender or gender-nonconforming persons found that 41% reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault (20).

Positions

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

Nondiscrimination policies are in place to prevent employment discrimination or

law (21). However, state law varies considerably on the inclusion of sexual orientation and gender identity in nondiscrimination policies and some policies based on sexual orientation alone may not include gender identity. Eighteen states have employment nondiscrimination or equal employment opportunity statutes that cover both gender identity and sexual orientation, and an additional 3 states have nondiscrimination statutes that cover sexual orientation only (22). The Human Rights Campaign, an LGBT rights organization, estimated that as a result of these assorted laws, 3 of 5 U.S. citizens live in an area that does not provide protection for gender identity or sexual orientation (23).

Sexual orientation and gender identity are inherently different and should be considered as such when assessing whether nondiscrimination or harassment policies provide protection to all members of the LGBT community. According to the Institute of Medicine, "sexual orientation" refers to a person's enduring pattern of or disposition to have sexual or romantic desires for, and relationships with, persons of the same sex or both sexes (8). "Gender identity" refers to a person's basic sense of being a man or boy, a woman or girl, or another gender. Gender identity may or may not correspond to a person's anatomical sex assigned at birth. The term "transgender" is now widely used to refer to a diverse group of persons who depart significantly from traditional gender norms (24). Persons who have a "marked difference" between their anatomical sex at birth and their expressed or experienced gender may be diagnosed with gender dysphoria, which is a diagnosis under the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (25).

Evidence shows that individuals with gender identity variants face increased discrimination, threats of violence, and stigma. The National Gay and Lesbian Task Force and the National Center for Transgender Equality conducted a national survey of transgender and gender-nonidentifying persons and found high rates of

workplace, and they experience double the rate of unemployment than the general population (20). Therefore, LGBT persons are more likely to lose their job or not be hired (26).

Employers have the option to include gender identity as part of their company's nondiscrimination or antiharassment policies even if their state does not, and many companies have chosen to include comprehensive protections policies. To reduce the potential for discrimination, harassment, and physical and emotional harm toward persons who are not covered by current protections, the medical community should include both sexual orientation and gender identity as part of any comprehensive nondiscrimination or antiharassment policy.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

The LGBT community is at increased risk for physical and emotional harm resulting from discrimination or harassment, and transgender persons may face greater inequalities in the health care system than the general population. Of note, 19% of transgender persons lack any type of health insurance (20). A handful of states have laws about insurance coverage for transgender health care, such as hormone replacement therapy or sexual reassignment surgery, which may be considered medically necessary as part of the patient's care. Eight states and the District of Columbia have prohibitions on insurance exclusion of treatments for sex reassignment surgery (27).

The World Professional Association for Transgender Health has developed health care standards for transgender persons who have been diagnosed with gender dysphoria. The standards emphasize treatments that will achieve "lasting personal

modification to a person's gender expression or how this individual appears or presents physically to others (28). Research shows that when transgender persons receive individual, medically appropriate care, they have improved mental health, reduction in suicide rates, and lower health care costs overall because of fewer mental health–related and substance abuse–related costs (29). However, not all health plans cover all services associated with transgender health or consider such services medically necessary; some plans may issue blanket exclusions on transgender health care, not cover certain services for a transgender person as they would for nontransgender persons, or only cover the cost of gender reassignment surgery if certain conditions are met. For example, an insurance company may cover posthysterectomy estrogenic hormone replacement therapy for biological women but will not cover a similar type of hormone therapy for a postoperative male-to-female transgender patient. Many professional medical organizations, including the American Medical Association, American Psychological Association, American Psychiatric Association, American Congress of Obstetricians and Gynecologists, and American Academy of Family Physicians, consider gender transition–related medical services medically necessary (30).

The decision to institute a hormone therapy regimen or pursue sexual reassignment surgery for transgender individuals is not taken lightly. Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs. Throughout the course of treatment, patients and their physicians or health care team should discuss available options and the evidence base for those treatments in which such evidence exists. It is especially important that transgender patients whose health care team has determined that treatment should include cross-sex hormone therapy or sexual reassignment surgery and postoperative hormone therapy be well-informed about the potential health risks associated with the long-term use of some hormonal

Without insurance coverage, the cost of treatment for persons with gender dysphoria may be prohibitively expensive. The most extensive and expensive sexual reassignment surgeries may cost tens of thousands of dollars; this does not include associated costs, such as counseling, hormone replacement therapy, copays, or aftercare. The high costs of treatment can result in persons who cannot access the type of care they need, which can increase their levels of stress and discomfort and lead to more serious health conditions. In 2014, the HHS lifted the blanket ban on Medicare coverage for gender reassignment surgery (31) and the federal government announced it would no longer prohibit health plans offered on the Federal Employees Health Benefits Program from offering gender reassignment as part of the plan (27). Transgender health advocates are hopeful this will result in wider coverage for transgender care in private health plans.

The cost of including transgender health care in employee health benefits plans is minimal and is unlikely to raise costs significantly, if at all. A survey of employers offering transition-related health care in their health benefit plans found that two thirds of employers that provided information on actual costs of employee utilization of transition-related coverage reported 0 costs (32). This is the result of a very small portion of the population identifying as transgender and a smaller portion of that group having the most expensive type of gender reassignment surgery as part of their treatment. An analysis of the utilization of transgender health services over 6 years after transgender discrimination was prohibited in one California health plan found a utilization rate of 0.062 per 1000 covered persons (33). The inclusion of transgender-related health care services within a health plan may also result in an overall reduction of health care costs over time because patients are less likely to engage in self-destructive behaviors, such alcohol or substance abuse.

3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

The term "family" as it is seen in society is changing and no longer means married heterosexual parents with children. An analysis shows only 22% of families fall into this category (34). Stepparents, single parents, grandparents, same-sex couples, or foster or adoptive parents all make up the changing face of U.S. families. Across the country, LGBT persons are raising children, and demographic data shows that 110 000 same-sex couples are raising as many as 170 000 biological, adopted, or foster children and 37% of LGBT adults have had a child (35). This modern concept of family is no longer dependent on parental status and does not only include adult heads of household with minor children. Same-sex couples and different-sex couples who do not have children may nevertheless have persons in their lives that they consider family.

Despite research that shows a growing trend toward acceptance of LGBT individuals and families (36), there is no widely used standard definition of family inclusive of the diverse nature of the family structure and definitions vary widely: They can differ from state to state, within the Internal Revenue Service for tax purposes, by employers to determine eligibility for health plans, and by hospitals for the purposes of visitation or medical decision making. If LGBT spouses or partners are not legally considered a family member, they are at risk for reduced access to health care and restrictions on caregiving and decision making; further, they are at increased risk for health disparities, and their children may not be eligible for health coverage (34). Therefore, LGBT persons and families may already be at a financial disadvantage, with single LGBT parents 3 times more likely to live near the poverty line than their non-LGBT counterparts and LGBT families twice as likely to live near the poverty threshold (35). These financial disadvantages can translate into lack of access to medical care and poorer health outcomes similar to those experienced by non-LGBT persons and their families who are uninsured or underinsured, in addition to the health disparities that are already reported among the LGBT community.

married couples and families and is an example of a broad, comprehensive definition of family that includes a person's biological, legal, and chosen family:

> Family means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. (37)

A definition of family inclusive of all types of families, including the LGBT population, is not only fundamental to reducing the disparities and inequalities that exist within the health care system, but also important for the equal treatment of LGBT patients and their visitors in the hospital setting. Countless accounts show loved ones being denied the right to visit; assist in the medical decision-making process for their partner, minor, or child; or be updated on the condition of a patient because hospital visitation policy broadly prohibits those who are not recognized family members from access to the patient. These policies are discriminatory against LGBT patients, their visitors, and the millions of others who are considered family, such as friends, neighbors, or nonrelative caregivers who can offer support to the patient.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may to act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

When persons or their loved ones need emergency care or extended inpatient stays in

rights as patients or visitors. Hospital visitation policies are not always clear or consistent about who can visit or make medical decisions for a patient if they become incapacitated or cannot do so themselves. The absence or limited access of loved ones can cause uncertainty and anxiety for the patient. In contrast, the involvement of family and outside support systems can improve health outcomes, such as management of chronic illness and continuity of care (38).

A highly publicized incident of LGBT families facing discrimination and being denied hospital visitation occurred in Florida in 2007. A woman on vacation with her family had an aneurysm and was taken to the hospital. Her same-sex partner and their children were denied the right to see her or receive updates on her condition, and she eventually slipped into a coma and died (39). In response to this incident, President Obama issued a presidential memorandum recommending that the HHS review and update hospital visitation policies for hospitals participating in Medicare or Medicaid and critical-access hospitals to prohibit discrimination based on such factors as sexual orientation or gender identity (40).

Throughout the rulemaking process, the HHS revised the Medicare Conditions of Participation to require that all hospitals explain to all patients their right to choose who may visit during an inpatient stay, including same-sex spouses, domestic partners, and other visitors, and the patients' right to choose a person to act on their behalf. The Joint Commission, the nation's largest organization for hospital accreditation, also updated its standards to include equal visitation for LGBT patients and visitors (41). As a result of these updated policies, most hospitals and long-term care facilities are required to allow equal visitation for LGBT persons and their families.

The presidential memorandum also recommended that the HHS instruct hospitals to disclose to their patients that patients have a right to designate a representative to

"should give deference to patients' wishes about their representatives, whether expressed in writing, orally, or through other evidence, unless prohibited by state law" (42). With piecemeal regulations and policies governing the legal rights of LGBT persons and their families, some same-sex spouses or domestic partners choose to prepare advance directives, such as durable powers of attorney and health care proxies, in an effort to ensure their access to family members and their ability to exert their right to medical decision making if necessary.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

The health and financial benefits of marriage for different-sex couples are widely reported, and contemporary research supports similar benefits in same-sex marriage. On the other hand, denial of marriage rights for LGBT persons may lead to mental and physical health problems. Health benefits associated with same-sex marriage result from improved psychological health and a reinforced social environment with community support (43). Research suggests that being in a legally recognized same-sex marriage diminishes mental health differentials between LGBT and heterosexual persons (5). A comparison study on the utilization of public health services by gay and bisexual men before and after Massachusetts legalized same-sex marriage found a reduction in the number of visits for health problems and mental health services. The study noted a 13% reduction in visits overall after the legalization of same-sex marriage (44).

In contrast, denial of such rights can result in ongoing physical and psychological health issues. Thus, LGBT persons encountering negative societal attitudes and discrimination often internalize stressors and have poor health unseen to those

increases in general anxiety, mood disorders, and alcohol abuse (45). The denial of marriage rights to LGBT persons has also been found to reinforce stigmas of the LGBT population that may undermine health and social factors, which can affect young adults (46). The American Medical Association's broad policy supporting civil rights for LGBT persons acknowledges that denial of civil marriage rights can be harmful to LGBT persons and their families and contribute to ongoing health disparities (47).

Since 2003, the overall support for marriage equality has increased. The shift in attitudes toward acceptance of same-sex marriage has broad positive implications for the future of U.S. civil marriage rights. A 2013 survey by the Pew Research Center revealed that nearly half of U.S. adults expressed support for same-sex marriage. Of note, millennials (those born after 1980) showed the highest rate of support for same-sex marriage rights at 70%. Not only has overall opinion changed, but individually, 1 in 7 respondents reported they had changed their minds from opposing to supporting same-sex marriage. The Pew survey found that 32% of respondents changed their mind because they knew someone who identified as lesbian or gay (36).

The legal landscape is also shifting in favor of inclusive civil marriage rights for same-sex couples. The American Bar Association has adopted a resolution recognizing "that lesbian, gay, bisexual and transgender (LGBT) persons have a human right to be free from discrimination, threats and violence based on their LGBT status and condemns all laws, regulations and rules or practices that discriminate on the basis that an individual is [an] LGBT person" (48). In June 2013, the U.S. Supreme Court struck down a provision of the Defense of Marriage Act that defined marriage as a "union between a man and a woman." The decision allowed legally married same-sex couples to have the same federal benefits offered to heterosexual couples (49). Currently more than half of the states and the District of Columbia allow same-

arguments in a case involving same-sex marriage bans in Michigan, Ohio, Kentucky, and Tennessee; this will ultimately determine the constitutionality of same-sex marriage bans, including whether states would be required to recognize same-sex marriages performed legally out of state (51).

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

Previous efforts to understand the LGBT population by including sexual orientation or gender identity in health surveys and data collection are a good first step, but there is a long way to go to understand the unique health needs of all members of the LGBT community. Understanding the demographics of the persons who make up this community is a key first step to understanding how environmental and social determinants may contribute to the health disparities they face. Overwhelming evidence shows that racial and ethnic minorities experience greater health disparities than the general population. In 2010, ACP published an updated position paper on racial and ethnic disparities in health care, which identified various statistics on health disparities in racial and ethnic minority groups, such as higher levels of uninsured Hispanics than white persons (34% vs. 13%) and lower rates of medication adherence in minority Medicare beneficiaries diagnosed with dementia (52). Persons who are part of both the LGBT community and a racial or ethnic minority group may face the highest levels of disparities. For example, data show that 30% of African American adults who identify as lesbian, gay, or bisexual are likely to delay getting a prescription compared with 19% of African American heterosexual adults (26).

Transgender persons may also face certain increased risk factors that can affect their health that are not included when discussing the LGBT population as a whole, which creates research gaps with the LGBT community. A survey study of transgender

education, employment, housing, and public accommodations than other sexual, racial, or ethnic minority groups. The lack of and unfamiliarity with research focused on the physical health issues of transgender persons, such as hormone replacement therapy and cancer risk, limit the understanding or development of best practices that could reduce the disparities felt by this population. The dearth of such research is detrimental to physicians' understanding of issues unique to transgender patients and reduces their ability to care for these patients.

Data that have been gathered in the relatively short time since the inclusion of sexual orientation, gender identity, and same-sex marital status have revealed information that can be used to create tailored plans to decrease health disparities in in the LGBT community. For example, in 2009 the California Health Interview Survey collected information on certain health indicators and included sexual orientation along with racial and minority status. The survey found a higher rate of uninsured lesbian, gay, or bisexual Latino adults in the state than their African American counterparts (36% vs. 14%) (20).

In addition to obtaining information from population surveys, including gender identity and sexual orientation as a component of a patient's medical record (paper or electronic) may help a physician to better understand an LGBT patient's needs and provide more comprehensive care. This can be particularly useful in the care of transgender persons, whose gender identity and gender expression may differ from their sex assigned at birth and are not in line with the standard sex template on many forms. Including this information—especially in electronic health records that can standardize information, such as anatomy present and the preferred name/pronoun—can create a more comfortable experience for the patient and keep the physician up to date on the patient's transition history, if applicable (53). If a physician uses paper medical records, the patient's chart should be flagged using an indicator, such as a sticker, to alert staff to use the preferred name and pronoun of the patient (54).

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

Establishing understanding, trust, and communication between a physician and a patient is key to an ongoing and beneficial physician–patient relationship. However, reported instances of physician bias or denial of care to LGBT patients may influence patients to withhold information on their sexual orientation, gender identity, or medical conditions that could help the physician have a better understanding of the potential health needs of their patients. Physicians can play an integral role in helping an LGBT patient navigate through the medical system by providing respectful, culturally, and clinically competent care that underscores the overall health of the patient. In an article published in *The New England Journal of Medicine,* Makadon noted how physicians can create a welcoming and inclusive environment to LGBT patients:

> [G]uidelines for clinical practice can be very simple: ask the appropriate questions and be open and nonjudgmental about the answers. Few patients expect their providers to be experts on all aspects of gay and lesbian life. But it is important that providers inquire about life situations, be concerned about family and other important relationships, understand support systems, and make appropriate referrals for counseling and support when necessary. (55)

Providing clinically and culturally competent care for transgender persons in the primary care setting may present a challenge to physicians who are not knowledgeable about transgender health. Transgender persons have reported encounters with physicians who are unaware of how to approach treatment of a transgender person, and half of transgender patients reported having to "teach"

transgender status (20). Resources for physicians on how to approach the treatment of transgender patients should emphasize respecting the patient's gender identity while providing prevention, treatment, and screening to the anatomy that is present (56).

To better understand the unique health needs of the LGBT community, physicians and medical professionals must develop a knowledge base in cultural and clinical competency and understand the factors that affect LGBT health; this should begin in the medical school setting and continue during practice. Assessment of LGBT-related content at medical schools found a median of 5 hours spent on LGBT-related issues over the course of the curriculum (57). Exposure to members of the LGBT population in medical school has been shown to increase the likelihood that a physician will take a more comprehensive patient history, have a better understanding of LGBT health issues, and have a more positive attitude toward LGBT patients (58). Studies show that undergraduate students pursuing a career in medicine are receptive to incorporating LGBT-related issues into their education and agree that it applies to their future work (59). The College recognizes the importance of incorporating LGBT health into the medical school curriculum and publishes a comprehensive medical textbook on LGBT health, *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd Edition* (60).

In November 2014, the Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development released a comprehensive report recommending strategies on how to implement changes in academic medical institutions to better address the needs of LGBT patients; further, the committee identified challenges and barriers to carrying out these changes. The report recognizes 3 methods of integrating LGBT health into the medical school curricula: full curriculum revision, the addition of a required class, or LGBT health study as a part of elective materials. The report also identifies barriers to curricular

institutional time that would permit teachers to participate in continuing education on the topic (61).

For some LGBT persons interested in pursuing careers in medicine, there continues to be an underlying concern that their sexual orientation or gender identity may affect their selection into a medical school or residency program and acceptance by their peers. In 2012, Dr. Mark Schuster published his personal story about being gay in medicine starting in the 1980s when he entered medical school, through residency, and into practice. In his article, he spoke of a former attending physician he worked under who acted as an advisor and had indicated he would offer him a recommendation for residency, only to find this physician later renege on that offer after Dr. Schuster shared that he was gay (62). Little research has been done on the recruitment of LGBT physicians into the practice of medicine or how disclosing sexual orientation may affect training. One survey measuring the perceptions and attitudes toward sexual orientation during training found that 30% of respondents did not reveal their sexual orientation when applying for residency positions for fear of rejection (63).

Academic medical institutions can make efforts to create a welcoming and inclusive environment for students and faculty. The University of California, San Francisco, LGBT Resource Center developed a checklist for medical schools to assess LGBT curriculum, admissions, and the working environment within their institution. The checklist includes inclusive application procedures, measurement of retention of LGBT students, and efforts and resources dedicated to student well-being (64). In a 2013 white paper, the Gay and Lesbian Medical Association made several recommendations to support an LGBT-inclusive climate at health professional schools in such areas as institutional equality, transgender services and support, diversity initiatives, admissions, staff and faculty recruitment and retention, staff and faculty training, and other areas that underscore simple yet thoughtful ways to

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

Since 1973, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has not considered homosexuality an illness (66). All major medical and mental health organizations do not consider homosexuality as an illness but as a variation of human sexuality, and they denounce the practice of reparative therapy for treatment of LGBT persons (67). The core basis for "conversion," "reorientation," or "reparative" therapy, which is generally defined as therapy aiming at changing the sexual orientation of lesbian women and gay men, is mostly based on religious or moral objections to homosexuality or the belief that a homosexual person can be "cured" of their presumed illness.

In 2007, the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change sexual orientation. It found serious flaws in the research methods of most of the studies and identified only 1 study that met research standards for establishing safety or efficacy of conversion therapy and also compared persons who received a treatment with those who did not. In that study, intervention had no effect on the rates of same-sex behavior, so it is widely believed that there is no scientific evidence to support the use of reparative therapy (68). The Pan American Health Organization, the regional office for the Americas of the larger World Health Organization, also supports the position that there is no medical basis for reparative therapy and that the practice may pose a threat to the overall health and well-being of an individual (69). Dr. Robert Spitzer, the author of a 2003 research study often cited by supporters of the reparative therapy movement to purport that persons may choose to change their sexual orientation, has denounced the research as flawed and apologized to the LGBT community in a letter for misinterpretations or misrepresentations that arose from the study (70).

actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons. Research done at San Francisco State University on the effect of familial attitudes and acceptance found that LGBT youth who were rejected by their families because of their identity were more likely than their LGBT peers who were not rejected or only mildly rejected by their families to attempt suicide, report high levels of depression, use illegal drugs, or be at risk for HIV and sexually transmitted illnesses (71). The American Psychological Association literature review found that reparative therapy is associated with the loss of sexual feeling, depression, anxiety, and suicidality (68).

States have delved into the debate over the use of reparative therapy for minor children given the potential for harm. California; New Jersey; and Washington, DC, have enacted laws banning the practice. Several other state legislatures, such as those in Washington state, Massachusetts, New York, and Oregon, have introduced or passed legislation through one chamber but failed to pass the bill into law (72). The New Jersey law was challenged on the grounds that the ban limited the free speech of mental health professionals, but the law was upheld by the Third U.S. Circuit Court of Appeals (73). In May 2015, the U.S. Supreme Court declined to hear a challenge to the law (74).

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Persons who are considered at increased or possible risk for certain infectious diseases, such as intravenous drug users, recipients of animal organs or tissues, and those who have traveled or lived abroad in certain countries, are prohibited by the U.S

deferral of blood donation for MSM was instituted during a time when the incidence of HIV and AIDS increased to epidemic levels in the United States, and the disease and how it was transmitted were largely misunderstood by the scientific community. In the following years, concerted efforts by the medical community, patient advocates, and government officials and agencies resulted in advancements in blood screening technology and treatments for the virus. However, during that time of uncertainty, policies were implemented to balance the risk for contaminating the blood supply with what was known about the transmissibility of the disease.

Several medical organizations support deferral policy reform based on available scientific evidence and testing capabilities. The American Medical Association policy on blood donor criteria supports, "the use of rational, scientifically based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of risk" (76). The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have long advocated for a modification to deferral criteria to be "made comparable with criteria for other groups at increased risk for sexual transmission of transfusion-transmitted infections" and recommend a 12-month deferral for men who have had sex with another man since 1977, which is in line with deferral criteria for others who have exhibited high-risk behavior (77). The eligibility standards and policies on the donation of tissues or tissue products (5-year deferral since last sexual contact) (78) and vascular organs (risk assessed individually, disclosed to transplant team, and consent required) (79) by MSM also reflect a measured assessment of disease transmission risk to donor recipients.

Many countries, including the United Kingdom, Canada, Finland, Australia, and New Zealand, have successfully instituted deferral periods ranging from 12 months to 5 years in lieu of a lifetime ban on blood donation by MSM without measurable increased risk to the blood supply. A study of the risk of blood donations from MSM

transfusion-transmitted HIV (80). Australia changed the deferral policy for MSM from 5 years to 12 months over 1996 to 2000. A study that compared the prevalence of HIV among blood donors from the 5-year deferral period compared with the 12-month deferral period found no evidence that the 12-month period increased risk for HIV in recipients (81).

In late 2014, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted in favor of recommending a 1-year deferral policy for MSM and increased surveillance of the blood supply. The U.S Food and Drug Administration announced it would be updating its policy on blood donation from MSM after considering recommendations made by the HHS, reviews of available scientific evidence, and recommendations from its own Blood Products Advisory Committee. The policy about indefinite deferral on blood donation from MSM is being updated to a 1-year deferral period from the last sexual contact, and the U.S. Food and Drug Administration will issue draft guidance on the policy change in 2015. In addition, the agency announced it has already taken steps to implement a national blood surveillance system to monitor what, if any, effects the new policy has on the nation's blood supply (82). Lifting the lifetime ban on blood donation by MSM is an important first step toward creating equity among those wishing to donate blood. The U.S Food and Drug Administration should continue to monitor the effects of a 1-year deferral and update its policy as information and data are gathered through surveillance to make further strides toward policies that assess donor eligibility on the basis of scientific data and individual risk factors, such as the length of time since a high-risk behavior has occurred, type of sex that occurred, number of partners during a period of time, or a combination of factors (83).

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* This paper, written by Hilary Daniel, BS, and Renee Butkus, BA, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee from initiation of the project until its approval and authored this position paper are Thomas G. Tape, MD (*Chair*); Douglas M. DeLong, MD (*Vice-Chair*); Micah W. Beachy, DO; Sue S. Bornstein, MD; James F. Bush, MD; Tracey Henry, MD; Gregory A. Hood, MD; Gregory C. Kane, MD; Robert H. Lohr, MD; Ashley Minaei; Darilyn V. Moyer, MD; and Shakaib U. Rehman, MD. Approved by the ACP Board of Regents on 27 April 2015.

This article was published online first at www.annals.org on 12 May 2015.

Published: *Ann Intern Med.* 2015;163(2):135-137.
DOI: 10.7326/M14-2482

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ARTICLE

Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults

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The authors have indicated they have no financial relationships relevant to this article to disclose.

What's Known on This Subject

To our knowledge, no other study has examined the relationship between family rejection of LGB adolescents with health and mental health problems in emerging adulthood.

What This Study Adds

This study expands our understanding of predictors of negative health outcomes for LGB adolescents and provides new directions for assessing risk and preventing health and mental health problems in LGB adolescents.

ABSTRACT

OBJECTIVE. We examined specific family rejecting reactions to sexual orientation and gender expression during adolescence as predictors of current health problems in a sample of lesbian, gay, and bisexual young adults.

METHODS. On the basis of previously collected in-depth interviews, we developed quantitative scales to assess retrospectively in young adults the frequency of parental and caregiver reactions to a lesbian, gay, or bisexual sexual orientation during adolescence. Our survey instrument also included measures of 9 negative health indicators, including mental health, substance abuse, and sexual risk. The survey was administered to a sample of 224 white and Latino self-identified lesbian, gay, and bisexual young adults, aged 21 to 25, recruited through diverse venues and organizations. Participants completed self-report questionnaires by using either computer-assisted or pencil-and-paper surveys.

RESULTS. Higher rates of family rejection were significantly associated with poorer health outcomes. On the basis of odds ratios, lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence.

CONCLUSIONS. This study establishes a clear link between specific parental and caregiver rejecting behaviors and negative health problems in young lesbian, gay, and bisexual adults. Providers who serve this population should assess and help educate families about the impact of rejecting behaviors. Counseling families, providing anticipatory guidance, and referring families for counseling and support can help make a critical difference in helping decrease risk and increasing well-being for lesbian, gay, and bisexual youth. *Pediatrics* 2009;123:346–352

www.pediatrics.org/cgi/doi/10.1542/peds.2007-3524

doi:10.1542/peds.2007-3524

Key Words
LGB adolescents, risk factors, sexual orientation, gay youth, homosexuality

Abbreviations
LGB—lesbian, gay, and bisexual
FAP—Family Acceptance Project
CES-D—Center for Epidemiologic Studies Depression Scale
STD—sexually transmitted disease
OR—odds ratio

Accepted for publication Jul 31, 2008

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SINCE STUDIES WERE first published on homosexual youth in the 1970s and 1980s,[1,2] serious health disparities[3–8] have been documented among lesbian, gay, and bisexual (LGB) adolescents compared with their heterosexual peers. Population-based and community studies have documented higher levels of suicide attempts,[9–11] substance use,[3,4,6] symptoms of depression and mental health problems,[12,13]and sexual health risks, including risk for sexually transmitted infections, HIV,[3,14,15] and adolescent pregnancy.[16–18] Similarly, population-based studies have reported high levels of negative health outcomes for LGB adults compared with heterosexuals.[19–22]

Both practitioners and researchers have noted that risks to physical, emotional, and social health for sexual minority adolescents are primarily related to social stigma and negative societal responses,[23–26] particularly in schools[3,25–29] In addition, several studies have linked minority stress (experiencing and internalizing negative life events and victimization in the social environment) with negative health outcomes in LGB adults, including depressive symptoms, substance use, and suicidal ideation.[30,31]

Pediatric providers are trained to work closely with families and to recognize that families have "a central and enduring influence" on a child's life.[32] Because parents and key caregivers are perceived to play a vital role in an

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adolescent's health and well-being,[33] it is surprising that so little attention has focused on parents and caregivers' influence on their LGB children and adolescents' health and well-being.

This article presents findings related to family rejection from the Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of lesbian, gay, and bisexual adolescents and young adults. To our knowledge, no other study has previously examined this relationship. The current study was designed to link specific family reactions to their children's sexual orientation and gender expression with health and mental health problems in emerging adulthood.

METHODS

Sampling and Recruitment

The FAP uses a participatory research approach advised at all stages by the population of interest (LGB adolescents, young adults, and family members), as well as health care providers, teachers, and advocates. Participatory research increases both the representativeness and the cultural competence of sampling and research strategies.[34] Providers, youth, and family members met regularly with the research team to provide guidance on all aspects of the research, including methods, recruitment, instrumentation, analysis, coding, materials development, and dissemination and application of findings.

We recruited a sample of 245 LGB young non-Latino white and Latino adults, ages 21 to 25 years, who were open about their sexual orientation to at least 1 parent or primary caregiver (including guardians) during adolescence. Twenty-one participants self-identified as transgender. Because of the small number of transgender participants, we only report here on outcomes from 224 LGB respondents. Participants were recruited conveniently from 249 LGB venues within 100 miles from our office. Half of the sites were community and social organizations that serve LGB young adults, and half were from clubs and bars serving this group. Bilingual recruiters conducted venue-based recruitment from bars and clubs and contacted each agency to access all young adults who use their services.

Study Procedures

Young adults who expressed interest in the study were screened for eligibility, and those meeting inclusion criteria were enrolled. Criteria included: age 21 to 25 years; ethnicity (non-Latino white, Latino, or Latino mixed); self-identification as LGB, homosexual, or queer/non-heterosexual during adolescence; knowledge of their LGB sexual orientation by at least 1 parent or guardian during adolescence; and having lived with at least 1 parent or guardian during adolescence at least part-time. LGB young adults, ages 21 to 25 years, were studied to assess the impact of family reactions to their LGB identity at an age when most young people have achieved greater independence and are more likely to be living on their own with fewer immediate parental buffers or behavioral restrictions.

The family rejection measures in the survey were developed based on a previous in-depth qualitative study conducted in English and Spanish among 53 socioeconomically and geographically diverse Latino and non-Latino white LGB adolescents and 49 completed families throughout California from 2002 to 2004. These in-depth individual interviews of 2 to 4 hours each generated 106 specific behaviors that families and caregivers used to express acceptance or rejection of their LGB children; 51 of these family reactions were rejecting (such as excluding their LGB child from family activities or events).

Measures

Family Rejection

On the basis of transcripts of in-depth interviews, we created 51 close-ended items that assessed the presence and frequency of each rejecting parental or caregiver reaction to participants' sexual identity and gender expression when they were teenagers, creating at least 3 close-ended items for each type of outwardly observable rejecting reaction documented in transcripts. For example, "Between ages 13–19, how often did your parents/caregivers blame you for any anti-gay mistreatment that you experienced?"

For each survey item, participants indicated whether their parents or caregivers reacted in the way specified by the item "many times," "a few times," "once or twice," or "never." For the current analysis, however, we dichotomized responses to each item into never (0) or ever (1). We dichotomized item responses because, at this point in the research program, it is unclear whether the frequencies of different rejecting reactions are equivalent with respect to potential health impact. For example, are multiple acts of exclusion from family activities equivalent to multiple disparaging comments made by the family about LGB persons? We plan to address these questions in subsequent analyses. In addition, the dichotomous scoring of items facilitated comparison of the mean number of different types of family rejecting reactions for different gender and ethnic subgroups. Dichotomized scores were then added to create a family rejection score, with values ranging from 0 to 51 (mean: 20.91; SD: 15.84). Reliability analyses indicate that the FAP Family Rejection Scale has high internal consistency (Cronbach's $\alpha = .98$).

To facilitate use of the findings by pediatric providers, we also divided the sample equally into 3 subgroups based on the tertile in which their family rejection score fell: low rejection scores ($n = 76$; scores ranging from 0–11.00 [mean: 4.86]), moderate rejection scores ($n = 74$; scores ranging from 11.09 to 25.50 [mean: 17.48]), and high rejection scores ($n = 74$; scores ranging from 26.56 to 51.00 [mean: 40.83]).

Mental Health

We assessed 3 mental health outcomes: current depression, suicidal ideation in the last 6 months, and lifetime

TABLE 1 Demographics

Variable	Total ($N = 224$)	Male		Female		Statistically Significant Effects[a]
		White ($n = 52$)	Latino ($n = 62$)	White ($n = 55$)	Latina ($n = 55$)	
Mean age, y	22.82	22.88	22.74	23.09	22.58	None
Education, %						
Less than high school	9.8	13.5	11.3	5.5	9.1	None
High school graduate	18.3	19.2	19.4	18.2	16.4	
Some college	50.9	46.2	62.9	43.6	49.1	
College degree or higher	21.0	21.2	6.5	32.7	25.5	
Employment and income, %						
Currently employed	76.3	61.5	85.5	80.0	76.4	G[b], GxE[b]
In school	56.6	40.0	66.7	45.5	84.6	E[b]
Weekly income <$100	23.3	30.8	14.5	25.5	24.1	None
Weekly income $101[en]$300	32.7	19.2	33.9	40.0	37.0	
Weekly income $301[en]$500	28.3	34.6	29	21.8	27.8	
Weekly income $500+	15.7	15.3	22.6	12.7	11.1	
Sexual identity, mean ages, y						
Aware of same-sex attraction	10.76	9.54	9.74	11.47	12.36	G[c]
Came out to self	14.16	13.88	13.64	14.2	14.95	G[b]
Came out to others	15.32	15.21	15.34	15.21	15.73	None
Came out to family	15.82	15.27	15.81	16.24	16.13	None

G indicates gender effect; E, ethnicity effect; GxE, gender-by-ethnicity interaction.
[a] Results of logistic regressions testing gender, ethnicity, and their interaction as predictors of demographic variables.
[b] $P < .05$.
[c] $P < .001$.

suicide attempts. Level of current depression was assessed through the Center for Epidemiologic Studies Depression Scale (CES-D). We used the recommended cutoff point for adolescents and young adults[35] (>16 indicates probable depression). Suicidal ideation and suicide attempts were measured by single items that were scored dichotomously yes (1) or no (0).

Substance Use and Abuse

We assessed substance use and abuse in 3 ways: heavy alcohol drinking in the past 6 months, use of illicit drugs in the past 6 months, and substance use–related problems in the last 5 years. Heavy drinking was defined by drinking 1 to 2 times per week or more with 3 or more drinks on a typical day. Illicit drug use was assessed by a single item answered dichotomously about use in the past 6 months. Four items assessed the potential negative consequences of alcohol and/or drug use: problems with the law, loss of employment, loss of consciousness, and conflicts with family, lovers, or friends. Measure of substance use–related problems was scored dichotomously (≥1 substance use–related problems [1] versus none [0]).

Sexual Risk Behavior

We assessed sexual behavior in the last 6 months by asking about number, gender, and type of sexual partners, type of sexual activity, and whether condoms were used when activity involved anal or vaginal penetration. Based on these responses, we created 2 measures of sexual risk: Any unprotected anal and/or vaginal sex with a casual, nonmonogamous, or HIV-serodiscordant partner (1) at last intercourse, and (2) any time in the past 6 months. Because young lesbian and bisexual women experience their greatest risks for HIV infection through sexual behaviors with men, sex between 2 women was not categorized as "risky" for HIV infection. Significant percentages of young women reported unprotected vaginal sex with casual male partners. Finally, we asked whether participants had ever in their lives been diagnosed by a health care professional as having an STD. The 3 measures were scored dichotomously as yes (1) or no (0).

RESULTS

Demographic Profile of the Sample

Table 1 includes the demographic profile of the sample. The mean age was 22.82 years, with no significant age differences by gender or ethnicity. Forty-eight percent were non-Latino whites and 52% were Latino; 51% identified as male, 49% as female. Contrary to what would be expected for non-LGB populations, non-Latino white men were the least likely to be employed (61.5%) and were less likely to be in school (40%). The findings on sexual identity development indicate that, on average, men were aware of same-sex attraction 2 years earlier than women and self-identified as LGB ~1 year earlier than the women. No gender differences were found for disclosure of sexual orientation to family and others.

Negative Health Outcomes According to Gender and Ethnicity

Table 2 reports the prevalence of negative health problems for the sample according to gender and ethnicity. Rates are high for depression, suicidal ideation and at-

TABLE 2 **Health-Related Problems According to Gender and Ethnicity**

Variable	%					Statistically Significant Effects[a]
	Whole Sample	Male		Female		
		White	Latino	White	Latino	
Mental health problems						
Current depression (CES-D>16)	43.3	44.2	58.1	41.8	27.3	GxE[b]
Suicidal ideation	25.4	25.0	35.5	27.3	12.7	GxE[b]
Suicide attempts (any, ever)	40.6	44.2	54.8	34.5	27.3	None
Substance use and abuse						
Heavy drinking (past 6 mo)	41.5	48.1	58.1	32.7	25.5	None
Illicit substance use (last 6 mo)	54.5	47.3	43.6	63.5	62.9	None
Substance use[en]related problems (any, ever)	54.7	55.8	67.7	50.9	42.6	None
Sexual risk						
Unprotected sex with casual partner (last 6 mo)	27.2	40.4	45.2	7.3	14.5	G[c]
Unprotected sex with casual partner (at last intercourse)	20.7	13.7	32.3	20.0	14.8	GxE[b]
STD diagnosis (any, ever)	27.6	38.0	38.0	23.5	11.5	None

GxE indicates gender-by-ethnicity interaction.

[a] Results of logistic regressions testing gender, ethnicity, and their interaction as predictors of demographic variables.

[b] $P < .05$.

[c] $P < .001$.

tempts, substance use, and sexual health risks. More than half (54.7%) reported at least 1 substance use–related problem, and 40.6% reported at least 1 lifetime suicide attempt. Taken together, the data indicate that about half of this sample of young LGB adults show considerable mental health and substance use problems. Sexual risk behavior appears somewhat less frequently but still at a relatively high incidence.

To determine whether health outcomes differed according to gender and ethnicity, a series of logistic regression analyses were conducted, regressing each outcome onto gender (G: male, female), ethnicity (E: non-Latino white, Latino), and their interaction. Results of these analyses are presented in Table 2. For 2 of the 3 mental health outcomes, significant gender-by-ethnicity interactions were observed, with Latino men showing higher rates of depression and suicidal ideation. Latino men also showed higher levels of HIV risk behavior.

Family Rejection According to Gender and Ethnicity

Table 3 reports means and SDs for the FAP Family Rejection Scale according to gender and ethnicity. Because scale items were scored dichotomously (ever [1] versus never [0]), scale means reflect the mean number of different negative parental/caregiver reactions experienced during adolescence within each subgroup. Non-Latino white women reported the least (mean: 17.65), whereas Latino men reported the highest number (mean: 24.52) of negative family reactions to their sexual orientation in adolescence. To determine whether levels of family rejection differed by gender and ethnicity, a 2 (gender) × 2 (ethnicity) analysis of variance was conducted on the number of reported rejecting experiences (see Table 3). Statistically significant main effects were observed only for gender, indicating that men reported more rejecting reactions than women.

Family Rejection as Predictor of Negative Health Outcomes

The relationships between experiences of family rejection and the 9 negative health outcomes were analyzed in 2 different ways. First, we analyzed the relationship between continuous scale scores and health outcomes in logistic regressions where continuous scores were the independent variable controlling for gender and ethnicity. For this analysis, continuous scores were rescaled so that 1 unit equaled 1 SD. Resulting odds ratios (ORs) can be interpreted as the increased risk for an outcome, given a 1-SD increase in family rejection. A second series of logistic regression analyses were conducted in which each health outcome was regressed onto the trichotomized rejection score, also controlling for gender and ethnicity. These results are reported in Table 4, including the proportion of participants within each family rejection subgroup (low, moderate, and high) who experienced the given negative health outcome.

Greater experiences of family rejection were associated with poorer health outcomes. This was true for all but 2 of the 9 outcomes (heavy drinking in the past 6 months and lifetime history of STD diagnosis). In general, large statistically significant differences in health outcomes were observed when participants scoring in the upper tertile of family rejection were compared with those in the lower tertile. Fewer differences were observed when moderate levels of rejection were compared with low rejection. As Table 4 shows, LGB young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to report illegal drug use, and 3.4 times more likely to report having engaged in unpro-

TABLE 3 **Family Rejection**

Gender	White	Latino
Male	21.30 (17.03)	24.52 (17.12)
Female	17.65 (13.83)	19.74 (14.60)

Range of scale: 0 [en]51. Ethnicity: $F_{1220} = 1.58$, not significant; gender: $F_{1220} = 4.06$, $P < .05$; gender by ethnicity: $F_{2239} < 1$, not significant.

TABLE 4 **Family Rejection as Predictors of Negative Health Outcomes**

Outcome Variable	Rejection Scale Score, OR (95% Confidence Interval)[a]	Percentage of Participants Experiencing Outcome			Moderate Rejection, OR (95% Confidence Interval)[b]	High Rejection, OR (95% Confidence Interval)[b]
		Low Rejection Scores	Moderate Rejection Scores	High Rejection Scores		
Mental health						
Suicidal ideation	2.13 (1.53–2.95)[c]	11.8	21.6	43.2	2.12 (0.86–5.18)	5.64 (2.42–13.14)[c]
Suicide attempts	3.09 (2.18–4.37)[c]	19.7	35.1	67.6	2.29 (1.08–4.83)[d]	8.35 (3.90–17.85)[c]
Depression (CES-D >16)	2.21 (1.62–3.01)[c]	22.4	44.6	63.5	2.92 (1.42–6.00)[e]	5.94 (2.86–12.34)[c]
Substance use/abuse						
Heavy drinking (past 6 mo)	0.84 (0.63–1.12)	40.8	47.3	36.5	1.34 (0.69–2.63)	0.71 (0.36–1.42)
Illicit substance use (past 6 mo)	1.83 (1.35–2.49)[c]	42.1	50.0	71.6	1.42 (0.74–2.72)	3.38 (1.69–6.77)[e]
Substance-related problems (any, ever)	1.60 (1.19–2.14)[e]	48.0	47.3	68.9	0.98 (0.51–1.88)	2.28 (1.16–4.50)[d]
Sexual risk behavior						
Unprotected sex with a casual partner (past 6 mo)	1.73 (1.25–2.40)[e]	23.7	12.2	45.9	0.41 (0.16–1.04)	2.50 (1.17–5.34)[d]
Unprotected sex with a casual partner (last intercourse)	1.72 (1.23–2.42)[e]	13.2	13.9	35.1	1.04 (0.41–2.69)	3.36 (1.47–7.67)[e]
STD diagnosis (any, ever)	1.32 (0.95–1.85)	24.0	27.1	32.8	1.25 (0.58–2.69)	1.49 (0.68–3.27)

All effects were adjusted for gender (female, male) and ethnicity (Latino, white).
[a] Continuous scale score, rescaled such that 1 unit = 1 SD; ORs can be interpreted as the change in odds of the outcome for a 1-SD change in rejection.
[b] Low rejection is the reference group.
[c] $P < .001$.
[d] $P < .01$.
[e] $P < .05$.

tected sexual intercourse, compared with peers from families with no or low levels of family rejection.

DISCUSSION

The results of this study show that negative family reactions to an adolescent's sexual orientation are associated with negative health problems in LGB young adults. As such, this study provides empirical evidence to begin addressing long-standing questions about the precursors of high levels of risk consistently documented in studies of LGB youth and young adults. Because families play such a critical role in child and adolescent development, it is not surprising that adverse, punitive, and traumatic reactions from parents and caregivers in response to their children's LGB identity would have such a negative influence on their risk behaviors and health status as young adults. This study begins to help us understand the important role that parents and caregivers of lesbian, gay, and bisexual youth play in contributing to health problems in their LGB children. Given that higher levels of family rejection and higher rates of negative mental health and HIV risk outcomes were found among Latino gay and bisexual men, our study suggests that this subgroup is particularly affected.

Our findings also underscore a key recommendation of the American Academy of Pediatrics Task Force on the Family: to expand practice to encompass assessment of family relationships and behaviors.[36] Although the current study does not determine causality, it establishes a link between specific parental and caregiver rejecting behaviors and negative health problems in LGB young adults. LGB young people from families with no or low levels of rejection are at significantly lower risk than those from highly rejecting families related to depression, suicidality, illicit substance use, and risky sexual behavior. So helping families identify and reduce specific rejecting behaviors is integral to helping prevent health and mental health problems for LGB young people.

Parents consider pediatricians[36] and other health providers to be important sources of guidance in childrearing. By asking LGB adolescents about their relationships with their families and experiences with family rejection, providers can obtain important information in determining the adolescent's risk profile. Anticipatory guidance offers a direct opportunity to advise parents of LGB youth on how to support their child's health and development.[23]

The current study also has important implications for identifying youth at risk for family violence and for being ejected from their homes or placed in custodial care because of their LGB identity. LGB youth are overrepresented in foster care, juvenile detention, and among homeless youth. Moreover, conflict related to the adolescent's sexual and gender identity is a primary cause of ejection or removal from the home. Early intervention to help educate families about the impact of rejecting behaviors is important to help maintain these youth in their homes.

There are several limitations to the study. This is a retrospective study that measures young adults' reported experiences that occurred several years earlier, which may introduce some potential for, recall bias. To minimize this concern, we created measures that asked whether a specific family event related to their LGB identity actually occurred (eg, verbal abuse), rather than asking generally about "how rejecting" parents were. Although we went to great lengths to recruit a diverse sample drawing from multiple venues, our sample is

technically one of convenience, and thus shares the limitations inherent in all convenience samples.[37] Thus, these data might not represent all subpopulations of LGB young adults, as well as individuals who are neither white nor Latino. The study focused on LGB non-Latino white and Latino young adults to permit more in-depth assessment of cultural issues and experiences related to sexual orientation and gender expression, so it did not include all other groups and drew from 1 urban geographic area. Subsequent research should include greater ethnic diversity to assess potential differences in family reactions. Lastly, given the cross-sectional nature of this study, we caution against making cause–effect interpretations from these findings.

RECOMMENDATIONS FOR PRACTICE

Pediatric providers can help decrease family rejection and increase support for LGB young people in several ways:

1. Ask LGB adolescents about family reactions to their sexual orientation and gender expression and refer to LGB community support programs and for supportive counseling as needed.
2. Identify LGB support programs in the community and online resources to educate parents about how to help their LGB children. Parents need access to positive parental role models to help decrease rejection and increase family support for their LGB children.
3. Advise parents that negative reactions to their adolescent's LGB identity may negatively influence their child's health and mental health.
4. Recommend that parents and caregivers modify highly rejecting behaviors that have the most negative influence on health concerns, such as suicidality.
5. Expand anticipatory guidance to include information on the need for support and the link between family rejection and negative health problems in LGB young people.

Unlike children and adolescents, in general, who receive services and care in the context of their families, LGB adolescents are typically served as adults as if they have no families, across a wide range of settings. These findings indicate that providers serving LGB young people must begin to assess family dynamics and consider the role of families when assessing an LGB adolescent's risk and making decisions about their care. Counseling families, providing anticipatory guidance, and referring families for counseling and support can help make a critical difference in decreasing risk and increasing well-being for many LGB youth who have limited support. Our preliminary work with families who are ambivalent and conflicted about their children's LGB identity indicates that they are receptive and interested to learn about how their words, actions and behaviors affect their children's health. Additional work is needed to demonstrate how to help families increase support for their LGB children by building on family strengths and the love they have for their LGB children.

APPENDIX: RESOURCES FOR FAMILIES WITH LGB CHILDREN

PFLAG

Education, information, and support for parents and families with LGB family members; referrals to LGB community resources and services: www.pflag.org

PFLAG for Families of Color & Allies (New York City)

Education, information, and support for families of color with LGB family members, including information, resources, and support in Spanish: www.pflagfamiliesofcolor.org

API Family Pride

Education, information, and support for Asian and Pacific Islander (API) families with LGB family members: www.apifamilypride.org

Family Acceptance Project

Research-based education and services for ethnically diverse families with LGB children in English, Spanish, and Chinese; currently developing provider assessment tools and interventions to help increase family support for ethnically diverse LGB children and youth: http://familyproject.sfsu.edu

Gender Spectrum Education & Training

Family information, support, and annual conference for families with gender-variant children; training on gender identity and expression for schools and providers for helping gender nonconforming and transgender children and youth: www.genderspectrum.org

ACKNOWLEDGMENTS

This work was funded by a grant from The California Endowment awarded to Drs Ryan and Diaz.

We gratefully acknowledge the support of our funder and the contribution of our community advisory groups and the many adolescents, families and young adults who shared their lives and experiences with us. We also thank The California Endowment, the reviewers, and our colleagues for their assistance and insightful comments: Elizabeth Saewyc, PhD, RN, PHN; Stephen Russell, PhD; Janet Shalwitz, MD; and Donna Futterman, MD.

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SB1028 (CH0685)

2018 Regular Session

Entitled: Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)

Sponsored by: Senator Madaleno

Status: Approved by the Governor - Chapter 685

Chamber	Calendar Date	Legislative Date	Action	Proceedings
Senate	2/5/2018	2/5/2018	First Reading Education, Health, and Environmental Affairs	
	2/7/2018	2/7/2018	Hearing 3/07 at 1:00 p.m.	
	3/22/2018	3/22/2018	Favorable with Amendments Report by Education, Health, and Environmental Affairs	
	3/22/2018	3/20/2018	Favorable with Amendments {664932/1	51
			Special Order until 3/26 (Senator Simonaire) Adopted	51
	3/26/2018	3/22/2018	Favorable with Amendments {664932/1	53
			Laid Over (Senator Reilly) Adopted	53
	3/27/2018	3/23/2018	Committee Amendment Adopted	54
			Favorable with Amendments Report Adopted (32-14)	54
			Floor Amendment {893529/2 (Senator Simonaire) Rejected (13-33)	54
			Floor Amendment {453624/1 (Senator Simonaire) Rejected	54
			Floor Amendment {263124/1 (Senator Salling) Rejected	54
			Second Reading Passed with Amendments	54
	3/28/2018	3/24/2018	Third Reading Passed (34-12)	55
House	3/29/2018	3/22/2018	First Reading House Rules and Executive Nominations	56
	3/30/2018	4/2/2018	Rereferred to Health and Government Operations	
	4/3/2018	4/3/2018	Favorable Report by Health and Government Operations	
	4/3/2018	3/25/2018	Favorable Report Adopted	59
			Second Reading Passed	59
	4/4/2018	3/26/2018	Floor Amendment {353422/1 (Delegate Parrott) Rejected (39-81)	60
			Floor Amendment {133826/2 (Delegate Parrott) Rejected (37-88)	60
			Floor Amendment {353825/1 (Delegate Parrott) Rejected (36-86)	60
			Motion vote previous question (Delegate Atterbeary) Adopted	60
			Third Reading Passed (95-27)	60
Senate	4/5/2018	3/31/2018	Returned Passed	62
Post Passage	5/15/2018	5/15/2018	Approved by the Governor - Chapter 685	

May 15, 2018 1:17 P.M.

EXHIBIT 5

UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC, individually and on behalf of his clients,	)	
Plaintiff,	)	Civil Action No. 1:19-cv-00190-DKC
v.	)	**INJUNCTIVE RELIEF SOUGHT**
LAWRENCE J. HOGAN, JR., Governor of the State of Maryland, in his official capacity, and BRIAN E. FROSH, Attorney General of the State of Maryland, in his official capacity,	)	
Defendants.	)	

PLAINTIFF'S CONSOLIDATED MEMORANDUM IN OPPOSITION TO MOTIONS OF FREESTATE JUSTICE, INC. AND THE TREVOR PROJECT TO FILE BRIEFS AS AMICUS CURIAE IN SUPPORT OF DEFENDANTS

Plaintiff, CHRISTOPHER DOYLE, LPC, LCPC ("Doyle"), pursuant to Local Rule 105, files this memorandum in opposition to the Motion of FreeState Justice, Inc. for Leave to File Brief as *Amicus Curiae* in Support of Defendants (Doc. 28, the "FreeState Motion") and The Trevor Project's Motion for Leave to File *Amicus Curiae* Brief in Opposition to Plaintiff's Motion for Preliminary Injunction (Doc. 31, the "Trevor Motion").

INTRODUCTION

The proposed amicus briefs of FreeState Justice, Inc. ("FreeState") and The Trevor Project ("Trevor") would be neither useful nor timely. Among the critical issues before the Court on Plaintiff's Motion for Preliminary Injunction (Doc. 2) is whether Maryland's counseling ban was constitutionally tailored to its asserted governmental interests **when enacted**. (Pl.'s Mot. Prelim. Inj., Doc. 2, at 25–31.) Proposed amici's outsider "perspective" on what Maryland could have, should have, or might have considered when enacting its counseling ban has no bearing whatsoever on the question of Maryland's actual constitutional tailoring (or complete lack thereof).

Proposed amici's motions should be denied also because they are attempting to put new, purportedly factual matter before the Court to prop up Defendants' case. They should not be allowed to introduce unverifiable "facts" into these proceedings. Their motions make clear that they are attempting to bolster Defendants' legislative record after-the-fact with their own "data" and "research," which Doyle will have no opportunity to investigate, cross examine, or rebut prior to the preliminary injunction hearing. The Court does not need such friends and should reject their attempts.[1]

I. THE AMICUS MOTIONS SHOULD BE DENIED BECAUSE THE INFORMATION PROFFERED IS NEITHER TIMELY NOR USEFUL.

Whether to grant or refuse leave to amicus parties is a matter of the Court's discretion, but "a motion for leave to file an *amicus curiae* brief . . . should not be granted unless the court deems the proffered information **timely and useful**." *Finkle v. Howard Cnty.*, 12 F. Supp. 3d 780, 783 (D. Md. 2014) (emphasis added) (modification in original) (citation and internal quotation marks omitted); *see also American Humanist Ass'n v. Maryland-National Capital park & Planning Comm.*, 303 F.R.D. 266, 270 (D. Md. 2014) (same); *Glynn v. EDO Corp.*, No. JFM-07-1660, 2010 WL 3294347, *2 n.4 (D. Md. Aug. 20, 2010) (same); *Tafas v. Dudas*, 511 F. Supp. 2dd 652, 659 (E.D. Va. 2007) (same); *Georgia Aquarium, Inc. v. Pritzker*, 135 F. Supp. 3d 1280, 1288 (N.D. Ga. 2015); *Waste Mgmt. of Pennsylvania, Inc. v. City of York*, 162 F.R.D. 34, 36 (M.D. Pa. 1995). The proposed briefs are neither, and the Court should decline to accept them.

[1] Doyle responds herein only to proposed amici's motions for leave to file, and interacts with the substance of their proposed briefs only as necessary to oppose the Court's granting leave to file. If leave to file is granted, then Doyle will substantively respond to the briefs in due course.

A. The Proposed Amicus Briefs Are Not Useful.

Assuming Maryland's counseling ban statute, SB 1028, is not a viewpoint-based restriction on speech and therefore unconstitutional *per se* (which it is), Maryland still must prove its content-based counseling ban was narrowly tailored to its purported governmental interests **when enacted**. (Pl.'s Mot. Prelim. Inj., Doc. 2, at 18–31.) As the Supreme Court taught in *McCullen v. Coakley*, the First Amendment "demand[s] a close fit between ends and means." 134 S. Ct. 2518, 2534 (2014). But FreeState and Trevor provide no hint of a relevant connection between their proffered narratives and Maryland's enactment of its counseling ban, and proffer no information about what happened in Maryland leading to the ban's enactment. They certainly do not proffer any information about what less restrictive alternatives to the counseling ban Maryland considered. Accordingly, the information proposed amici proffer is not useful, and therefore does not meet the basic threshold for an amicus filing.

FreeState claims to provide "'a helpful, alternative viewpoint.'" (FreeState Mot., Doc. 2, at 2.) But when it gets to the point, it is clear FreeState wants to introduce untimely facts. Under the guise of "context" (FreeState Mot., Doc. 28, at 3), FreeState indulges in commentary about the source documents recited in the SB 1028 Preamble, and then misrepresents as research findings the mere suggestions of a new unempirical study article. The 2018 article, *Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment* (Doc. 28-2), is not relevant to Maryland's narrow tailoring burden **because it did not exist when SB 1028 was enacted**. Moreover, FreeState misrepresents the article as scientifically supportive of Maryland's patently false but persistent causal narrative—that "conversion therapy" **causes** harm[2]—despite the "several limitations" self-identified by the article,

[2] Pl.'s Mot. Prelim. Inj., Doc. 2, at 6–17.

including the most important: "**causal claims cannot be made**[!]" (Doc. 28-2 at ECF 13 (emphasis added).) A close second is the admission that only persons currently identifying as LGBT were recruited to participate in the study. (Doc. 28-2 at ECF 12–13.) Thus, the study excluded **by design** any person who positively experienced change as a minor and either never identified as LGBT or no longer identifies as LGBT as an adult. Finally, the title of the study itself (***Parent*-*Initiated Sexual Orientation Change Efforts***) demonstrates that it is inapplicable to what Doyle has done and wants to do in Maryland, which is to provide voluntary, client-centered counseling that his minor patients seek and wish to receive. (Pl.'s Mot. Prelim. Inj., Doc. 2, at 2–6.) In sum, the 2018 article offers the same unempirical, unrigorous aspersions already contained in the APA Report (Pl.'s Mot. Prelim. Inj., Doc. 2, at 6–17), and would not have justified SB 1028 even if Maryland could have considered it at the time of enactment.[3]

Moreover, FreeState has a far more relevant perspective that it **hides** from the Court, namely that **FreeState agrees with Plaintiff Doyle that SB 1028 was not necessary in the first place**. FreeState is the successor by merger to Equality Maryland[4], which publicly stated in 2014 that Maryland did not need a "conversion therapy" ban because Maryland's existing regulation of licensed mental health professionals provided minors and their advocates sufficient recourse against professionals who inflicted harm. Kevin Rector, *Gay 'Conversion Therapy' Bill*

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[3] FreeState also introduces another 2018 article as support for the general statement that "sexual minority youth are more than three times more likely to have attempted suicide than heterosexual youth." (FreeState Mot., Doc. 28-1, at 4.) FreeState does not make any attempt, however, to tie this asserted statistic to "conversion therapy" as prohibited by SB 1028, rendering it entirely irrelevant to SB 1028 and this case.

[4] *Who We Are*, FreeState Justice, https://freestate-justice.org/who-we-are/ (last visited Mar. 29, 2019) ("FreeState Justice was formed when FreeState Legal Project and Equality Maryland merged in the spring of 2016; the new name (an earlier name of Equality Maryland) was announced at an event in Baltimore on June 30, 2016.").

Withdrawn as Advocates Pursue Regulatory Oversight, The Baltimore Sun, https://www.baltimoresun.com/features/bs-xpm-2014-03-14-bs-gm-gay-conversion-therapy-bill-withdrawn-20140314-story.html (Mar. 14, 2014). Equality Maryland's statement was a joint statement with Maryland Delegate John Cardin, in connection with Del. Cardin's withdrawal of his 2014 proposed "conversion therapy" ban, because,

> in research for the bill, and in talking to "several organizations with expertise in regulatory protections for patients," they concluded that patients who feel they have been harmed by "conversion" or "reparative" therapy **already have avenues to complain to state health occupation boards**.
>
> "Minors or anyone advocating on their behalf can file a complaint with a board, triggering a vigorous investigation," the statement said. "If the investigation uncovers proof that a licensed health care professional violated the standard of care, then the board has an array of regulatory tools to keep this from happening again."
>
> The statement went on: "Delegate Cardin and Equality Maryland are **confident that the existing regulatory framework provides a precise tool to protect minors** from this harmful therapy, and we will work together and with other advocates to ensure that the process for filing complaints against anyone who engages in these practices is transparent and widely disseminated."
>
> Carrie Evans, Equality Maryland's executive director, said the organization will "work to ensure LGBT youth and their parents have the information they need to file complaints."

Id. (emphasis added). Notably, that SB 1028 was not necessary because minors were adequately protected by existing regulations, that were less restrictive of speech, is one of Plaintiff Doyle's central contentions in this lawsuit. (V. Compl., Doc. 1, at 13–14, 16, ¶¶ 53–60, 76; Pl.'s Mot. Prelim. Inj., Doc. 2, at 30.) But FreeState chooses to hide the ball on the one issue that it could shed helpful light on.

Nevertheless, in offering its "perspective" to the Court regarding SB 1028, FreeState does not disclose (nor can it) how Maryland's professional regulations were less able in 2018, when SB

1028 took effect, to vindicate complaints of harm by minors and their advocates.[5] And given FreeState's undoubtedly effective activism, the absence of any complaints of harm from "conversion therapy" in Maryland since FreeState's 2014 promise to promote the complaint procedure compels the conclusion that there has been no harm to complain about.

FreeState claims to have "played an integral role in advocating for the passage and subsequent enactment of [SB 1028]." (FreeState Mot., Doc. 28, at 2.) FreeState presumably said all it wanted during the legislative process, and those comments are in the public record, which Maryland can proffer to this Court if it deems them relevant. It is too late now for FreeState to attempt to supplement Maryland's legislative record to save the counseling ban from Maryland's lack of narrow tailoring.

Trevor, for its part, seeks to foist on the Court a parental-rejection narrative (Trevor Mot., Doc. 31, at 4) that is already memorialized in SB 1028 (Doc. 1-1 at 4), **but that Maryland has now admitted is not true** in the context of the counseling Doyle has provided and wants to provide. In response to Doyle's request for admission, **Defendants admitted**,

> **no third-party empirical study, research, investigation, resolution, or position paper in the Legislative Record of SB 1028 identified or provided causal evidence of family rejection from, or a causal attribution of family rejection to, voluntary SOCE counseling**, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive.

(Defs.' Resp. Pl.'s Req. Admis. (copy attached hereto as Exhibit A) at 7 (emphasis added).) Falsity is the epitome of uselessness in an amicus filing.

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[5] Maryland's Rule 30(b)(6) representative testified at the State's deposition on March 28, 2019 (transcript pending) that nothing has changed since 2014 in Maryland's regulatory process for handling complaints against licensed mental health professionals.

Furthermore, proposed amici's offers of an "alternative viewpoint" and "unique and important perspective" are illusory. (FreeState Mot., Doc. 28, at 2; Trevor Mot., Doc. 31, at 3–4.) In light of Maryland's unequivocal and strident condemnation of SOCE counseling and all its practitioners in SB 1028, proposed amici offer nothing close to an "alternative" or "unique" viewpoint. Rather, FreeState and Trevor offer only to pile on with more of the same. In these tightly scheduled proceedings, the Court does not need such friends. Granting proposed *amici's* motions will open the floodgates for "alternative viewpoints" which are hopelessly indistinguishable from the viewpoint being presented by Maryland as its justifying interest in enacting its counseling ban. Additionally, if the Court allows these proposed *amici*, the Court will have to allow the same number or more *amici* in support of Doyle to obtain a truly "alternative viewpoint."

B. The Proposed Amicus Briefs Are Not Timely.

Closely related to the constitutional uselessness of proposed amici's proffered information is its untimeliness. Not only is proposed amici's help untimely because it proffers information months after enactment of the counseling bans, but also because their proposed briefing will disrupt the current preliminary injunction proceedings. Indeed, their amicus motions have already disrupted the taut schedule for these proceedings, requiring Doyle's response by March 29, pulling Doyle's counsel away from preparing for the depositions of Doyle (March 26) and Defendants' Rule 30(b)(6) designee (March 28). Granting proposed amici leave to file briefs will create the necessity for Doyle to respond to them prior to the preliminary injunction hearing, unduly interfering with an already crowded schedule.

II. THE AMICUS MOTION SHOULD BE DENIED BECAUSE FACTUAL ARGUMENT SHOULD NOT BE WELCOMED IN AN AMICUS FILING.

Proposed amici's motions should be denied for another critical reason: "[A]n *amicus* who argues facts should rarely be welcomed . . . ." *Strasser v. Doorley*, 432 F.2d 567, 569 (1st Cir. 1970); *see also Bryant v. Better Bus. Bereau of Greater Md., Inc.*, 923 F. Supp. 720, 728 (D. Md. 1996) ("Traditionally, the role of amici has been to act as a friend of the court, providing guidance on **questions of law**. 'At the trial level, where issues of fact as well as law predominate, the aid of amicus curiae **may be less appropriate** . . . .'"); *Finkle v. Howard Cnty.*, 12 F. Supp. 3d 780, 783 (D. Md. 2014) (same); *SEC v. North Star Fin., LLC*, GJH-15-1339, 2017 WL 4407955, *1 n.1 (D. Md. Aug. 4, 2017) (noting standard is whether amicus can provide helpful and relevant analysis of the law); *Washington Gas Light Co. v. Prince George's Cnty. Council*, No. DKC 08-0967, 2012 WL 832756, *3 (D. Md. Mar. 9, 2012) (same); *Waste Mgmt.*, 162 F.R.D. at 36 ("An *amicus* cannot initiate, create, extend, or enlarge issues."). Under the guise of "perspective" and "context," proposed amici are attempting to create an *ex post facto* evidentiary record to bolster Maryland's counseling ban enactment. The Court should see through and reject their improper attempt.

Trevor also reveals that its proposed after-the-fact evidentiary assistance will be based on the content of "confidential" (and presumably anonymous) telephone calls, instant messages, and text messages from its constituents. (Trevor Mot., Doc. 31, at 2.) There is, of course, no indication that any of these unidentified communicants have a connection to Maryland, or received counseling from Doyle. To be sure, Maryland has not identified a single individual claiming to have been harmed by voluntary SOCE counseling in Maryland. In any event, allowing Trevor to introduce anonymous hearsay "facts" would work a profound prejudice on Plaintiffs because Plaintiffs would have no opportunity to investigate or rebut such "facts."

Even if the Court were to disregard proposed amici's improper, purportedly factual submissions, their proposed legal arguments are no more helpful. FreeState leads its legal argument with *Nat'l Inst. for Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (hereinafter, "*NIFLA*"). Doyle and Defendants are more than capable of arguing *NIFLA* to this Court and have done so. (Pl.'s Mot. Prelim. Inj., Doc. 2, at 19, 20, 22, 24, 31; Defs.' Mem. Opp'n Pl.'s Mot. Prelim. Inj., Doc., 25, at 14, 15, 17.) FreeState has not demonstrated it can offer legal insight on *NIFLA* beyond what Defendants are capable of arguing. Trevor's proposed 15-page brief does not cite a single legal authority until page 13, and then leads with two cases expressly **abrogated** by *NIFLA*, 138 S. Ct. at 2371–72: *King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014), and *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014). (Proposed Trevor Br., Doc. 31-1, at 13.) In short, proposed amici offer the Court no helpful or uniquely insightful legal analysis.

CONCLUSION

For all of the foregoing reasons, proposed amici's motions for leave to file amicus briefs should be denied.

/s/ John R. Garza
(signed by Roger K. Gannam
with permission of John R. Garza)
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been filed this March 29, 2019, through the Court's ECF system, which will send a notice of electronic filing to all parties and counsel of record, including the following:

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC

Plaintiff

v. Civil Action No.

1:19-cv-00190-dkc

LAWRENCE J. HOGAN, JR., et al.

Defendants

_____/

The deposition of KIMBERLY CHRISTINE LANG, Ph.D. was held on Thursday, March 28, 2019, commencing at 9:07 a.m., at the Office of the Attorney General, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201, before Robert A. Shocket, a Notary Public.

REPORTED BY: Robert A. Shocket

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ALSO PRESENT: Morgan Clipp, Esquire
Office of the Attorney General
(Present after lunch recess)

INDEX

Deposition of KIMBERLY CHRISTINE LANG, Ph.D.

March 28, 2019

INDEX (Cont.)

(Exhibits retained by Mr. Gannam.)

PROCEEDINGS

Whereupon,

KIMBERLY CHRISTINE LANG, Ph.D.

called for examination, having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION BY MR. GANNAM:

Q. Good morning.

A Good morning.

Q. I'm Roger Gannam and I represent the plaintiffs in the lawsuit of Doyle versus Hogan. And we're here today to take your deposition. I suppose you understand that already?

A I do.

Q. Great. I'm going to go over a couple of ground rules to just get us started and then we'll get into the questions. First of all, we're making a written transcript through the court reporter. So it's very important that all of your answers be verbal, out loud as opposed to, you know, nodding your head or shaking your head.

A I understand.

Q. Great. It's also important that if I ask a question and you don't understand it for some reason that you let me know. Is that okay?

A Certainly.

Q. If I ask a question and you answer it I will assume that you understood it.

A Thank you.

Q. And also in normal conversation we may tend to anticipate each other's responses but it's very important that you let me finish my question before you answer and likewise I will do my best to let you finish your answer before I ask my next question. Is that okay?

A Certainly.

Q. And you know if we mess that up we may remind each other throughout the day. Is that okay?

A Of course.

Q. Your lawyer may object to some questions that I ask. And if your lawyer objects, the generally you should go ahead and answer the question after the

objection unless your lawyer tells you not to answer. Is that okay?

A Correct.

Q. And we are, you know, this is not a marathon on an endurance contest. We can take breaks if we need to. I would just ask that if a question is pending that you answer the question before you take a break.

A Understood.

Q. Great. Do you have any questions for me before we start?

A Not at this time.

Q. Okay. I want to go over a couple of definitional things just because I might use some terminology and I want to make sure we're on the same page. When I say the state I'm talking about the state of Maryland. Is that okay?

A Yes.

MS. ELLIS: I want to impose an objection. The state of Maryland for this purpose is the executive branch. It's not the judiciary or the legislative

branch.

Q. And when I say SB 1028 do you know what I'm talking about?

A I do.

Q. Okay. And I may refer to SB 1028 as the Youth Mental Health Protection Act or the House version which was HB 902 or I might just refer to it as the counseling ban. Is all that understandable?

A Understood.

Q. The ban that's the subject of this lawsuit. When I use the term LGBT it's an acronym or an abbreviation for lesbian, gay, bisexual, transgender. Do you understand that?

A I do.

Q. And if I use SOCE or S-O-C-E, I'm referring to sexual orientation change efforts. Do you understand that?

A I do.

Q. And, okay. Let's proceed then. Please state your name and address for the record, please.

A May I ask, is that my work address or my

home address?

Q. Just take your work address, is fine.

A Okay. Kimberly Christine Lang, L-A-N-G. And my work address is 4201 Patterson Avenue, Baltimore, Maryland 21215.

Q. And it's Dr. Lang, correct?

A Yes, sir.

Q. And you hold a Ph.D.?

A I do.

Q. And what is that subject matter?

A Policy sciences.

Q. Can you just sort of give me a summary of your education after high school?

A My undergrad was at Towson, formally Towson State University here in Baltimore, in social sciences. I have a master's degree from Loyola College in Maryland, here in Baltimore, and that was administration supervision, and the Ph.D. is from University of Maryland Baltimore County in policy sciences.

Q. You're a native Marylander?

A I am.
Q. And did I say Marylander right?
A Close enough.
MR. GANNAM: Okay.
MS. ELLIS: Some people would say "Merliner".
MR. GANNAM: Gotcha. Being from Florida, you know, Floridian just seems easier to say but --
BY MR. GANNAM:
Q. All right. So, can you kind of give me a kind of a summary, thumbnail sketch of your professional career after college?
A I worked for ten years with Anne Arundel County Public School System here in Maryland, taught school, and also worked with new teachers, spent 14 years at the White House in various positions, and then came here to Maryland Department of Health for the last two years.
Q. When did you begin at the Maryland Department of Health officially?
A Would have been July of 2017.

Q. And what position did you take when you first started working for the Department of Health?

A I worked with Maryland Department of Health and their legislative group or GA.

Q. What does GA mean? Is that what you said, GA?

A It's the legislative group.

Q. Okay. And is that still the position you hold now?

A No. I am now the Director of Occupations Boards and Commissions -- Health Occupations Boards and Commissions.

Q. Did you have any positions in between that first position and your current position?

A No, sir.

Q. How long have you been in your current position?

A A little over a year.

Q. Do you recall the month that you began in this position?

A It would have been October 2018 -- October

2017.

Q. Okay.

A I'm sorry.

Q. I was going to say the math wasn't working out with that.

A I'm sorry.

Q. Now it works. Okay.

A I apologize.

Q. No worries. Okay. And in your -- or let me strike that. Have you ever been involved in doing any advocacy for LGBT organizations or causes at any point?

MS. ELLIS: Could you -- I'm going to object that it's not clear. The question is not clear as to what time period or in what function. Are you asking about her job responsibilities?

Q. Have you personally been involved in advocacy for any LGBT causes ever?

A Forgive me. I believe that we were discussing my personal -- I'm sorry -- my work background, not my personal issues.

MR. GANNAM: Well, the depositions are generally when it comes to background information pretty wide-ranging but the issue I'm going to is we're dealing with an LGBT rights issue and I'm entitled to ask questions that get to any potential for bias in testimony or responses. So, so that's why I'm asking the question.

MS. ELLIS: I object. It's completely irrelevant what her personal views are or activities are on any given issue.

MR. GANNAM: Well, we disagree. So the question stands.

MS. ELLIS: And you can choose whether or not you wish to disclose your personal views.

A No, I have not.

BY MR. GANNAM:

Q. And in a related question, have you ever been involved in any, personally in any advocacy relating to the subject of conversion therapy?

MS. ELLIS: Same objection.

A No, I have not.

Q. You mentioned your degrees. Do you hold any other kind of professional licensures or certifications?

A I am licensed in the state of Maryland as an educator.

Q. And have you ever been involved in any -- strike that. Have you ever held any positions professionally that were in the counseling or mental health field?

A No, I have not.

Q. All right. Going to your current position of Director of Health Occupations -- I'm sorry. Could you say that again, what your current position is?

A Director of Health Occupations Boards and Commissions.

Q. Thank you. In that current position can you sort of describe your responsibilities?

A I'll read my job description if that's acceptable.

Q. Please.

A The Director of Health Occupations Boards

and Commissions serves as the liaison between the Office of the Secretary and the 22 health occupations boards and commissions. The director assists in keeping the senior leadership of both the Maryland Department of Health and Boards and Commissions, informed of important and sensitive topics. The director also serves as a conduit between and among the various MDH administrations and boards, helping to ensure open avenues of communication by frequently attending the public session of Boards and Commissions meetings.

Q. And what are you reading from?

A This is my job description.

Q. Is that an official job description published by the State of Maryland?

A It was provided to the executive directors of the Boards and Commissions and to their board chairs. So I don't believe you would be able to find it on a website but it is a public document.

Q. And who created it?

A It was in consultation with the HR

department.

Q. HR department of?

A Maryland Department of Health.

Q. Okay. So it would be fair to say that's a Maryland Department of Health document, your understanding?

A I believe so.

Q. I mean it wasn't created by any government entity outside the Maryland Department of Health?

A No, sir.

Q. And going forward if I say the department will you understand I mean the Department of Health?

A Yes, sir.

Q. Okay. And now that you've read it do you concur that those are your responsibilities?

A I do.

Q. And what did you do for the Department of Health when you first joined prior to your current position?

A I worked with the legislative office.

Q. And what does that entail or what did it

entail?

A Worked with various bills that were being considered, to see the possible impact that it would have on the Maryland Department of Health.

Q. And in that position did you have an opportunity to become familiar with the Maryland legislative process, generally speaking?

A In general.

Q. And, you know, as you sit here today do you remain familiar in general with the Maryland legislative process?

A In general.

Q. And are you familiar with the process involved in the passage and enactment of the counseling ban that we're here to talk about today?

A As far as public documents are concerned, yes.

Q. And by public documents what are you talking about?

A The publicly available documents for the bill, the information that was introduced to the

legislature, possible amendments that were introduced at the floor vote.

Q. Did you have any involvement in the enactment of the bill apart from what's reflected in the public record?

A Nothing.

Q. And did the Maryland Department of Health, you know, contribute any commentary or advice or other information to the legislative body in connection with the counseling ban?

A Not to my knowledge, aside from what might be in the public record.

Q. Did any of the individual health occupation boards or commissions that you are responsible for communicating with provide their own commentary or information to the Maryland legislative body in connection with the conversion therapy bill?

A Not to my knowledge.

Q. Did you review any documents to prepare for your testimony today?

A I did.

Q. And what did you review?

MS. ELLIS: To the extent that you reviewed documents at my request, that I directed you to documents, please don't disclose that fact. That's privileged information. If you recall a document you looked at you can tell him.

A Reviewed the publicly available information on the bill, reviewed the publicly available on the Boards and Commissions websites.

Q. Anything else?

A Not to my recollection.

Q. And for the record you have a notebook. Looks like maybe it's a two-inch, three-inch binder of papers in front of you. What does that notebook contain?

A It is the information that I believe was provided to counsel.

MS. ELLIS: Are you referring to your counsel or that counsel?

THE WITNESS: I'm sorry. To opposing counsel.

BY MR. GANNAM:

Q. Meaning information provided to us?

A Correct. Bill filings, and I also have copies of relevant sections of the publicly available documents on Boards and Commissions websites.

Q. Is there anything to your knowledge in that notebook that was not produced to counsel for Mr. Doyle?

A The only thing that I'm aware of are some notes that I put together for myself including my job description.

Q. Anything else?

A Not to my knowledge.

Q. When you said notes for yourself regarding your job description, do you have other notes that you prepared regarding other subject matters?

A Summary statements from other parts of the notes -- I'm sorry -- from other parts of the documents.

Q. Summary statements that you authored yourself?

A Correct.

Q. And what was your purpose in preparing these summary statements?

A Nerves.

Q. And did you refer to any of these summary statements to refresh your recollection for purposes of your testimony today?

A Yes.

Q. And did any of those statements, summary statements that you reviewed in fact refresh your memory or your recollection for purposes of your testimony today?

A I've not referred to them yet but I hope they would if the need arises.

Q. So I would ask you in case it's not obvious to me if you would let me know if I've asked you a question and you refer to notes in order to answer.

A I understand.

Q. About how long would you say you spent reviewing documents to prepare for your testimony today?

A Several hours over the last two weeks.

Q. And by several hours you mean three or four or more or less than that?

A Sir, I would approximate five.

Q. Fair enough. Did you speak to anyone in preparation for your testimony today?

A Yes.

Q. And I'm going to ask you who you spoke to and if the answer is your lawyer or one or more lawyers, I'm not asking you to disclose anything you spoke about with them but just who you spoke to. So with that in mind, with whom did you speak to prepare for your testimony today?

A My lawyers.

Q. Anyone else?

A Not to my recollection.

Q. And just for the record did you speak to anyone in the governor or the attorney general's office to prepare for your testimony today?

A No, sir.

MS. ELLIS: Objection. To clarify, I am in

the attorney general's office as is Mr. Felter so you did speak with two lawyers.

MR. GANNAM: Understood.

MS. ELLIS: I want the record to be clear. Thank you.

BY MR. GANNAM:

Q. Apart from the lawyers that are in the room with us today, did you speak with any other representative from the attorney general's office?

A No, sir.

Q. And about how long did you spend speaking to your lawyers about your testimony today? Again, without telling me what you talked about.

A I would say a total of one to two hours.

Q. And over what period of time?

A Two separate days, as I recall.

Q. And were those days recently?

A Yes, sir.

Q. When were they?

A One day this week and I believe one day last week.

Q. When did you first become aware that you would testify in this case?

A I believe it was the week prior to our discussions. So I would estimate three weeks ago, two and a half weeks, somewhere in that area.

Q. And back to your discussions you had with your lawyers. Was anyone else present in those discussions besides your lawyers?

A Yes.

Q. Who else was there?

A I'm going to have to lay it on counsel. I don't remember the young lady's name.

MS. ELLIS: A law clerk in our office was there.

THE WITNESS: Thank you.

MS. ELLIS: The same law clerk that was, attended the deposition on Tuesday.

BY MR. GANNAM:

Q. So apart from that one other person, the law clerk identified by your lawyer, was anyone else present in those meetings?

A No, sir.
Q. Have you ever given a deposition before?
A No, sir.
Q. Is it the most fun thing you've ever done?
A No, sir.
Q. A couple preliminary questions I forgot to ask. Are you currently under, have any medical condition or are taking any medicines that would affect your ability to testify truthfully today?
A No, sir.
MR. GANNAM: Could I just, do you mind if I just mark the stickers and add them myself?
COURT REPORTER: Oh, sure, that's fine.
MR. GANNAM: I can just kind of get in the rhythm that way. I can start with 1.
(Plaintiff's Exhibit 1 was marked for purposes of identification.)
BY MR. GANNAM:
Q. All right. I'm showing you a document I marked as Plaintiff's Exhibit 1. Here's a copy for counsel. This long distance might be an issue. This

is a public LinkedIn profile for Kim L. Is this your LinkedIn profile?

A It appears to be, yes.

Q. And is the -- and I'm mainly focused on the first page that lists the experience with the Maryland Department of Health. Are those statements that are printed there accurate?

A Yes, sir.

(Plaintiff's Exhibit 2 was marked for purposes of identification.

BY MR. GANNAM:

Q. I'm handing you a document I marked as Plaintiff's Exhibit 2, a copy for counsel. This document is titled Plaintiff's Notice of Taking Deposition of State of Maryland. Did I read that correctly?

A It appears to be the statement.

Q. And have you seen this document before?

A I don't recall seeing that specific document.

Q. Can I ask you to turn to page 3 of the

document?

A I apologize. I have seen that.

Q. Okay. Is there a copy in your book in front of you?

A There is.

Q. Okay.

A I apologize.

Q. Oh, no worries. Can you turn to page 3 of the document?

A Yes, sir.

Q. At the top it reads: "Matters for Examination." Do you see that?

A I do.

Q. And what follows are or is a listing of thirteen subject areas. Have you read those subject areas before today?

A Yes, sir.

Q. And is it your understanding that you are here to testify today regarding those thirteen listed subject areas?

A Yes, sir.

MS. ELLIS: I just want to impose a, I guess more of a statement than an objection. As you know, based on our previous conversations, Mr. Gannam, it is my position and my client's position that the topics 1 through 6, 1 through 7 and 9 are covered by legislative privilege except to the extent there are, there is information in the publicly available record relating to those topics.

MR. GANNAM: And I hear and understand your objection. And for the record, we disagree as to the extent or propriety of evoking the legislative privilege for those same subjects. And I'm sure we will discuss it further through objections in the course of the deposition.

BY MR. GANNAM:

Q. So Dr. Lang, do you understand that as a, as the designee pursuant to this notice of deposition that you answer questions today not only based on your personal knowledge but you're answering for the noticed deponent which is the state of Maryland?

MS. ELLIS: And again I would interpose the

objection that this is the executive branch of the state of Maryland for whom she is providing testimony. The governor, neither the governor nor the attorney general, the defendants in this litigation, have any authority to compel the legislative branch or the judicial branch of the state of Maryland to participate or provide information for this deposition.

MR. GANNAM: And through the record, for the record, it is the plaintiff's position that the plaintiff has sued the state of Maryland through the two named officers, Governor Hogan and Attorney General Frosh and that the deposition notice is to the state of Maryland and the expectation is for a witness to testify on behalf of the state of Maryland.

BY MR. GANNAM:

Q. And your counsel, Dr. Lang, just made an objection or statement regarding who you are here to testify for today. Is it your understanding that you are here to testify today on behalf of the state of Maryland or on behalf of some subdivision of the state of Maryland?

A

MS. ELLIS: If you have any understanding.

A To the extent that I am aware, on behalf of the State.

Q. And so for the record, the answer that you provide is binding for the entity for whom you are here to testify for. Do you understand that?

MS. ELLIS: And I have the same objection and statement about the, there is absolutely no authority to provide testimony on behalf of the judicial branch or the legislative branch of the state of Maryland. We don't have that authority.

Q. And so my question stands. Do you understand that you are here to testify and that your answers are binding for the entity that you are here to testify for today?

A Yes.

Q. And do you understand that if your answer, for example, to a question is "I don't know," that that answer means that the entity for whom you are testifying doesn't know the answer?

MS. ELLIS: I would object to that characterization. Go ahead and answer it to the best of your ability.

A To the extent to which I am aware, I will testify.

Q. Okay. And so but my question was, do you understand that when you say "I don't know," that also is binding on whatever entity you are here testifying for today?

MS. ELLIS: I have the same objection. You can answer.

A Yes.

MR. GANNAM: All right. Now I'm handing you a document I will mark as Plaintiff's Exhibit 3.

(Plaintiff's Exhibit 3 was marked for purposes of identification.)

MR. GANNAM: And just so I don't have to keep saying it, for the record, when I hand you an exhibit I'm also handing you a copy for your counsel.

THE WITNESS: I understand.

MR. GANNAM: And if you see that I don't,

let me know because I want to make sure that --

MR. MIHET: She'll let you know for sure.

MS. ELLIS: Yeah, I will let you know too.

BY MR. GANNAM:

Q. This document is Defendants' Response to Plaintiff's First Set of Interrogatories. Did I read that correctly?

A Yes, sir.

Q. And have you seen this document before?

A I have.

Q. And will you look at the, page 15 of the document?

A Yes, sir.

Q. And is that your signature on page 15?

A It is.

Q. And did you understand that you were verifying these answers on behalf of the, the -- well, let's see. I'll just, let me just read it. It reads: "I, Kimberly C. Lang, Ph.D., am duly authorized to execute these answers to interrogatories under oath on behalf of the Defendants, the Governor of Maryland and

the Attorney General of Maryland in their official capacities." Did I read that correctly?

A Yes, you did.

Q. And is that your understanding that you in fact were executing the answers on their behalf?

A Yes.

Q. Will you look at page 2, specifically item number 2 beginning at the top of the page?

A Yes, sir.

Q. And I'll read it for the record. The Defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities object to definition number 11 as overly broad. The governor and the attorney general construe the term legislative record to include only materials that are publicly available, all of which are listed below, and they will respond to these requests for admission based on these materials. Did I read that correctly?

A You did.

Q. And the listing of materials, items A through T below, do you see that?

A I do.

Q. And did you participate in preparing this list of materials?

A I reviewed them before I signed the document.

Q. And did, you know, verify or execute the interrogatory answers based on the qualification in this item number 2 that the term legislative record is construed to mean only these listed materials?

MS. ELLIS: Objection. Your instructions which we've complied with were that the objections were the legal, were the lawyers and the lawyers signed based on, for the objections.

Q. And my question is not did you make the objection but in answering the interrogatories and signing those answers on behalf of the defendants in this case, did you understand the term legislative record to mean only these listed A through T?

A Yes.

Q. To your knowledge have all of the items listed A through T been produced to counsel for Mr.

Doyle in this litigation?

A I believe so, yes.

Q. Have you personally reviewed all of the items listed in A through T?

A Yes.

Q. So going forward when I say the legislative record, for the sake of understanding between us, will you understand that I'm referring to the items listed A through T?

A Yes.

Q. Earlier today you spoke of publicly available information about the legislature's enactment of SB 1028 or the counseling ban. Do you recall doing that?

A I do.

Q. And when you talk about the publicly available information, are you referring to the same set of items that are identified here as items A through T?

A I do, yes.

Q. And are you aware of any publicly available

documents that relate to the enactment of SB 1028 that are not included in this listing A through T?

A No.

Q. Now, as you sit here today, regarding all of the interrogatory answers contained in this document, are you aware of any inaccuracies in the answers as you sit here today?

A No.

MS. ELLIS: I would note for the record that in 2 what you read, where the last, last line, last two lines of the introductory paragraph, instead of request for admission it should say answers to interrogatories.

MR. GANNAM: Thank you.

MS. ELLIS: Or respond to these interrogatories.

THE WITNESS: Actually, could we pause for a moment?

MR. GANNAM: Want to take a break?

THE WITNESS: I just want to take a look at something -- okay. Counsel, I don't want to waste your

time. To my recollection there is a page in the legislative record that was provided to us that appeared to be completely unrelated to the bill we're discussing. And I made a notation. I don't know if it's important. I would be happy to flip through it if we take a break and try to identify it.

BY MR. GANNAM:

Q. So this is a document that's in the, this destination of materials as the legislative record that you believe is not related to SB 1028?

A Yes, sir. It looked to me like it was testimony from another bill.

Q. Okay. Well, thank you for letting me know.

A I don't know if that's important.

Q. I may ask you to identify it later. And feel free to look for it on a break if you want to.

A That's fine. Thank you.

(Plaintiff's Exhibit 4 was marked for purposes of identification.)

BY MR. GANNAM:

Q. All right. I'm handing you a document I

have marked as Plaintiff's Exhibit 4.

A Thank you.

Q. This document is Defendants' Response to Plaintiff's Requests for Production of Documents. Did I read that correctly?

A You did.

Q. Have you seen this document before?

A I have.

Q. And did you participate in preparing this response?

A I reviewed the information.

Q. Okay. Looking at item number 2 on page 2 it contains a similar listing of items A through T. Do you see that?

A I do.

Q. Is that the same listing of items that is in the interrogatory answers that we spoke about in Exhibit 3?

A Without comparing line by line, I believe it is.

Q. Now, in terms of compiling the documents

that were provided by defendants' counsel to Mr. Doyle's counsel, did you participate in that process?

THE WITNESS: Would you repeat that, please?

MR. GANNAM: Can you read it back?

(The reporter read back as requested.)

A In compiling, no.

BY MR. GANNAM:

Q. What about in identifying the documents that should be produced?

A Identifying, no.

Q. So what was your involvement, if any, in that process of producing documents to Mr. Doyle's counsel?

A I reviewed the information.

Q. Meaning the documents themselves?

A Yes, sir.

Q. But you didn't pull those together or tell anyone to gather them or anything like that?

A No, sir.

Q. Do you know who was responsible for that?

A Through counsel's office. I don't know if

counsel personally conducted the search or not.

Q. So apart from counsel you're not aware of any personnel within the Department of Health who, you know, physically took part in gathering documents or identifying documents to be produced?

A No, sir, I'm not aware.

Q. So as you sit here today are you aware of any documents that the defendants sought or looked for to produce to Mr. Doyle's counsel that were not located or could not be found?

A No, sir.

MS. ELLIS: To clarify, with respect to the witness's last answer, just to make sure you understand, counsel, the response to request for production number 14 does indicate that the defendants are still working and the defendants' counsel is still working to determine whether there's any documents and once I learn that, we will promptly supplement our production.

MR. MIHET: Do you expect to learn that before the preliminary injunction hearing?

MS. ELLIS: I hope so. You know, there are limits. But I am, those documents, to determine whether there are any responsive documents, non-privileged responsive documents there's active work going on and as soon as I, as soon as I get them I will be producing them to the extent that they are responsive and to the extent they exist.

MR. GANNAM: I wouldn't normally ask to take a break this early but I'm about to sort of switch into a different subject. So if it's okay can we just do maybe a five-minute break?

MS. ELLIS: That's fine. That's fine.

(There was a break in the proceedings from 9:50 a.m. to 10 a.m.)

MR. GANNAM: All right. We can go back on.

(Plaintiff's Exhibit 5 was marked for purposes of identification.)

BY MR. GANNAM:

Q. All right. I'm showing you a document I have marked as Exhibit 5.

A Thanks.

Q. For identification purposes, this reads at the lower right-hand corner, a Bates number of MD 0179 through MD 0191. And this is a document produced by the defendants to the plaintiff. And at the top left it reads SB 1028 and below that it says, entitled, "Health Occupations - Conversion Therapy for Minors - Prohibition and in parentheses Youth Mental Health Protection Act." Did I read all that correctly?

A Yes, sir.

Q. And have you seen this document before?

A I have.

Q. What is this?

A This is a part of the publicly available record on the bill in question.

Q. That category of the legislative record that we talked about earlier?

A Yes, sir.

Q. And are you familiar with the contents of this document?

A I've reviewed it.

Q. And I want to go to the second page. There is a listing, under the heading document name there's a listing, there are several amendments and then an analysis and then text. Do you see that?

A I do.

Q. And then finally votes. Did I read all that correctly?

A I believe so.

Q. So what is this list describing or referring to?

A Sir, at the risk of being blunt, I think it's describing exactly what's written, just the information that's available in the bill.

Q. And to your knowledge is this listing here a complete listing of the various recall steps or stages in the enactment of SB 1028?

A To my knowledge, yes.

Q. So, for example, the first item there says "Amendments, Senate-Senator Salling" and then a number "263124/01 rejected." Did I read that correctly?

A You did.

Q. And if I flip the page do I see in fact that amendment that is referred to in that first line there?

A That appears to be correct, yes.

Q. And that number at the top left of the amendment SB 1028/263124, that corresponds to that same number on that first line item on the previous page correct?

A It does.

Q. So at least through the end of this document, and I'll say for the record it was produced in this form, at least, as being a complete document. The last item in this document appears to begin four pages from the end. MD 0188 is the Bates number. Can you turn to that?

A Yes, sir.

Q. It says, "Department of Legislative Services, Maryland General Assembly, 2018 Session, Fiscal and Policy Note." Did I read that correctly?

A Yes, sir.

Q. And if you could turn back to that second

page, the listing of items, does that correspond to the line item that says, "Analysis, fiscal and policy note"?

A I agree it appears to, yes.

Q. And is everything in between that fiscal and policy note and that Salling amendment that we have already looked at correspond to all the line items between those same two items on the second page there?

A Without reviewing each page it appears to be, yes.

Q. Just so I'm oriented to what's here.

A Yeah.

Q. Okay. Great. So this, going back to page 2 it refers to a total of seven amendments, one of which was adopted and all the rest were rejected. Am I interpreting that correctly?

A That's what I see as well, yes.

Q. And to your knowledge were there any other amendments proposed to SB 1028 before its enactment besides what's listed here?

A Not to my knowledge, no.

Q. And to your knowledge is there a video or audio record of the disposition or the result of each of these proposed amendments?

A I will caveat with I believe so. I have listened personally to some of the testimony that was given on the floor so I have firsthand knowledge of some of it and I would assume that the others would have it as well.

Q. Do you have any reason to believe that there is not audio or video for each of the amendments?

A No, I have no reason to believe that.

Q. Are there written transcripts of the same floor proceedings or committee proceedings where these amendments were discussed?

A There again, sir, I have firsthand knowledge of some it. I would assume that there would be for the rest of it as well.

Q. Written transcripts?

A I believe so.

Q. And do you know who holds those or where they're located?

A I know that the audio information was pulled from the publicly available website. And I'm certain we can find the citation for it. And if there would be a written transcript I would assume it would be located there as well.

MS. ELLIS: There is, to my knowledge, no written transcripts of the committee hearings or the floor proceedings.

THE WITNESS: Just the audio?

MS. ELLIS: To my knowledge.

MR. GANNAM: Thank you for that.

BY MR. GANNAM:

Q. So I'll ask the witness. Are you aware of a procedure for requesting a written transcript of any of the Senate or House proceedings in connection with SB 1028?

A I am not personally aware of how to request that.

MR. GANNAM: Counsel, do you know if there's a --

MS. ELLIS: There are none. There are no

written transcripts.

MR. GANNAM: I mean, but is there a process to make a request for one and have one prepared either for a fee or not?

MR. MIHET: From an audio transcript that exists.

MS. ELLIS: Not to my knowledge. And this is what you get. I mean I will confirm that but that's my understanding.

MR. GANNAM: I appreciate that, yeah. It wouldn't be the first government entity that doesn't make that available.

THE WITNESS: And for the record what I was referring to, I have seen some quotes written down from testimony that was given. That is the written part that I am referring to.

MR. GANNAM: I understand. Thank you.

BY MR. GANNAM:

Q. Going back to page 2 of the document, in the items that are votes starting with "Vote, Senate Committee Education Health and Environmental Affairs,"

do you see that?

A I do, sir.

Q. And then below that it says, "Vote, House Committee Health and Government Operations." Do you see that?

A I do.

Q. Besides those two committee votes are there any other or were there any other committee votes on SB 1028 or any version of it?

A Not that I'm aware of, no.

MR. GANNAM: If you would keep this page 2 to Exhibit 5 open, you know, nearby as I pass you these next couple because we'll refer back to it.

(Plaintiff's Exhibit 6 was marked for purposes of identification.)

MR. GANNAM: I'm now handing you Exhibit 6.

THE WITNESS: Thanks.

BY MR. GANNAM:

Q. And Exhibit 6 continues sequentially in the Bates numbering at the lower right, MD 0192 and goes to MD 0197. This document at the top says, "Senate Bill

1028." In the introductory material below that, it says, "By Senators Madaleno and others," and then it says "introduced and read first time, February 5, 2018." Do you see that?

A I do.

Q. Does this document correspond to page 2 of Exhibit 5 where it says, "Text, First, Health Occupations - Conversion Therapy for Minors - Prohibition"?

A It appears to, yes.

Q. And would another way referring to that be the version of the bill printed for the first reader?

A Yes.

MR. GANNAM: Okay. All right. I'm now handing you a document I'm marking as Exhibit 7.

(Exhibit 7 was marked for purposes of identification.)

BY MR. GANNAM:

Q. And again this proceeds sequentially in the page numbering. It begins MD 0198 and goes through MD 0203. Did I say that correctly?

A You did.

Q. And this item also reads Senate Bill 1028 at the top. It says "by Senators Madaleno and others." And there's a strike-through and an addition changing it from "and Zucker" to "Zucker and Young." Do you see that?

A I do.

Q. And would this correspond then to the -- going back to Exhibit 5, page 2, the second text item that says "Third, Health Occupations - Conversion Therapy for Minors?

A Yes.

Q. And would another way of referring to this be the third reader version of the bill?

A It would be.

Q. And even though I'm using that terminology, I won't represent that I understand it completely. Can you tell me the difference between the first reader and a third reader?

A It would reflect any amendments, which is the area, part of the document that you referred to

with the strike-through. If there had been other amendments it would incorporate those as well.

Q. And is the general process for the adoption of a bill in Maryland for each bill to go through a first, second and third reader before adoption?

A That's correct.

Q. And to your knowledge -- strike that. Did SB 1028 go through a first, second and third reader before adoption?

A It did.

MR. GANNAM: All right. The next item will be Exhibit 8.

(Plaintiff's Exhibit 8 was marked for purposes of identification.)

BY MR. GANNAM:

Q. This document continues sequentially with the page number MD 0204 to MD 0209. Do you see that?

A I do.

Q. And this one reads at the top: "Lawrence J. Hogan, Junior, Governor," and then below that Chapter 685 and below that in parentheses Senate Bill 1028. Do

you see that?

A I do.

Q. Does this correspond to the, on Exhibit 5, page 2, the third text item that reads: "Chapter, Health Occupations - Conversion Therapy for Minors - Prohibition"?

A It does.

Q. And is this the final or enacted version of SB 1028?

A A copy of it, yes.

Q. So between Exhibits 6, 7 and 8, the first reader version, the third reader version, and the final reader version, were there any other publicly available versions of SB 1028?

A No.

Q. Who originally proposed the SB 1028?

A It would go back to the sponsors of the bill.

Q. And do you know who the original sponsor was or original sponsors if there was more than one?

A Sir, it's written on the first reader,

Senators Madaleno, Ferguson, Guzzone, Kagan, Lee, Manno, Pinsky, Smith and Zucker.

Q. And that was on Exhibit 6, the first reader?

A Yes, sir.

Q. Were any one or more of those listed sponsors responsible for drafting SB 1028 the first time?

MS. ELLIS: Objection. Instruct the witness not to answer. It's covered by the legislative privilege.

Q. Was SB 1028, the original version, created wholly by or drafted wholly by one or more Maryland senators or was the text copied from some other source?

MS. ELLIS: Objection. Instruct the witness not to answer. Legislative privilege.

Q. Did any person or organization outside of the Maryland legislature provide draft language or proposed language for SB 1028 before it was put into the first reader version?

MS. ELLIS: Same objection and instruction.

MR. MIHET: For the record can we assume that the witness will abide by counsel's instruction and save the time and not ask her whether she will comply with the instruction?

MS. ELLIS: You can ask her.

THE WITNESS: Yes.

MS. ELLIS: I think she will abide by it.

MR. MIHET: So when instructed not to answer we understand that you in fact will decline to answer?

THE WITNESS: Correct.

MR. MIHET: Even if we don't confirm that for each question?

THE WITNESS: Correct.

MR. MIHET: Okay.

MS. ELLIS: I would ask counsel to confine questioning to one counsel, please. I think that's the general rule.

MR. MIHET: Generally, yes. This was just to tidy up the record.

(Plaintiff's Exhibit 9 was marked for

purposes of identification.)

MR. GANNAM: I'm handing you now Exhibit 9.

THE WITNESS: Thanks.

BY MR. GANNAM:

Q. This document is numbered MD 0102, just one page. At the top it reads: "Floor Sheet, SB 1028, Youth Mental Health Protection Act." Did I read that correctly?

A You did.

Q. What is this document?

A It's essentially a summary.

Q. A summary of SB 1028?

A Yes, sir.

Q. Who prepared this document?

MS. ELLIS: Objection. Legislative privilege, instruct the witness not to answer.

Q. Was it prepared by a member of the Maryland Senate?

MS. ELLIS: Same objection and instruction.

Q. What is the purpose of this document in the legislative process?

MS. ELLIS: If you know.

A Again I'll refer back to it's a summary of the information in the bill.

Q. And when would this summary have been used in the process from the first reader through enactment?

MS. ELLIS: Objection. Same objection and instruction.

Q. This document is in the publicly available legislative record, correct?

A Correct.

Q. At what point did it enter into the legislative record?

MS. ELLIS: Same objection and instruction.

MR. GANNAM: I'm just going to say for the record I think we're going too far with the legislative privilege. This is a publicly available document. I think I'm entitled to ask when it became publicly available in the legislative process.

MS. ELLIS: It's in the bill file, counsel, as I think I have told you before, and is listed in our objections. It's part of the Senate bill, Senate bill

file.

MR. GANNAM: And again for the record, it is our position that it's appropriate for us to ask questions about documents that are in the bill file.

BY MR. GANNAM:

Q. Did all legislators who considered SB 1028 have access to this document?

MS. ELLIS: Objection. Same objection and instruction.

Q. This document is called a floor sheet, correct?

A Correct.

Q. Is a floor sheet used in, generally speaking, in the enactment of other statutes in the state of Maryland?

MS. ELLIS: Objection. Same instruction.

Q. Is it common in the legislative record of other Maryland legislation for there to be a document called a floor sheet?

MS. ELLIS: If the witness knows.

MR. GANNAM: I just want to say for the

record, we were only asking questions that, to find out if the witness knows and it is improper for counsel to instruct the witness to answer only what she knows because it suggests that she may, should answer that doesn't know.

MS. ELLIS: Do you need the question repeated?

THE WITNESS: I don't think so. This would be more informal than my counsel is going to appreciate but I have seen floor sheets before. When this particular floor sheet was produced I would need to go back and look. I don't have a date stamp on this so I can't answer that. It would also assume that folks in the legislature have an equal opportunity to review this but again I don't have firsthand knowledge of that so I can't testify to that.

BY MR. GANNAM:

Q. Is any legislator entitled to submit a floor sheet in connection with proposed legislation?

MS. ELLIS: Objection. Instruct the witness not to answer. Same objection and instruction.

MR. GANNAM: So just so I'm clear, I'm talking about the process of enacting legislation in the state of Maryland. And the question is can any legislator submit a floor sheet as a matter of right or privilege in connection with any proposed legislation in the state of Maryland. I'm not asking could anyone have in connection with SB 1028.

MS. ELLIS: Same objection and instruction.

(Plaintiff's Exhibit 10 was marked for purposes of identification.)

MR. GANNAM: I'm showing you a document I marked as Exhibit 10.

THE WITNESS: Thanks.

BY MR. GANNAM:

Q. This is numbered, the orientation is different but at the, I guess as oriented at the upper right it says MD 0163 to MD 0164. Do you see that?

A I do.

Q. And the title of this document is Education, Health and Environmental Affairs, 3/72018.

18. Did I read that correctly?

A You did.

Q. Are you familiar with this document?

A I am.

Q. What is this?

A It is testimony that was given on behalf of the bill that's being considered.

Q. And was this testimony delivered in the Education, Health and Environmental Affairs Committee of the Senate?

A It would have been, yes.

Q. Whose handwritten notes are on this document?

A I don't know.

Q. And just for the record, by handwritten notes I'm referring to, you know, under the title of the document it appears to be handwritten LBGTQ in all caps, do you see that?

A I see that. I see the underlining. I see the checkmarks. I don't know where that came from. And I think it would be safe that we can make some

assumptions but I don't know.

Q. Is this document with the handwritten notes in the public record; in other words, is this version showing these handwritten notes the version that's in the publicly available record on this bill?

A It was provided in the bill file so yes, I believe so.

Q. Now, based on your understanding of the legislative process who would you assume or suppose these marks were made by?

MS. ELLIS: Objection. Calls for speculation.

MR. GANNAM: You can answer.

A I would assume that it would be someone obviously who is within the room at the time.

BY MR. GANNAM:

Q. And looking at the columns we see type, panel bill sponsors, the first entry. Do you see that?

A I do.

Q. And the next column says "position" and under that, and this, it's kind of this first section,

there's five entries, all say FAV. Do you see that?

A I do.

Q. Does that mean favorable towards the bill?

A Yes.

Q. And then the third column says "testified". Do you see that?

A I do.

Q. And these first five entries all say oral, is that correct?

A It does.

Q. Does that mean that someone appeared in person to this committee and testified orally where indicated?

A I believe it expresses the intent that someone said that they would testify orally. I would assume the checkmark that is next to it means that they did in fact do that.

Q. And so as a matter of example in the first line just reading across from left to right the type is panel dash bill sponsor, position FAV, testify oral with a checkmark, name Senator Madaleno. Did I say

that correctly?

A Yes, sir.

Q. And would that indicate that Senator Madaleno gave oral testimony in favor of the bill in this committee?

A I was not there personally. I would assume that's what this means.

Q. Moving down to about, well, let's say most of the way down the page, the third entry up from the bottom, the type is individual, the position is UNF, the "testify" is "both," and the name is Mary Beth Waddell. Do you see that?

A I see it.

Q. In that position field where it says UNF, does that mean unfavorable?

A I would assume so, yes.

Q. And in the testify field where it says "both," does that mean both oral and written?

A That would be my assumption, yes.

Q. And looking at this document are you able to tell whether Mary Beth Waddell did in fact appear to

give oral testimony at the committee meeting?

A I do not see an indication.

Q. So would it be fair to say we can't tell for sure from this document whether she did or didn't?

A Given the assumptions that we've apparently agreed to before, yes, I can't tell.

Q. And the entry above that for Alan Kittleman, do you see that?

A I do.

Q. And also in the "testify" it says "both" and the handwritten mark appears to be the letter A. Do you see that?

A I see that.

Q. Do you know that means?

A I do not. And I do not see a key that would indicate what that means.

Q. Apart from this document that we have marked as Exhibit 10, is there any other public record of who either testified or intended to testify regarding the Education -- I'm sorry -- regarding SB 1028 in the Education, Health and Environmental Affairs

Committee?

A The audio recording should reflect this.

Q. And so apart from the, this Exhibit 10 any audio recording of the committee proceedings, are there any other documents that would reflect who testified or intended to testify on behalf or regarding the SB 1028?

A Not that I'm aware of.

Q. And wherever there was --

A And forgive me, counsel. We're speaking just about oral testimony?

Q. I'm glad you asked. I was going to say, wherever it's indicated that written testimony was provided or intended to be provided, is that written testimony in the public legislative record for these committee proceedings?

A It should be; yes, sir.

Q. So, understanding, of course, if someone didn't submit it, it wouldn't be there but to the extent it was actually submitted to the committee, is it in the public record?

A It should be, yes.

Q. And just as a matter of process, when a written document is submitted to, for example, the Education, Health and Environmental Affairs Committee, how is that written document distributed or is it distributed to the members of the committee?

MS. ELLIS: Objection. Instruct the witness not to answer. Same objection.

MR. GANNAM: Same objection based on the legislative privilege?

MS. ELLIS: Correct. And the same instruction.

BY MR. GANNAM:

Q. So do senators who are on the Education, Health and Environmental Affairs Committee have access to written testimony that is submitted to that committee?

MS. ELLIS: Same instruction and objection.

A So would a senator have to rely on what goes into the public record to be able to see written testimony submitted to the committee or is there another method for senators to get that information?

MS. ELLIS: Same objection and instruction.

Q. How does someone go about submitting written testimony to the Education, Health and Environmental Affairs Committee in connection with a proposed bill?

MS. ELLIS: You can answer.

A Okay. If testimony is being provided there is, for lack of a more elegant term, a point person for each committee that collects the information.

Q. And can that information be submitted electronically, by email, for example?

A My firsthand knowledge is that someone physically walks the information, a hardcopy, if you will, to the committee. I'm not aware of an electronic transfer.

Q. When you say someone walks into the committee, from where do they take it to the committee?

A I'm not trying to be cute or blunt but literally wherever their office happens to be they walk it into the committee.

Q. So would that be the --

A To the committee offices. Excuse me.

Q. I think I follow you but just so we're clear. Who is either by name or title the person who would receive written testimony submitted to the Education, Health and Environmental Affairs Committee?

A I certainly wouldn't be able to provide a name because I don't know. I would assume the title is administrative assistant or something along those lines.

Q. So is there one person responsible for receiving that information?

A Yes.

Q. And when you say a person would then walk it to the committee offices, is that the same person we're talking about?

A It would be, yes.

Q. And I believe you testified earlier that this publicly available information to the extent it's in the public legislative record is available on the Internet for any member of the public to access?

A I'm sorry. Could you repeat that.

Q. I believe you testified earlier that the documents that are in the publicly available legislative record are available on the Internet to any member of the public who wants to access it?

MS. ELLIS: Objection.

MR. GANNAM: You can answer.

A Counsel, I'm going to say yes with the caveat that I don't know if there is a lag time and if there is how significant it would be between when someone submits and when it's available to the public.

BY MR. GANNAM:

Q. Okay. And fair enough. So to the extent something is -- I'll strike that. If I asked this before forgive me. Is there any other record of the oral and written testimony either provided or intended to be provided to the Education, Health and Environmental Affairs Committee regarding SB 1028 that's not reflected on this document, Exhibit 10?

A Counsel, I don't think I can testify on something that I'm unaware if it exists or not.

Q. Do you have reason to believe that there

would be oral or written testimony submitted to the Education, Health and Environmental Affairs Committee that's not reflected on this Exhibit 10?

A Again I think that's speculation but I'm not aware of anything else.

Q. Are you aware of any other document in the public legislative record of SB 1028 that would reflect other testimony given to the Education, Health and Environmental Affairs Committee besides what's on this document?

A I am not aware, no.

(Plaintiff's Exhibit 11 was marked for purposes of identification.)

MR. GANNAM: I'm now handing you Exhibit 11.

THE WITNESS: Thank you.

BY MR. GANNAM:

Q. Again the orientation is a little different. This one, it would be on the lower left is the page number MD 0095 to MD 0096. Do you see that?

A I do.

Q. And this document is titled Health and Government Operations 3/1/2018, and below that HB 0902, Delegate Cullison. Do you see that?

A I do.

Q. Does this refer to the House of Delegates Health and Government Operations Committee?

A Correct.

Q. And HB 0902 is the same counseling ban we have been discussing up to this point as SB 1028, correct?

A It is.

Q. So basically would it be fair to say this is a record of committee proceedings in the House of Delegates on the same piece of legislation?

A Yes, sir.

Q. And on this document -- have you seen this before?

A I believe I have, yes.

Q. Would this document serve the same purpose for the House Health and Government Operations Committee as Exhibit 10 served for the Senate

Education, Health and Environmental Affairs Committee?

A Yes, sir.

Q. And do you know who the author of the handwritten marks on this document is?

A As with the previous document, no, I'm not aware.

Q. And these are perhaps more cryptic than the others. Do you know what the lines mean that are, that appear down the column here?

A My counsel would probably say speculation. No, I don't.

Q. So just for example then, the first entry, the type is panel dash bill sponsor, position FAV, testify oral, name, Delegate Cullison. Did I read all that correctly?

A You did.

Q. And does that indicate that Delegate Cullison either testified orally or had intended to testify orally at this committee proceeding for the Health and Government Operations Committee?

A Yes, sir. I believe it indicates the

intent.

Q. And where the testify column reads, oral or both, or written, would those terms mean the same thing as they meant on Exhibit 10 for the Senate committee?

A They should, yes.

Q. And the same for the position abbreviation FAV and UNF, would those mean favorable and unfavorable as they did on Exhibit 10 for the Senate committee?

A They should, yes.

Q. And is there any oral or written testimony or proposed oral or written testimony to the Health and Government Operations Committee on HB 902 that's not reflected on this document marked as Exhibit 11?

A Counsel, as with the previous conversation, I can't testify to something I'm not aware of. No, I don't know of anything else that exists.

Q. Do you have any reason to believe there is oral or written testimony or proposed testimony to the Health and Government Operations Committee on HB 902; that's not reflected on this document?

A No, I have no reason to believe it.

Q. Can I ask you to go back to Exhibit 3 which is the interrogatory answers?

A Yes.

Q. Will you turn to page 4? It's Interrogatory Number 1.

A Yes, sir.

Q. I'll read the question. It says, "If your" -- the second paragraph. "If your response to RFA1 is anything other than an unqualified admission then for each complaint in the legislative record of SB 1028 that a minor was harmed by any SOCE counseling provided within the state of Maryland identify, for definition number 9, the person or persons making the complaint, the date of the complaint, the nature of the conduct and harm alleged in the complaint, the person receiving the complaint, the person allegedly providing the SOCE counseling, the location of the SOCE counseling, the date of the SOCE counseling, the nature of the SOCE counseling and the person allegedly harmed." Did I read that correctly?

A You did.

Q. What follows is a response that contains an objection and then the answer begins with the word "without". Do you see that?

A I do.

Q. So the answer reads: "Without waiving these objections, see MD 0011, M.D. 0057, MD 0063, MD 0138, MD 0152 to MD 0153 for information responsive to this interrogatory." Did I read that correctly?

A You did.

Q. It says "See also statement of Meagan Simonaire made during the floor proceedings on April 4, 2018 in the House of Delegates from time stamp 2 hours 55 minutes, 7 seconds, to time stamp 3 hours, 2 minutes, 24 seconds." Did I read that correctly?

A You did.

Q. Now, as you sit here today is that still an accurate answer to Interrogatory Number 1, subject to the objections stated by counsel?

A Yes, sir.

Q. Did you select the documents to identify in this interrogatory answer beginning with MD 0011?

A I did not personally select them. I did review them.

Q. Okay. So -- strike that. Do the documents identified here as MD 0011 through MD 0153 -- one, two, three, four -- five documents reflect the totality of complaints in the legislative record of SB 1028 that a minor was harmed by SOCE counseling in the state of Maryland?

THE WITNESS: Would you repeat that, please?

MR. GANNAM: Can you read it back?

(The reporter read back as requested.)

A So they reflect the testimony to that.

BY MR. GANNAM:

Q. Testimony that's in the public record?

A Correct.

Q. Regarding minors harmed by SOCE in the state of Maryland?

A Correct.

Q. Are there any other -- strike that. Do these documents reflect all of the testimony in the public record or the legislative record of SB 1028 --

MS. ELLIS: Objection. You're misrepresenting the interrogatory answer.

Q. Let me finish my question, please. Do these documents reflect all of the testimony in the legislative record regarding or indicating that a minor was harmed by SOCE counseling provided in the state of Maryland?

MS. ELLIS: Objection. You're misrepresenting the interrogatory answer.

MR. GANNAM: You can answer.

A Counsel, again forgive me. The numbers correspond to the publicly available record for the testimony.

BY MR. GANNAM:

Q. And so this is not the entire legislative record, correct, these documents identified in response to Interrogatory Number 1?

A I'm sorry. I've gotten lost in the question.

Q. The legislative record you testified earlier is items A through T on page 2 of this

document?

A Right.

Q. So these five documents that are identified here by Bates number, would you agree with me that's not the entire legislative record for SB 1028, it's some smaller set of documents within that record?

A It is not the entire record.

Q. So my question is, are the documents identified in response to number one all of the documents in the legislative record that reflect a minor who was harmed by SOCE counseling in the state of Maryland?

MS. ELLIS: And the same objection.

A Assuming I understand the question that's being asked, yes.

Q. Is there any part of the question you don't understand?

A Am I allowed to restate the question to make sure I understand what's being asked?

Q. You may, sure.

A You're asking if these are the documents

that are used to support the response plus the objection that's being listed?

Q. Not exactly. Maybe I'll ask it this way. Are there documents in the public legislative record of SB 1028 that reflect a minor who was harmed by SOCE counseling in the state of Maryland besides these documents identified in response to Interrogatory Number 1?

A I don't believe so. I'm sorry. I probably made this much more complicated.

MS. ELLIS: No, you didn't.

THE WITNESS: I'm sorry.

BY MR. GANNAM:

Q. What is the statement of Meagan Simonaire during the floor proceedings on April 4, 2018 in the House of Delegates that is identified in the last sentence?

A I've listened to that. I don't know that it would be proper for me to provide a summary of that. It's publicly available.

Q. Tell me what you remember about it. I

understand, I mean you have told me you can't repeat it word-for-word. I understand that. But what do you recall about it?

A In general she participated in some kind of conversion therapy and had an unpleasant experience.

Q. Did she say in that statement where she participated in conversion therapy?

A Counsel, I don't recall.

Q. And did she say what occurred in any conversion therapy she may have participated in?

A Again counsel, I don't recall.

Q. Did she say how old she was when this occurred?

A That was exactly what I was struggling to remember as these questions started rolling out. I don't remember. I would assume but I don't know for a fact.

Q. So do you have any knowledge of Delegate Simonaire's experience with conversion therapy beyond whatever she said on the public record at this time stamp that's identified here?

A No, sir.

Q. And am I correct that you didn't speak to Delegate Simonaire about her statement?

A I don't believe I have ever spoken to the delegate so no, I didn't.

(Plaintiff's Exhibit 12 was marked for purposes of identification.)

Q. I'm showing you a document that I have marked as Exhibit 12.

A Thanks.

Q. This is a collection of documents from the documents produced by defendants' counsel to Mr. Doyle's counsel. It begins with the document numbered MD 0011. It ends with MD 0153. And I will represent that it contains the five documents identified in defendants' answer to Interrogatory Number 1. Will you take a look at the page numbers or the document numbers and compare it to the interrogatory number 1 answer and confirm that that's the case?

A They do seem to correspond except with the caveat that 0064 is a continuation of what starts on 63

and that number does not seem to be noted here.

Q. Okay. Would you agree that 064 does appear to be the second page of 063?

A I agree.

Q. And would it be correct to assume you did not intend to indicate in the answer to number 1 that 064 didn't belong?

A Again having not personally put this together I would agree that it's the same document, just the second page.

Q. Okay. Great. Now, to the extent that Interrogatory Number 1 asked for identification of any minor harmed by SOCE within the state of Maryland and the understanding that the answer says simply see these documents for information responsive to the interrogatory, I would like to go through these with you and see if you can point out for me where any of these documents identifies a minor who was harmed by SOCE in the state of Maryland, starting with MD 0011. And if you have to read the document to find it, that's fine. But starting with that one, can you point to me

where in this document it identifies a minor who was harmed by SOCE in the state of Maryland?

A Counsel, for Exhibit 4-10, it in general appears to be a father testifying on behalf of a transgender child and it seems to infer that there is harm. I could not point to a specific sentence.

Q. What part of it do you believe infers that there was harm?

A I think starting in paragraph 3 relating to gender being confusing and maybe a bit upsetting.

Q. Anywhere else?

A The final paragraph, again not specifically but in general that the child does not need to be converted or repaired.

Q. Okay. Is there anywhere in this document that identifies a specific minor who was harmed or claims to have been harmed by conversion therapy in the state of Maryland?

A Again counsel, at the risk of appearing unfriendly, I think I answered that.

Q. Well, what is the answer; was the answer no

or yes?

A That in general it seems to point to it but I would not be able to underline a specific sentence for you.

Q. And have you told me everywhere where you believe it in general referrals to --

MS. ELLIS: Objection. Asked and answered.

Q. I understand you have a right to object but I would appreciate it if you would let me finish my question before you object.

MS. ELLIS: I apologize. I thought you had finished.

Q. Have you told me all the points in this document or places in this document that you believe generally infer that harm had occurred to a minor?

A Yes, sir.

Q. Will you look at the second page? It's numbered MD 0057. Can you show me where, anywhere in this document it refers to a minor who has been harmed or claims to have been harmed by SOCE therapy in the state of Maryland?

A Counsel, if I may?
Q. I'm sorry?
A If I may?
Q. Yeah, please.
A It appears the second paragraph is referring to the different associations that have deemed conversion therapy of minors harmful.
Q. And so just so we're clear, my question is, does this document indicate that any minor in Maryland has been harmed by SOCE counseling or claims to have been harmed by SOCE counseling in Maryland?
A In Maryland specifically, no, I couldn't underline that.
Q. And in this document does it identify any minor, any specific minor who has been harmed by SOCE counseling anywhere outside of Maryland?
A Counsel is referring to associations and without the documents from those specific associations I wouldn't be able to draw a specific conclusion, no.
Q. The next document is MD 0063 to MD 0064, appears to be a letter from The Trevor Project. Do you

see that?

A I do, sir.

Q. Can you show me anywhere in this document that refers to any specific minor who was harmed or claims to have been harmed by SOCE in the state of Maryland?

A Counsel, the first paragraph, again it refers back to the different associations and in paragraph -- 1, 2, 3 -- 4 it mentions The Trevor Project and 1,237 Maryland youth in crisis and the calls that they are receiving.

Q. All right. I'll read the sentence that I believe you're referring. It says, "The Trevor Project has been contacted by over 1,237 Maryland youth in crisis in the past year." I did read that correctly?

A You did, sir.

Q. Does that sentence refer to conversion therapy in any way?

A The letter doesn't specify.

Q. The next sentence says, "These youth call us considering suicide and needing someone to speak to

when they feel alone and scared." Did I read that correctly?

A You did.

Q. The next sentence, not all of these youth are victims of conversion therapy but all have been wounded by a culture that allows the idea of a choice of one's sexual orientation to permit violence, bullying, and family rejection. Did I read that correctly?

A I agree that's a statement in the letter, yes.

Q. Now, taking those three sentences together, does this letter tell us that any minors in Maryland have been harmed or claimed to have been harmed by conversion therapy in Maryland?

A Counsel, this is public testimony. All I can agree to is what's in the letter.

Q. And so based on your reading of the letter does that identify any minors in the state of Maryland who have been harmed or claimed to have been harmed by conversion therapy?

A I do not see a specific reference.

Q. The next document begins at MD 0138, appears to be a letter from www.spdocs.net, pediatrics and internal medicine. Do you see that?

A I do.

Q. In this letter do you see anything that identifies a minor who is harmed or claims to have been harmed by conversion therapy in the state of Maryland?

A Counsel, before we go any further with this -- and this will come as a surprise to my own counsel -- the letterhead reflects a doctor that has in the past treated my father. I don't know if I should appropriately comment on this.

MS. ELLIS: I think that's fine.

THE WITNESS: I think we're fine but --

BY MR. GANNAM:

Q. Which doctor is that?

A Jeffrey Schmidlein, who I actual think thought was retired by now. But what do I know?

Q. Okay. Thank you for the disclosure. Have you -- let me ask. Have you discussed anything in this

letter with Dr. Schmidlein?

A I haven't discussed this with Dr. Schmidlein or Dr. Hackett or Dr. Ginsburg. My father knows where I am today but he doesn't know the content.

Q. So would it be fair to say you haven't had any discussions with any author of this letter or any doctor identified in this letter regarding this subject matter?

A None. But as I testified earlier, this is my first deposition and I want to make sure I'm doing everything I should do.

Q. Great. I appreciate the disclosure. So we'll continue then. Is there anything in this letter that indicates or identifies a minor who was harmed by conversion therapy or SOCE counseling or claims to have been so harmed in the state of Maryland?

A Counsel, in the first paragraph it refers to, quote, one such young man -- I assume that's one -- was sent to a summer camp for conversion therapy only to leave camp with his self-esteem damaged immensely. I'll concede it doesn't say that the young man was in

Maryland but if the doctor is practicing in Maryland, I think we can infer that.

Q. Okay. Does the letter reveal what practice or what therapy this young man experienced that's called conversion therapy in the letter?

A Again this is public testimony. All I can testify to is what's in the letter and I see conversion therapy in quotations but no specific definition.

Q. And would you agree with me where although it identifies him as a young man it does not indicate specifically the age of this young man?

A I agree that there's no age.

Q. Is there anything in the public legislative record of SB 1028 or the House counterpart that indicates the legislature considered banning only a residential or summer camp style version of what's called conversion therapy?

MS. ELLIS: Objection. Legislative privilege. Instruct the witness not to answer.

Q. My question regards specifically the public record so I don't think the objection --

MS. ELLIS: And I'll add the record speaks for itself.

BY MR. GANNAM:

Q. So based on that, can you answer, is there anything in the public record showing that the legislature considered banning only a residential or summer camp style conversion therapy program as opposed to all conversion therapy as defined in the statute?

MS. ELLIS: Same objection and instruction.

Q. Isn't it true there is nothing in the public record indicating that the legislature considered a ban of only residential or summer camp style of conversion therapy as opposed to the ban that they did enact in SB 1028?

MS. ELLIS: Objection to form. You can answer it if you can.

A To my recollection I did not see any reference to camps.

Q. And besides camps any kind of residential program, any reference to that?

MS. ELLIS: Same objection.

A To my recollection I did not see that.
Q. And so it is true then that there is nothing in the public record that refers to residential or summer camp style conversion therapy programs?
MS. ELLIS: Objection to form. Asked and answered.
MR. GANNAM: You can answer.
A I agree that I do not see that.
BY MR. GANNAM:
Q. And you testified earlier that you did review the legislative record and you have now said you didn't see it. Would it be fair to say that it's not in there?
MS. ELLIS: Objection. Asked and answered and objection to form.
A Yes.
Q. In the second paragraph here --
A We're still on Exhibit 6-41?
Q. Yes.
A Thank you.
Q. And just for the record Exhibit 6-41 is

also MD 0138?

A Yes, sir.

Q. Okay. The second paragraph begins, "The Youth Mental Health Protection Act." Do you see that?

A I do.

Q. It goes on to say, "HB 902/SB 1028 would protect LGBT youth from so-called conversion therapy, a range of dangerous and discredited practices that falsely claim to change a person's sexual orientation or gender identity or expression. These practices are based on the false premise that lesbian, gay, bisexual, transgender or queer (LGBTQ) is a mental illness that needs to be cured, a theory which has been rejected by every major medical and mental health organization." Did I read that correctly?

A Yes, sir.

Q. Is there anything in the public record indicating that the legislature considered banning only conversion therapy based on the assumption that being LGBTQ is a mental illness as opposed to banning conversion therapy as it is currently defined in SB

1028?

A Sorry, counsel. Is there anything in the public record?

Q. Correct, differentiating conversion therapy based on the assumption that LGBTQ is a mental illness as opposed to conversion therapy that is not based on that assumption?

A Not to my recollection.

Q. Let's look if the next document. It's MD 0152 to MD 0153, also numbered Exhibit 6-55 to Exhibit 6-56. Do you see that?

A I do.

Q. And at the top it indicates it's from Kate MacShane, MED, MSW, LCSW-C. Did I read that correctly?

A You did.

Q. And in this letter from Kate MacShane does it indicate anywhere or reflect a minor who was harmed by SOCE counseling in the state of Maryland or a minor who claims to have been so harmed?

A Counsel, it appears in the second paragraph approximately halfway down essentially starting with

the line "therapeutic relationship" and for most of the remainder of the paragraph.

Q. All right. Let me catch up to you. Just a moment here.

A Sure.

Q. So the sentence beginning "The therapeutic relationship" is what you're talking about?

A Essentially; yes, sir.

Q. Okay. Well, I'll read from there. "The therapeutic relationship should be one in which all people have confidence that they will not be condemned, exploited or harmed. Unfortunately, many of my clients have experienced family members, teachers, doctors and even previous therapists trying to dissuade and even prevent them from being themselves." Did I read that correctly?

A Yes, sir.

Q. Now, does that, do those two sentences specifically refer to conversion therapy or SOCE counseling?

A I can only testify to what's in the

sentence.

Q. So would you agree with me it doesn't reference specifically conversion therapy or SOCE counseling?

MS. ELLIS: Objection.

A I believe there are inferences but the words conversion therapy, no, sir.

Q. The next sentence begins, "Imagine seeking help from a professional and being told that the path to healing is to destroy, ignore or deny a part of yourself that you couldn't change even if you wanted to." Did I read that correctly?

A Yes, sir.

Q. And then "I have personally treated people who identify as survivors of conversion therapy and I can attest that it can take years to overcome the traumatic violation of trust that this type of therapy represents." Did I read that correctly?

A Yes, sir. And if I may, taken in totality with the other sentences, that's what I was referring to.

Q. Okay. Now, does this letter reveal what practices or words are included within this author's concept of conversion therapy?

MS. ELLIS: Objection. The letter speaks for itself.

A Counsel, as with the other responses, I can only testify to what's in the letter.

Q. And so in the letter does it explain or describe what practices or statements by a counselor or a therapist constitute conversion therapy in this author's view?

MS. ELLIS: Same objection.

A I do not see a word-for-word definition; no, sir.

Q. I read where it refers to or it suggests, "Imagine seeking help from a professional and being told that the path to healing is to destroy, ignore or deny a part of yourself that you couldn't change even if you wanted to." Do you see that part?

A Yes, sir.

Q. Does any part of the public record of SB

1028 reflect a discussion or consideration by the legislature of banning only conversion therapy that involves telling a patient that the path to healing is to destroy, ignore or deny a part of yourself that you couldn't change even if you wanted to?

MS. ELLIS: Objection.

A Word-for-word to cross-reference, no.

Q. Apart from any word-for-word correlation in the public record, are you aware of any part of the public record that indicates the legislature considered banning something less than the ban that was adopted in the definition of SB 1028, for example, a ban that only would apply to telling a child to change something the child couldn't change?

MS. ELLIS: Objection. There's nothing in the record or there's no testimony that you have elicited from the witness regarding the definition in the bill or the now statute. And so your question is vague, ambiguous and probably all of the other objections that's Mr. Mihet made to every question in Tuesday's deposition.

MR. MIHET: Are you incorporating those objections by reference as a fully stated herein?

MS. ELLIS: Correct. As well as objecting to the form of the question.

MR. GANNAM: So subject to that objection, will you read the question back, please?

(The reporter read back as requested.)

MS. ELLIS: Objection to all of the unwarranted assumptions in that question and it's vague and I think pretty incomprehensible.

THE WITNESS: I'll give it a shot.

MS. ELLIS: Okay.

A I am aware that there were, I will characterize it as a handful -- we can go back and take a look at the actual of number of amendments proposed, some of which would have been restrictive -- strike that -- more narrow, and all except one where it expanded the number of co-sponsors did not pass. And that is the only information that I'm aware of.

MR. GANNAM: Let's take a break.

(There was a break in the proceedings from

11:18 a.m. to 11:29 a.m.)

MR. GANNAM: All right. Let's go back on.

BY MR. GANNAM:

Q. All right. Can I ask you to refer back to Exhibits 6, 7 and 8? These are the first reader, third reader, and final versions of SB 1028. I want to start with Exhibit 8, which is the final, and go to page 5 of that document, which is also numbered MD 0208.

A I'm sorry, counselor. Which document?

Q. Exhibit 8.

A Yep.

Q. The final version.

A Okay.

Q. On page 5, also numbered MD 0208.

A Yes, sir.

Q. So we're looking at page 5 of the final version, the enacted version of SB 1028, correct?

A Yes, sir.

Q. And I want to refer to the, under the heading 1-212.1, which I understand is where it's actually numbered within the Maryland statutes, is that

correct?

A Yes, sir.

Q. In Chapter 685 of the Health Occupations Article, correct?

A Yes, sir.

Q. So in, beginning in item A, it's followed by the number 1 and it says, "In this section the following words have the meanings indicated." Did I read that correctly?

A You did.

Q. And in number 2 has three subparts, Roman numerals I, II and III, correct?

A It does.

Q. So Roman numeral I one reads: "Conversion therapy," in quotes, "means a practice or treatment by a mental health or child care practitioner that seeks to change an individual's sexual orientation or gender identity." Did I read that correctly?

A You did.

Q. And under that it reads: "Conversion therapy," in quotes, "includes any effort to change the

behavioral expression of an individual's sexual orientation, change gender expression, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender." Did I read that correctly?

A You did.

Q. Now, would you look at the corresponding definitions in the first reader and third reader versions of the bill and tell me if there are any differences in the definition between the bills.

A No change, sir.

Q. So would it be fair to say that the version of SB 1028 that was enacted did not include any changes in the definition of conversion therapy from its first reader version to the final version?

MS. ELLIS: Objection to form.

MR. GANNAM: You can answer.

A I agree there's no change.

BY MR. GANNAM:

Q. I want to look at, if you would go back to Exhibit Number 5, which is the packet of documents

containing part of the legislative history of SB 1028.

A I have it.

Q. And we discussed how on the second page it refers to several proposed amendments. Do you see those?

A I see the references, yes.

Q. And there are three Senate amendments that were rejected. It's the first, second and fourth line items. Do you see that?

A I do.

Q. And I believe you testified earlier that that corresponds to the first, second and fourth pages following page 2, correct?

A Correct.

Q. Understanding that the record indicates these amendments were rejected, does the record indicate any reason why the amendments were rejected?

MS. ELLIS: Objection. Legislative privilege.

MR. GANNAM: And instruction not to answer?

MS. ELLIS: Correct.

BY MR. GANNAM:

Q. Does the public record reflect the reason why any of these amendments were rejected?

A The documents that we have before us for the public record do not. There may be something on the audio recordings of floor debate that may reflect that.

Q. Are you aware of any of those audio recordings disclosing or publicly stating a reason for the rejection of any of the amendments?

A I'm not personally aware of it.

Q. Did you listen to the audio recording of proceedings relating to these three amendments in preparation for your deposition today?

A Not to the amendments, no.

Q. So let me ask the question a little different. Let's look at MD 0181 which is the first of the three amendments that we're talking about here.

A I have it.

Q. By Senator Salling. Do you see that?

A Yes, sir.

Q. Understanding that the public record reflects this amendment was rejected, what is the reason or reasons why the legislature rejected this amendment?

MS. ELLIS: Objection. Instruct the witness not to answer. It's covered by the legislative privilege.

Q. And the next one is MD 0182 by Senator Simonaire. Understanding the public record reflects that this amendment was rejected, what is the reason or reasons for the rejection of this amendment?

MS. ELLIS: Same objection and same instruction.

Q. And skipping one to go to MD 0184, also by Senator Simonaire, understanding the public record reflects that this amendment was rejected, what is the reason or reasons why the Senate rejected this amendment?

MS. ELLIS: Same objection and instruction to the witness. I would also note that voting records would show that it was rejected but, you know, beyond

that, I don't think there's anything in the public record.

Q. On the next page, MD 0185, is a House proceeding -- or strike that. MD 0185 appears to be an amendment offered by Delegate Parrott in the House of Delegates, is that correct?

A It does.

Q. And does the public record also reflect that this amendment was rejected?

A It does.

Q. What is the reason or reasons why this amendment was rejected by the House of Delegates?

MS. ELLIS: Same objection and instruction.

Q. And the next page is MD 0186, also a proposed amendment by Delegate Parrot. Does the public record reflect that this amendment was rejected?

A It does.

Q. And what is the reason or reasons why this amendment was rejected by the House of Delegates?

MS. ELLIS: Same objection and instruction.

Q. And then MD 0187, also a proposed amendment

by Delegate Parrott, does the public record reflect that this amendment was rejected by the House of Delegates?

A It does.

Q. And what is the reason or reasons why this amendment was rejected by the House of Delegates?

MS. ELLIS: Same objection and same instruction.

A I think, counsel, in the interest of full disclosure I'm sure my counsel is saying I'm going further than I need to. Delegate Parrott and I went to high school together. I don't believe I've seen him in 20 years.

MR. GANNAM: Is there anyone you don't know in these documents? Strike that.

MS. ELLIS: Maryland is a small state, counsel, and Baltimore is frequently referred to as "Smalltimore," so.

MR. GANNAM: We come from a "small big town" ourselves so I understand.

By MR. GANNAM:

Q. So the six amendments that we just covered, three in the Senate and three in the house, is it correct that there are no reasons why these amendments were rejected?

MS. ELLIS: Objection. Mischaracterizes the witness's, the mischaracterizes your former questions, and the fact that I objected and instructed the witness not to answer.

MR. GANNAM: And so just so I'm clear, that this is a new question. I'm not characterizing any former question.

BY MR. GANNAM:

Q. Is it true that there are no reasons why any of these six amendments was rejected?

MS. ELLIS: Objection. It's covered by the legislative privilege.

MR. MIHET: Are you instructing --

MS. ELLIS: Instruct the witness not to answer.

MR. GANNAM: All right. I'm going to attempt to play some audio that was produced to us in

this case. And I say attempt because it's always a gamble at a deposition to do something like this.

COURT REPORTER: And I'll just put "audio played" in the transcript?

MR. GANNAM: Well, it's not a lot but I would ask that if it's possible for you to attempt to, I understand there may be some limitations. Since we don't have a written transcript of this audio otherwise.

COURT REPORTER: Okay.

MR. GANNAM: For the record this is the audio file produced by the defendants identified as, by the file name SEN underscore 03272018 underscore 1. And I will play beginning at time stamp 2 hours and 6 minutes, 49 seconds through time stamp 2 hours, 10 minutes, 56 seconds. So something in the neighborhood of about four minutes of the proceeding. And just to, I will represent to the extent it's not clear from the audio, this is the three Senate amendments, two from Senator Simonaire and one from Senator Salling, just to give you, orient you to what I am proposing to play.

And you can -- let's see. Can we go off for a minute?

(A discussion was held off record.)

BY MR. GANNAM:

Q. All right. So it lacks the precision so let me start it exactly where I wanted. So for the record I'm starting at 2:06:42.

CHAIRPERSON: The Senator may begin to explain his amendments.

SENATOR SIMONAIRE: Thank you. During committee we had debates about this bill, and there were terms brought out that there's torture camps, beatings and so forth. We heard on the floor today that the sponsor believes there is abuse, child abuse. So what this bill does is says let's go after those who are abusing. And this amendment basically says keep the definition as is and adds that it is also abuse as defined in the criminal law or is coercive. We have heard the floor leader several times say coercive, coercive. Apparently there is nothing in this bill that says it has to be coercive. You could have a parent and child go and say we want this treatment to

help us work through this issue because of our religious beliefs that they don't believe that they are of the same identity or sexual orientation and they won't help. This bill will prohibit it. But if it's done in an abusive manner this amendment would say let's stop the abuse. So we've heard about abuse. We've heard about coercion. This just says that this has to be part of the definition, not just a broad one that would sweep everybody in that's not coercive and that is not abusive.

CHAIRPERSON: The question before us is the amendment offered by the Senator from the 31st. The Chair recognizes the Chair of the Committee.

A SENATOR: Yes. We reject the amendment.

CHAIRPERSON: All right. By voice vote those who accept the amendment?

VOICES: Aye.

CHAIRPERSON: Those who oppose?

VOICES: No.

CHAIRPERSON: Roll call?

A SENATOR: Please.

CHAIRPERSON: Gentleman wants a roll call. Clerk will call the roll.

VOICE: Mr. President --

CHAIRPERSON: Clerk will take the call. Thirteen in the affirmative, 33 in the negative. I think we have a preview of coming attractions. Any further amendments the bill? At this time the Chair recognizes again the Senator from the 31st.

MR. GANNAM: I'm going to stop right there at 2:08:50 and represent that this first amendment that was discussed is the amendment at MD 0184 within Exhibit 5, which on page 2 of Exhibit 5 is the fourth line item amendment from Senator Simonaire.

BY MR. GANNAM:

Q. Now, in that audio that we just played from the Senate floor, did you hear any reason given for the rejection of the amendment?

A As with the other testimony I can only agree to what I'm hearing or seeing and it appeared to be a simple floor vote. I did not hear any discussion.

Q. And are you aware of any other portion of

the legislative record of SB 1028 that discloses a reason for rejecting this amendment?

A I'm not aware of any.

MR. GANNAM: I'm going to resume the audio. And this one for the record is the amendment identified on page 2 of Exhibit 5 as the second line item, and so it appears on page MD 0182.

CHAIRPERSON: Pages -- Senator may explain his amendment.

SENATOR SIMONAIRE: Thank you, Mr. President. This is a very simple bill. We have almost four or five pages of whereas's saying we why we need this bill. There is adding some whereas clauses from the exact same studies that are referenced in the bill. This is not expanding it. And basically what these studies said in addition to what was in the whereas clause was that you should work collaboratively with those in the religious circles and those and their families who are dealing with this issue, and then it also asserts that they respect the rights of individuals to privacy, confidential self-determination

and autonomy. So I would add that they would put this in the whereas since we have so many already. Thank you.

CHAIRPERSON: Amendment offered by the Senator from the 31st. All in favor say aye.

VOICES: Aye.

CHAIRPERSON: All opposed?

VOICES: No.

CHAIRPERSON: Looks like the no's have it.

BY MR. GANNAM:

Q. All right. I'll stop the audio at 2:09:49, and ask you regarding this amendment at MD 0182 with these proposed whereas clauses, did you hear any reason given in the audio for rejecting the amendment?

A I heard a voice vote taken. I did not hear any debate.

Q. And are you aware of any other portion of the public legislative record of SB 1028 that discloses any reason for rejecting this amendment?

A I am not aware.

MR. GANNAM: All right. I'll resume the

audio where we left off at 2:09:49. Going to the amendment proposed by Senator Salling, which is on page 2 of Exhibit 5, the first line item, and it appears on the very next page of Exhibit 5 at MD 0181.

CHAIRPERSON: Any further amendments to the bill that's titled? Senate Chair recognizes the Senator from Dundalk.

SENATOR SALLING: Okay. Do I explain the amendment, Mr. President?

CHAIRPERSON: Yes, sir.

SENATOR SALLING: Thank you. Now, this amendment will provide for protection for those who are questioning. It will also provide for religious exemptions. In 2014 a similar bill was offered, as we talked about, was House bill 91 by Delegate Cardin. These are very similar to the language offered to that bill. It has religious protection which are not in the current bill which would allow, provide to refer religious leaders. Thank you, sir.

CHAIRPERSON: Question before the body is the amendment from the Senator form the 6th legislative

district. Chair recognizes --

A SENATOR: Yes, Mr. President, ladies and gentlemen of the Senate, we reject the amendment because the religious organizations are not a part of this bill.

CHAIRPERSON: On the amendment offered by the Senator from the 6th, all in favor say aye.

VOICES: Aye.

CHAIRPERSON: All opposed?

VOICES: No.

CHAIRPERSON: Looks like the no's have it.

BY MR. GANNAM:

Q. I stopped the audio at 2:10:56. And regarding this amendment that was rejected, the amendment at MD 0181, did you hear on the audio any reason given for the rejection?

A I heard one statement.

Q. And apart from that one statement are you aware of any other portion of the public record of SB 1028 disclosing a reason for rejecting this amendment?

A I am not aware of anything else.

Q. And as I heard the one statement, a Senator said that the reason for rejection of the amendment was that religious persons are not covered by SB 1028. Am I characterizing that fairly?

MS. ELLIS: I would object. I think the language was different. The language on the audio was different from your characterization of it.

MR. GANNAM: Okay. Fair enough.

BY MR. GANNAM:

Q. How did you understand the reason that was given?

A That religious organizations were not involved.

Q. And when you say not involved you mean not covered by the bill?

A Correct.

Q. Meaning that any religious organization that would perform what's defined as conversion therapy in the bill would not be prohibited by the bill from doing so, correct?

A I can't expound on anything that's not on

the recording.

Q. Apart from that one reason that we did hear, were there any others that you heard on this recording?

A No, sir.

Q. And you're not aware of any others in the public record?

A I'm not.

BY MR. GANNAM:

Q. All right. I want to change gears a little bit and talk about the interpretation of the enacted ordinance. Let's go back to, for reference, the enacted version of the statute which is Exhibit 8.

A Yes, sir.

Q. And going back to page 5, also numbered MD 0208, to the definition, where it says, "Conversion therapy means a practice or treatment by a mental health or child care practitioner that seeks to change an individual's sexual orientation or gender identity and then conversion therapy includes any effort to change the behavioral expression of an individual's

sexual orientation, change gender expression, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender." Did I read that correctly?

A You did.

Q. With respect to gender identity and how it's defined or how it states here that conversion therapy means a practice that seeks to change an individual's gender identity and that it includes any effort to change the behavioral expression of -- I'm sorry -- to change gender expression, what efforts to change gender expression or gender identity are banned by this statute as it's defined here; can you give me an example?

A Sir, I can testify to what's on the page. As far as the intent, I believe that's a judicial decision on anything that's not expressly discussed.

Q. Is gender identity as a term defined anywhere were in SB 1028?

A I do not see a definition.

Q. What about the term gender expression?

A I do not see a definition.

Q. So as a licensed counselor in Maryland who may be covered by this statute, for example, Mr. Doyle, the plaintiff in this case, I believe he's entitled to know how the state interprets the statute, what practices it intends to ban. And so I want to go back to my question. Can you give me an example of a practice that would seek to change an individual's gender identity or change an individual's gender expression that would be banned by the statute?

A Again, sir, my testimony would be the same. I can testify to what's before me, what the law specifically says. Anything after that it's my understanding would be a judicial decision.

Q. So I'm going to give you an example, a hypothetical. So suppose a prepubertal child, say around 10 years old, was born biologically a boy but has expressed a female gender identity. Would this statute prohibit a therapist from encouraging that child to embrace his given male body or biological male body and to align with a male gender role?

A Again, I'm not able to speculate on that. That's a hypothetical and I wouldn't be able to do that. If it's not specifically written in the law, I can't testify to anything after that.

Q. Well, has the state either at any level be it the Department of Health or one of the subsidiary boards that regulate the various professions issued any rules or guidelines or any help at all with how this statute is to be interpreted?

A Interpretation, again my answer would be same.

MS. ELLIS: I think if you listen to, listen to the question, if you could have, if you could read back the question, Mr. Court Reporter.

(The reporter read back as requested.)

A Again with the word interpretation my testimony stands. If you're asking enforcement --

BY MR. GANNAM:

Q. The question is, have there been any published guidelines or rules to assist in understanding what the statute means?

A Not to my awareness.

Q. Have there been any rules or guidelines created or published with respect to enforcing SB 1028 by the government?

A The board would handle a complaint as unprofessional, unprofessional conduct.

Q. And when you say the board, what board are you talking about?

A Any board that would be involved in conversion therapy.

Q. I want to go to page 6 of the -- I'm sorry -- actually starting at the bottom of page 5. It's item C, begins a mental health or child care practitioner. Do you see that?

A I do.

Q. I'll read the whole thing. "A mental health or child care practitioner who is engaged in conversion therapy with an individual who is a minor shall be considered to have engaged in unprofessional conduct and shall be subject to discipline by the mental health or child care practitioner's licensing or

certifying board." Did I read that correctly?

A You did.

Q. How many licensing or certifying boards are involved with potentially enforcing SB 1028?

A Potentially four.

Q. And what four are those?

A Make sure I got it right. It's easier to go to my notes if that's okay.

Q. Sure.

A Professional counselors and therapists, nursing physicians and psychologists. I'm sorry. And social work. I apologize. There are five.

Q. So those are five separate boards, professional counselors and therapists?

A Yep.

Q. Nurses?

A Yes, sir.

Q. Physicians?

A Yes, sir.

Q. Social workers?

A Yes, sir.

Q. And what was the last one?
A Psychologists.
Q. Psychologists, okay. So each of those has its own jurisdiction over the professionals who are its constituents, correct?
A Yes, sir. They are independent.
Q. And so SB 1028 authorizes those boards to -- or strike that. Are those boards responsible for enforcing is SB 1028 with respect to their respective constituencies?
A With respect to their practitioners, yes.
Q. Is there any other government agency or body in the state of Maryland that has enforcement authority under SB 1028?
A No, sir.
Q. Which of those five boards has jurisdiction over the plaintiff, Christopher Doyle?
A I believe Mr. Doyle is a therapist so he would fall under the Board of Professional Counselors and Therapists.
Q. Has the Board of Professional Counselors

and Therapists issued any guidelines or memoranda explaining how it intends to interpret or enforce SB 1028?

A The Board of Professional Counselors and Therapists like the other four boards I mentioned before would consider that unprofessional conduct if a complaint was brought to them.

Q. Because that's what SB 1028 says, right?

A Correct.

Q. But has the Board of Professional Counselors, for example, itself published any guidelines or rules identifying what kinds of things count as unprofessional conduct as they interpret that term?

A If I'm understanding the question correctly, for conversion therapy specifically?

Q. No. Just unprofessional conduct in general.

A I don't have it in front of me. I believe that there is a general list but I don't have it in front of me.

Q. Okay. So, does the board of Professional Counselors and Therapists, has it identified by rule or guideline what specific practices by a professional counselor or therapist would be considered conversion therapy under SB 1028?

A Not to my knowledge.

Q. Does the Board of Professional Counselors and therapists intend to put forth any guidelines or rules on the subject of conversion therapy?

A Sir, that's speculation. I can't answer that.

Q. So I'm not asking you to speculate. I'm asking, have you heard or do you know of any expressed intent by that board to put forth such rules or regulations?

A There again, I can't answer that. Do I have personal knowledge? No.

Q. And sort of understanding your capacity here also testifying on been on behalf of the defendants, I want to ask you to, I want you to understand I'm asking not just based on personal

knowledge. I'm just asking the question. Have any of these boards expressed any intent -- I'm sorry -- has the Board of Professional Counselors and Therapists expressed any intent to issue rules or regulations regarding conversion therapy?

A Again underscoring that these boards are independent, I am not aware of any.

Q. And that's the same for all five boards?

A Yes, sir.

Q. Given your role in the Department of Health with respect to these boards, at what point in the usual process, if there is a usual process, would you become aware of an intention to promulgate rules or guidelines by one of these boards?

A I regularly attend the public meetings of these boards. I certainly would not testify that I'm at every meeting, but as my schedule allows, I do attend the public meetings and it would probably be somewhere in that public meeting.

Q. And would you have access to that information before it becomes public in your role

within the Department of Health?

A I believe that would be privileged conversation but in this case I do not have any knowledge of it.

Q. In SB 1028 itself, if we could go back to the statute, item E on page 6 reads: "The Department shall adopt regulations necessary to implement this section." Did I read that correctly?

A You did.

Q. Has the Department of Health adopted any regulations necessary to implement SB 1028?

A I'm not aware of any.

Q. Has the department indicated any intent to adopt regulations on the subject?

A My answer to that, sir, would be the same as what I previously said with the boards. If there is public discussion, that would probably be the point at which I would become aware. I think any other discussion would be privileged. Having said all of that, I'm not aware.

Q. I want to ask to you look at Exhibit 2,

which is the deposition notice in this case.

A Thank you. Yes, sir.

Q. Would you go to page 4 and look at item 10.

A Yes, sir.

Q. These are the subjects which this deposition notice covers. Item 10 reads: The interpretation, application, and enforcement of SB 1028 by the government of the state of Maryland."

A Yes, sir.

Q. Did I read that correctly?

A You did.

Q. So is it your understanding that you are here to testify today on that subject matter in item 10?

A That is my understanding.

Q. So I want to go back to the interpretation question. I have asked you one hypothetical that you did not answer or attempt to answer. If I can't ask you how it may be interpreted in a specific situation then I'm not sure how else I can ask you about the interpretation of the statute. So I'm going to try

again with the hypothetical, and it is this. If a prepubertal child around 10 years old was born as a boy biologically, has expressed a female gender identity, would SB 1028 prohibit a therapist under its coverage from encouraging that child to embrace his male biological body and to align with male gender roles?

A And again, counselor, speculation. I can't answer, and I will refer back to what I said originally, that it would be held as unprofessional conduct.

Q. Would the hypothetical I just explained be considered unprofessional conduct under SB 1028?

MS. ELLIS: Objection. I don't think you understand the way in which the boards enforce or interpret statutes such as this. And perhaps you could get more information if you asked the witness how boards function with respect to alleged violations of their practice act or alleged violations of some statute like Senate Bill 1028.

MR. GANNAM: Or I could ask a witness put forth under Rule 30(b)(6) who has knowledge of how it

would be interpreted in a given situation. It was our understanding that that would be Dr. Lang. But I'll ask the question.

BY MR. GANNAM:

Q. Using, for example, the Board of Professional Counselors and Therapists, since that's the board that has jurisdiction over Christopher Doyle, how would that board approach interpreting SB 1028 for purposes of enforcing it on its constituents?

A Counselor, if you will allow me a little latitude, I'm going to reframe the question slightly and you can agree or disagree if that's how we proceed. The boards that I work with, specifically the 22 boards for the Department of Health, they are independent entities. As such they are complaint-driven. So if a complaint was made to a board in your example of conversion therapy, there is a complaint process then that is followed. I would be happy to talk on that.

Q. Who can make a complaint to the Board of Professional Counselors and Therapists regarding a claimed violation of SB 1028?

A As with any complaint it would be any member of the public who would be involved.

Q. What happens when a complaint is made?

A To clarify, are we speaking specifically for the Board of Counselors and Professional Therapists --

Q. For now.

A -- or in general?

Q. For now. We'll talk about the Board of Professional Counselors and Therapists.

A Okay. If I may I'm going to refer back to my notes from the publicly available website to guide me along.

Q. Okay.

A If a complaint is received by in this case the Board of Professional Counselors and Therapists, it then goes to their Disciplinary Review Committee. Whenever this committee receives the information they can do one of three things. They can dismiss a complaint, take informal disciplinary action, or refer the complaint for an investigation. And before I go

any further, is this agreeable that we follow this line of reasoning?

Q. I'll let you know if I want you to expand on something or answer something different.

A I'm sure you will, counsel.

Q. So when a complaint comes in, you said there's three things that can happen?

A Yes, sir.

Q. Can you just say those again just so I'm sure?

A You bet. Dismiss the complaint. First of all, it's triaged by the Disciplinary Review Committee and that Disciplinary Review Committee can dismiss the complaint, take informal disciplinary action, or refer the complaint to an investigation.

Q. And is the Disciplinary Review Committee always the first recipient of a complaint that comes in; in other words, is it always the Disciplinary Review Committee that will decide to do one of those three things?

A Yes.

Q. And under what circumstances would they dismiss a complaint?

A If they found it had no merit.

Q. And would they refer to any particular statutes or rules or other guidelines to make that determination?

A They certainly could.

Q. What is available to them to make that determination in terms of statutes or rules or guidelines?

A At the risk of sounding glib, exactly what you just listed out, their statutes, their guidelines, their regulations.

Q. Where are the Maryland regulations that apply to the Board of Professional Counselors and Therapists located? When I say where, I mean where within the code, not physically where are they.

MS. ELLIS: I mean I think you've been provided with those.

MR. GANNAM: So I'm going to show you a document that I will mark as Exhibit 13.

(Plaintiff's Exhibit 13 was marked for purposes of identification.)

THE WITNESS: Thank you.

BY MR. GANNAM:

Q. This document is numbered MD 0274 through MD 0290. And at the top it says, "Title 10, Maryland Department of Health, Subtitle 58, Board of Professional Counselors and Therapists." Did I read that correctly?

A You did.

Q. Does this document contain the state regulations applicable to the Board of Professional Counselors and Therapists?

A It does.

Q. Now, does this document that we're looking at contain all of Subtitle 58 or only portions of it?

A I would need to go back to original sourcing but it appears to be the whole thing.

Q. So just for the record, under that Subtitle 58 it reads: "Chapter 04, Hearing Procedures." And then on page 9 of the document which is also numbered

MD 0282, there is a similar heading except it says, "Chapter 09, Disciplinary Sanctions and Monetary Penalties." And as I read the document, I don't see any Chapters 5 through 8, for example, or anything before Chapter 4. Now, based on that sort of review of this document, would it be fair to assume there are other chapters within Subtitle 58 that are not included in this document?

A Again, I would need to go back to the original source but I would agree that there is other information here.

Q. So within this document that we have been provided, Exhibit 13, can you sort of orient me to what it tells us about how a complaint would be processed, specifically anything that shows the Disciplinary Review Committee, whether to dismiss a complaint, issue some informal disciplinary action or refer it for investigation?

A This is referring to the actual hearing proceedings.

Q. So you referred to some notes to tell me

about the Disciplinary Review Committee. What were you referring to?

A It is publicly available website for the Board of Counselors and Therapists. And specifically it's under the section labeled Complaints and Disciplinary Procedure.

Q. And can you provide me that URL or web address for that, at least the top-level domain, the something ".com" or ".gov" that would give me the --

A Certainly. You want me to do that orally now.

Q. Please.

A https://health.maryland.gov.

Q. Now, is there a lot after that?

A There's a little more.

Q. Okay. Go ahead and read me what you've got.

A /bopc and there's more but my guess is that will get you to where you're asking.

MS. ELLIS: And counsel, I believe that those documents were also provided to you as part of

the production.

Q. All right. So I guess what my question is, if a complaint comes in stating please take action against Mr. Doyle, he performed conversion therapy on me or on my child, what information would need to be in that complaint for the Disciplinary Review Committee to decide whether to dismiss it or issue informal disciplinary action or refer it for an investigation?

A On the publicly available website there is a link for an individual to make a complaint and I would assume each of those questions fields would need to be filled out. As far as what would happen in the example that you have given me, again that would be speculation.

(Plaintiff's Exhibit 14 was marked for purposes of identification.)

Q. I want to show you a document I marked as Exhibit 14.

A Thanks.

Q. It's numbered at the bottom. It's a little difficult because there's an overlay of the page number

and a date but it reads MD 0370 through the end, is MD 0378. Do you see that?

A I do.

Q. Is this document the same document you were just referring to that you were reading from in your own notes?

A It is. And as you can see, it has the same web address that I mentioned.

Q. So on page 2 of this document, the first bolded heading says, "What is the complaint process?" Do you see that?

A I do.

Q. And it says "complaints are initially reviewed by the Disciplinary Review Committee or DRC of the board. The DRC may recommend the following actions: (1) dismiss the complaint; (2) take informal disciplinary action; or (3) refer the complaint for investigation." Did I read that correctly?

A Yes, sir, you did.

Q. And is that the same information you just testified to a moment ago?

A It is.

Q. And you in fact took it from this very document?

A Not from your copy of it but yes.

Q. From your copy of it?

A Correct, which appears to be word-for-word the same.

Q. Now, if we turn several pages to the page numbered MD 0374, this appears to be a complaint form. Am I interpreting that correctly?

A I agree.

Q. And there are in this copy five pages to the complaint form, correct?

A In this version, yes. My guess is if you printed it in different font, give or take, it would look different but yes.

Q. I understand. This came off the Internet so it might be paginated differently online.

A I agree.

Q. Okay. But on this copy it says at the top, "Department of Health and Mental Hygiene." That's the

Department of Health, correct?

A It is.

Q. Now, is Mental Hygiene still part of the name?

A It is not.

Q. Okay. Department of Health, Board of Professional Counselors and Therapists, correct?

A Correct.

Q. It's a complaint form. Section 1 says "identify the type of healthcare provider." So if, for example, Christopher Doyle is an LCPC and someone was making complaint against him, they would check the box LCPC?

A I would assume.

Q. Or at least that's what's intended by the form?

A I would assume.

Q. And this form would cover complaints against any of these other designations, too, correct?

A Yes, sir.

Q. So there's a place, Section 2, identify the

healthcare provider; Section 3, client name; Section 4, identify complainant. Have I read all those correctly?

A You have.

Q. So the complainant does not have to be the client in this case? At least the form would accommodate a complainant who is different from the client of the therapist, correct?

A I agree.

Q. Section 5 is for the dates treated; Section 6, relationship of complainant to client. Have I read those correctly?

A You have.

Q. Section 7 asks for relationships with the health provider; 8 asks for information regarding all persons who have knowledge of your complaint. Have I read those correctly?

A You have.

Q. Or at least summarized them correctly?

A Sure.

Q. Section 9 reads: "Nature of complaint. Please describe with as much detail as possible what

event or events lead to the filing of this complaint. Include the dates and reason for seeing the healthcare provider in your description. Please type your information in the space provided below. Attach additional sheets if necessary." Did I read that correctly?

A Yes, sir.

Q. And then there's just an open box or an open field for all that information, correct?

A Correct.

Q. And then Number 10, Section 10 says "Nature of complaint. Please describe with as much detail as possible what events lead to the filing of this complaint. Include the dates and reason for seeing the healthcare provider in your description. Please type your information in the space provided below. Attach additional sheets if necessary." Did I read that correctly?

A You did.

Q. And is that the same as Section 9?

A It appears to be.

Q. But then there's also under Section 10 insurance identification number, insurance company name, and insurance company address, correct?

A I agree.

Q. Eleven says, "List the identity of any persons to whom you have made a similar complaint. Indicate when the complaint was made." Did I read that correctly?

A Yes, sir.

Q. And then finally there's a Section 12 but I'll skip to 13. It says, "I hereby attest that the foregoing information is true to the best of my knowledge and beliefs and that I am competent to make theses statements." Did I read that correctly?

A Yes, sir.

Q. And the last page is a medical information release, correct?

A Yes, sir.

Q. So we have just gone through all the fields in the complaint. I'm going to ask you some questions about it. Is this complaint specific to complaints

about conversion therapy as that's defined in SB 1028?

A It is a general complaint form specific to this board.

Q. So any complaint regarding a provider who is subject to this board's jurisdiction would be submitted on the same complaint form?

A Yes, sir.

Q. And as I read it I didn't see anyplace on the form to indicate specifically, meaning a check box or a specific field to say whether it was from conversion therapy or some other kind of therapy, correct?

A I would assume that box 9, and for reasons that I cannot explain at the moment, also box 10 would allow a complainant to be as specific as they would choose to be.

Q. When was the last time this complaint form was changed?

A I have no personal knowledge of that.

Q. Have any changes been made to it since SB 1028 became effective in October of 2018?

A My counsel would probably suggest that I not go this far but I would assume since the Department of Health and Mental Hygiene is still across the top of this and the name of the department has changed quite some time ago, that this has probably not been updated since the new law was passed.

MS. ELLIS: I was about to offer the same observation and also provide the additional information that the statute changing the name of the department prohibited anybody in the department from tossing stuff that had the Department of Health and Mental Hygiene on it until you used it all up. So apparently they've not used up all their or updated their website.

THE WITNESS: Yes. This is a web format.

MS. ELLIS: Right. Right.

THE WITNESS: I think it's safe to say that this has not been updated.

MS. ELLIS: Right.

BY MR. GANNAM:

Q. Okay. I want to ask you -- and I'm afraid I don't have a copy. I guess we could, I could request

your counsel to print one if we need to. But I want to read from a Maryland statute. And it is the Maryland Code Annotated Health Occupations Article, Section 17-509, titled Denial, Suspension or Revocation of License. Now, have you ever read that statute or are you familiar with it?

A I would not be able to say specifically yes or no at the moment. I can flip through the code.

MR. GANNAM: Okay.

MS. ELLIS: If you have no objection I can give her the --

MR. GANNAM: That would be fine, yes.

MS. ELLIS: -- copy of it.

MR. GANNAM: Can we just state for the record what volume you are showing her?

MS. ELLIS: I am -- you said 17-509?

MR. GANNAM: Yes.

MS. ELLIS: I am checking the 2018 supplement and that is not in the 2018 supplement, and turning to Section 17-509 of the Health Occupations Article of the Annotated Code of Maryland -- Section

509.

THE WITNESS: Okay. Thank you.

BY MR. GANNAM:

Q. Okay. So I will read and you can confirm if it's the same in your version there. "Subject to the hearing provisions of Section 17-511." So far, so good?

A Yes.

Q. Okay. Just making sure we're on the same statute. I'll continue. "Of this subtitle the board on the affirmative vote of a majority of its members then serving may deny a license or certificate to any applicant, place any licensee or certificate holder on probation, reprimand any licensee or certificate holder, or suspend or revoke a license of any licensee or a certificate of any certificate holder if the applicant, licensee or certificate holder:" Colon. Did I read that correctly?

A Yes, sir.

Q. And then there's several items numbered following that, is that correct?

A Yes, sir.

Q. And so I want to look at Number 16 which reads: "Commits an act of immoral or unprofessional conduct in the practice of clinical or nonclinical counseling or therapy." Did I read that correctly?

A You did.

Q. So does this statute provide authority to the Board of Professional Counselors and Therapists to discipline one of its licensees or certificate holders for committing an act of unprofessional conduct?

A It does.

Q. And is unprofessional conduct as used in this statute the same as unprofessional conduct as used in SB 1028 where it say that the relevant board will treat conversion therapy as unprofessional conduct?

A Yes.

Q. So prior to the enactment of SB 1028 is it correct that the Board of Professional Counselors and Therapists already had jurisdiction to discipline its licensees for acts of unprofessional conduct. Fair enough?

A Yes.

Q. Okay. And the complaint form would accommodate any complaint of unprofessional conduct as viewed by the complainant whether or not it involves conversion therapy, correct?

A Yes.

MR. GANNAM: Okay.

MS. ELLIS: Can we take a break soon?

MR. GANNAM: Let me confer with my colleague.

MS. ELLIS: Yeah.

MR. GANNAM: All right. We'll take a lunch break now.

(There was a lunch break in the proceedings from 12:35 p.m. to 1:26 p.m.)

(Ms. Morgan Clipp entered the deposition room.)

BY MR. GANNAM:

Q. All right. Dr. Lang, we were talking about enforcement and had been talking about the complaint form which is part of Exhibit 14 that is the complaint

form to the Board of Professional Counselors and Therapists. Do you recall that testimony before the lunch break?

A I do.

MR. GANNAM: Okay. I'm now going to show you a document I'm marking as Exhibit 15.

(Plaintiff's Exhibit 15 was marked for purposes of identification.)

THE WITNESS: Thank you.

BY MR. GANNAM:

Q. This is a news article from the Baltimore Sun. The date is March 14, 2014. And this for the record was identified on the audio recording that we listened to earlier. And I'll give the file name again so we don't have to go back and look it up. File name has SEN underscore 03272018 underscore 1. And I guess let me just for the record, we're going to designate that entire audio file Exhibit 16.

(Plaintiff's Exhibit 16 was marked for purposes of identification.)

MR. GANNAM: And I will after the

deposition provide links to the court reporter and to counsel so that we all know we're talking about the same file. And at time stamp 143:35 through 1:44:57 this article is spoken about by the Senator referred to as the Senator from the 5th District. His name was not indicated on the audio file.

MS. ELLIS: Could you please repeat the time stamp?

MR. GANNAM: Yes. 143:35 to 144:57.

BY MR. GANNAM:

Q. So this article, the first paragraph reads: "Gay rights advocates and the state legislator who introduced legislation this session to ban so-called gay conversion therapy in Maryland have withdrawn the bill saying they will instead pursue regulatory oversight of the controversial practice." Did I read that correctly?

A You did.

Q. Are you familiar with the conversion therapy bill that was proposed in 2014?

A In general.

Q. You have some knowledge that there was a bill that was proposed and then withdrawn?

A Yes.

Q. Do you have any knowledge of the content of that bill?

A Not specifically, no.

Q. And you didn't work for the Department of Health in 2014?

A I did not.

Q. I want to read a couple more excerpts from here and then ask some questions. On the second page the first full paragraph reads: "Equality Maryland, which backed Cardin's bill, said it would have established a law comparable to those in other states including California and New Jersey." Did I read that correctly?

A You did.

Q. And I want to skip a couple paragraphs and go to the paragraph that begins, in a joint statement. Do you see that?

A I do.

Q. It reads: "In a joint statement Friday Cardin and Equality Maryland officials said that in research for the bill and in talking to several organizations with expertise in regulatory protections for patients, they concluded that patients who feel they have been harmed by conversion or reparative therapy already have avenues to complain to state health occupation boards." Next paragraph.

"Minors or anyone advocating on their behalf can file a complaint with the board, triggering a vigorous investigation, the statement said. If the investigation uncovers proof that a licensed healthcare professional violated the standard of care then the board has an array of regulatory tools to keep this from happening again." Next paragraph.

"The statement went on, Delegate Cardin and Equality Maryland are confident that the existing regulatory framework provides a precise tool to protect minors from this harmful therapy and we will work together and with other advocates to ensure that the process for filing complaints against anyone who

engages in these practices is transparent and widely disseminated." Last paragraph.

"Carrie Evans, Equality Maryland's executive director said the organization will work to ensure LGBT youth and their parents have the information they need to file complaints." Did I read all that correctly?

A You did.

Q. So let me ask, first of all, have there been any changes in the ability of a person wanting to file a complaint against a therapist licensed under one of the occupational, the health occupation boards to file a complaint from March 14, 2014 to today?

MS. ELLIS: Objection. Relevance.

A You're referring specifically to conversion therapy?

Q. No. I'm just referring to the ability to file a complaint with one of the health occupation boards. Is that right or that ability to file a complaint any different today than it was in 2014?

A No, sir. The ability to file a complaint

to my knowledge has not changed at all. The only reason I'm asking is the forms themselves may have changed as we saw before. So there may be some subtle differences there but as far as the right to file, no.

Q. Focusing on a statement made in the article, the third to last paragraph that begins minors or anyone, do you see that?

A I do.

Q. Now, I'm going to read the statement again and ask you if this statement was made on the day before SB 1028 went into effect would have it have been true. And this is the statement. "Minors or anyone advocating on their behalf can file a complaint with the board triggering a vigorous investigation, the statement said. If the investigation uncovers proof that a licensed healthcare professional violated the standard of care then the board has an array of regulatory tools to keep this from happening again." So having read that statement, would that have been a true statement the day before SB 1028 took effect on October 1st of 2018?

MS. ELLIS: Objection. Relevance.

A I believe the statement is at least inferring that this refers to conversion therapy. Taking this statement separately, I would agree, then no, there has been no change. But after the bill was passed into law then conversion therapy would be a reason to list, if you will, for a possible violation.

Q. So let me ask this question then. On September 30, 2018, the day before SB 1028 took effect, would it have been a true statement that a minor or anyone advocating on the minor's behalf could file a complaint with one of the boards alleging unprofessional conduct as defined in the stature that we read before lunch?

A Yes, that would be correct.

Q. And is there any difference in the way that that complaint would have been filed or processed from September 30, 2018 to October 1, 2018 when SB 1028 took effect?

A The actual procedure, no.

Q. And unprofessional conduct would be the

basis for a complaint on September 30th or October 1st, 2018 correct?

A That's correct.

Q. Do you have any basis to believe that prior to the effective date of SB 1028 that there were not adequate processes in place for a client or someone advocating for a client to file a complaint with one of the health occupational boards?

MS. ELLIS: Object to the form.

A I believe that would be a personal opinion so I'm not quite sure what the relevance is.

Q. So can you answer the question?

A I can answer it in my professional capacity and no, I see no problem.

Q. Okay. So we talked about interpretation earlier and then we have now been talking about enforcement so I'm going to ask us to go back to Exhibit 14, which includes the complaint form and refer specifically to Section 9 which is numbered MD 0376 or page 3 of the complaint form and ask this. If this form is submitted by a parent, and the parent includes

in this Section 9 where they describe the nature of the complaint, if in that Section 9 the parent writes my 10-year-old child who was born as a boy but expressed a female gender identity went to a therapist who encouraged my child to embrace his male biological body and to align with male gender roles, would that complaint provide sufficient basis for the disciplinary committee to either prescribe some kind of informal discipline or so to launch an investigation into the complaint for a violation of SB 1028?

A I believe that's speculation.

Q. Well, I'm asking you here as a witness to testify about enforcement. Would that hypothetical provide sufficient basis for, to begin an enforcement action for the therapist having committed unprofessional conduct, specifically conversion therapy under SB 1028?

A Any complaint that's filed with the board is considered. What happens with that complaint, that is up to the board.

Q. You testified earlier that one outcome is

dismissal, correct?

A That would be a possible outcome.

Q. The other two were either administering informal discipline or referring for an investigation, correct?

A Correct.

Q. So my question is, would the enforcing committee have a sufficient basis based on the hypothetical that I gave you to conclude that conversion therapy has occurred and therefore we should either administer discipline or refer it for investigation?

MS. ELLIS: Objection to form.

A There again, sir, there would be an investigation that takes place and I would assume that there could possibly be other evidence that either would support or mitigate. I can't speculate.

Q. But as between dismissing the complaint for not having any merit and taking the step of referring it for further investigation, based on the hypothetical that I provided, is there sufficient evidence of a

possible conversion therapy violation under that hypothetical for it to be referred for investigation?

MS. ELLIS: Objection. There's absolutely no evidence in the hypothetical. There's a claim.

A And again not being a member of the board, this is speculation. We're going down a rabbit hole. I don't know.

Q. You identified the various boards that are under the Department of Health's umbrella as independent, is that correct?

A Statutorily independent; yes, sir.

Q. So what does that mean exactly?

A It means that they are tasked by the state of Maryland with enforcement of regulations that relate to their own profession.

Q. Are these boards within the executive branch of the Maryland state government?

A They are.

Q. So they're not legislative and they're not judicial, correct?

A That's correct.

Q. And as executive branch agencies of the state of Maryland are -- strike that. Since they are executive branch agencies of the state of Maryland is there any reason why you could not have spoken to any of these boards or board members about how they would enforce SB 1028 or any reason why one of their members could not have been presented as a witness to testify regarding enforcement under SB 1028?

MS. ELLIS: Objection. Compound.

A I see no reason.

Q. In preparing for your testimony today did you discuss the issues of interpretation or enforcement of SB 1028 with any members of any of the health occupation boards that are within the Department of Health?

A Again, I'll refer to my statements earlier this morning of the folks that I talked to before today.

Q. So only counsel and the legal intern were the only people you spoke with regarding your testimony today?

A Yes.

Q. And so just so it's clear, you did not speak to anyone from any of the health occupation boards for purposes of preparing for your testimony today?

A I asked a singular general question of one of our investigators, asking what the process of an investigation may typically be.

Q. And who was that investigator?

A Danielle Vallone.

Q. And what is Danielle Vallone's job title?

A I literally would need to look to be specific but I believe it's investigator for X number of boards.

Q. You say X number, does that mean more than one?

A Yes.

Q. Is it all of the boards that are within the Department of Health?

A It's several.

Q. Would it include the Board of Professional

Counselors and Therapists?

A I don't believe she is.

Q. So how many boards share investigators or use the same investigators?

A It varies.

Q. Are there any other shared personnel among the various boards?

A Yes.

Q. What kind of personnel are shared?

A It could go from an executive director who oversees more than one board, some of the staff members who work for multiple boards.

Q. Who is the executive director of the Board of Professional Counselors and Therapists?

A Kimberly Link.

Q. And I'm sorry. The investigator Danielle, what was her last name?

A Vallone.

Q. Vallone. Why did you pick Ms. Vallone to consult before your deposition as opposed to another investigator?

A Literally she was, I travel around the state pretty frequently with my current position and she happened to be in the hallway the day that I was thinking I should probably ask this question before we have this meeting.

Q. What did the investigator tell you?

A That there is typically for an investigation once it goes to the investigator, boards in general will have an investigator speak to the parties who would be involved, would take statements and then would provide this information back to the board.

Q. Does Ms. Link have any responsibilities on any board besides the Board of Professional Counselors and Therapists?

A Currently, no.

Q. What are the duties, generally speaking, of an executive director of the Board of Professional Counselors and Therapists?

A To carry out the will of the board.

Q. What role does the executive director play

in processing a new complaint when it comes in the door?

A I'm sorry. Repeat that.

Q. What role does the getting executive director play in the process of a new complaint that comes in to the board?

A In general because the executive director is a permanent staff member, they would be the ones that would receive it from, there are other staff members who provide it to them or they may sometimes pull it off of the Internet, however the complaint itself comes in, and they would assemble the information and then pass along to either the board chair or the CRC -- I'm sorry -- the intake committee, they would be a conduit to get the information to the next person.

Q. And when you say the executive director is a, did you say permanent staff member?

A Correct.

Q. Does that mean an employee of the Department of Health?

A No, sir. Of the board.
Q. So, and did you say Ms. Link was involved in another board or not?
A Currently, no.
Q. But there are some boards that share an executive director?
A There are some.
Q. And in that case who is the employer of that executive director?
A The boards.
Q. The boards themselves and not the Department of Health?
A That's correct.
Q. So you told me you spoke to Ms. Vallone. Is there anyone else you consulted to prepare for your testimony today besides meeting with counsel and then consulting Ms. Vallone?
A No.
Q. And just for the record then, did you ask anyone involved with any of the boards about what kinds of conversations or, or say conversations between a

therapist and a client could be deemed to violate SB 2018 or could be deemed conversion therapy?

A I did not. And again, forgive me, this is the first time I'm doing this but if we can somehow go back to amend the record for my morning statement of the individuals that I spoke to.

MS. ELLIS: That's fine.

THE WITNESS: That's embarrassing. I'm sorry.

MR. GANNAM: No, no. Fair, I mean it happens.

THE WITNESS: In the process I realized I had that conversation. It certainly wasn't meant as an intent.

BY MR. GANNAM:

Q. So who would be in your view the best person involved with the Board of Professional Counselors and Therapists to testify as to how they would enforce the directive of SB 1028 to treat conversion therapy as unprofessional practice?

MS. ELLIS: Objection to the suggestion

that this witness is not an appropriate witness.

A I would hope that I'm answering the questions that you have for me.

Q. Okay. So, but my question is, who knows more than you involved in the Board of Professional Counselors and Therapists about how they would handle a complaint that implicates SB 1028?

MS. ELLIS: If you can figure it out, you can go ahead and answer.

A I suggest looking at the website seeing the publicly available information for the names and descriptions of the employees and board members.

Q. So apart from looking at the website are you unable to answer the question?

A I think I did, sir.

Q. Well, my question is, apart from looking at the website are you unable to tell me any of the names of those people or that person who would be able to explain how the Board of Professional Counselors and Therapists would approach a complaint or enforce SB 1028?

MS. ELLIS: Objection. She's answered several times the way in which, about the complaint procedure. We have looked at the exhibit about the complaint procedure. She's told you how the board processes complaints.

MR. GANNAM: And my response to that objection is that, and we have dealt with this same issue before. The plaintiff is entitled to know how the government will interpret and enforce its ordinances, it's statutes or what have you. And we believe that the obligation to produce a witness able to testify to those things has not been met because our hypotheticals have not been answered or even attempted to be answered.

MS. ELLIS: Ms., Ms., Dr. Lang told you that this was a complaint-driven process and has told you how complaints are handled and that we can't speculate, we don't know how a board would handle a complaint. You might ask if there have been any complaints. I can tell you there have not been. It's a case-by-case adjudication, counsel.

MR. GANNAM: And I would respond again, you know, for the record that we believe we're entitled to know specifically what kinds of conduct would be deemed to be violations or potential violations of SB 1028. And I would also, well, I'll just leave it at that for now. This may be, we had, actually had a number of hypothetical situations that we wanted to present. I'm not going to get into them now but I think this is something that we may have to get the court involved with to request a new designee. But we will deal with that when I'm done with my questions.

BY MR. GANNAM:

Q. So before we move on, just so the record is clear, I've asked the same hypothetical a number of times about the 10-year-old. Do you recall that I've asked that?

A I do.

Q. And you have been unable to answer specifically whether that hypothetical would implicate a violation of SB 1028. Would it be fair to conclude that you would provide a similar answer to other

hypotheticals asking whether particular conduct would be deemed a violation of SB 1028?

A That's accurate.

Q. Okay. When a complaint is received by -- we'll just stick with the example of the Board of Professional Counselors and Therapists. When a complaint is received by the board, I guess I need some clarification. Who within the board would have the authority to, for example, stop the complaint and not proceed farther with it, you know, for whatever reason? Would that be only the Disciplinary Review Committee or would the executive director have the ability to do that; how would that work?

A I would go back to the information that's found on their website. The first triage, if you will, would be the Disciplinary Review Committee.

Q. So if a -- strike that. How many people are on the Disciplinary Review Committee?

A I believe it's three.

Q. And are there decisions whether to dismiss a complaint, administer informal disciplinary action,

or refer it for investigation driven by a majority rules approach, in other words, does it take two out of three or can any one out of the three make that decision?

A It's a committee, sir, and I'm not privileged to sit in on that.

Q. Do they have published rules of procedure that they're publicly available where we could see whether they go by a majority rule basis or whether only one of them could do that?

A I'm not aware of anything that's published.

Q. Is there any one or group of people within the Board of Professional Counselors and Therapists who's can overrule that initial determination by the Disciplinary Review Committee? And I'll give an example. Suppose the committee decides to dismiss a complaint as having no merit. Is there any person or group of persons within the board who can overrule that decision?

A It does say that the board votes after the CRC -- I'm sorry -- the DRC makes a recommendation.

Q. Would that include a recommendation to dismiss?

A Apparently. It's shown as number 1 and then it lists the board as voting after that so I would assume, yes.

Q. Okay. And as far as the board itself then, where it says it votes, does a simple majority become the decision or the will of the board in those cases?

A I have seen nothing to imply otherwise.

Q. How many members are there on the board?

A I believe there are nine on there currently.

Q. Are their names available publicly?

A Yes.

Q. Is that on the website as well?

A It should be.

Q. Does the board have a chairperson?

A It does.

Q. Do you know who that is?

A Counsel, if you gave me a few seconds I would be able to look it up. I don't have it in here

right now.

Q. Fair enough. That's okay. You believe it's in your notebook of materials?

A I know it is no longer in my notebook but I believe I could look it up on my iPhone.

Q. Fair enough. That's fine.

A The reason why I'm hesitating, counsel, just to paint an accurate picture, they change board chairs I believe this time of year and I want to make sure where we are.

Q. Okay. Your counsel alluded to this but I'll ask you since you're the witness. Have any complaints been submitted to any of the boards within the Department of Health alleging unprofessional conduct based on conversion therapy?

A Not to my knowledge.

Q. And let me ask, I'll split up my question. Are you aware of any such complaints regarding unprofessional conduct that involves conversion therapy prior to the effective date of SB 1028?

A I am not aware of any.

Q. And are you aware of any after the effective date?

A I am not aware of any.

Q. Is there any, do the -- let's start with one board. The Board of Professional Counselors and Therapists, does it provide statistics or summaries of the complaints it has received on any kind of regular basis either to the other boards or to someone within the Department of Health or even to the public?

A If a practitioner is officially sanctioned that would be public information.

Q. Is there any one place you could look to find out whether any of the boards had sanctioned a professional for unprofessional conduct based on conversion therapy or would you have to consult each board or each board's website, for example?

A As each board is independent I believe you would have to look at each board.

Q. Let's go back to Exhibit 8 which is the statute itself. Page 5 again and Section A2.

A Yes, sir.

Q. Back to the conversion therapy definition where it reads: "Conversion therapy means a practice or treatment by a mental health or child care practitioner that seeks to change an individual's sexual orientation and gender identity." I've read that correctly?

A You have.

Q. So a practice or treatment that seeks to change an individual's sexual orientation or gender identity, does that include a practice or treatment that is not initiated by the practitioner but is actually requested by the client and the practitioner merely agrees or facilitates what the client requests?

MS. ELLIS: Objection to form.

A As of, as with this morning I can only testify to what I see on the page. I think that's an interpretative question.

Q. Well, do you interpret it that way?

THE WITNESS: Legislative intent.

MS. ELLIS: Don't talk to me. Talk to him.

A It's legislative intent. I can only

testify to what I see on the page.

BY MR. GANNAM:

Q. Well, I think we've established you are the designee on the subject of interpretation so I'm asking you, is that how the statute is intended to be interpreted, that a treatment or a practice that seeks to change an individual's sexual orientation would include a practice or treatment initiated or requested by the client rather than something initiated by the practitioner?

A I can't render an opinion on that.

MS. ELLIS: And I object to the question as misstating the statute. I mean you're talking about practices by mental health practitioners, not by -- perhaps I'm misunderstanding your question but not by clients.

MR. GANNAM: Well, I --

MS. ELLIS: The record is what it is.

MR. GANNAM: But I believe I've read it correctly but since you made the objection I'll try it a different way.

BY MR. GANNAM:

Q. If a client presents to, a minor client presents to a practitioner and that minor indicates that the minor seeks to change his or her sexual orientation or gender identity and in response to that the practitioner does in fact assist the client in seeking to change sexual orientation or gender identity, is that a violation or is that conversion therapy as defined here in Senate Bill 1028?

MS. ELLIS: Objection.

A A minor cannot be the one to consent to therapy in the state of Maryland.

Q. My question isn't who consented as a legal matter. I'm saying if the minor requests it, requests help to change sexual orientation or gender identity and the practitioner responds by doing what the client asks, is that conversion therapy under is SB 1028?

MS. ELLIS: Objection.

A I believe that would be a matter for the board to consider if that's unprofessional conduct.

Q. So you're not able to tell me?

A I'm not.

Q. Just to keep the or make the record complete, underneath where it says, "Conversion therapy includes any effort to change the behavioral expression of an individual's sexual orientation, change gender expression, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender." Do you see that?

A I do.

Q. If a client or a minor client presents to a practitioner requesting help to eliminate or reduce same-sex attractions or romantic attractions towards individuals of the same gender and the practitioner responds by doing what the client requests, is that conversion therapy under SB 1028?

MS. ELLIS: Objection.

A Counsel, in an era whenever we're debating what the definition of "is" is in another case, saying any effort being able to interpret that here sitting across the table from you, I can only tell you what I see on the page.

Q. And I'm asking you based on what you see on the page, is that a correct interpretation of what's here, that when the minor requests assistance to change or reduce or eliminate same-sex attractions and a practitioner responds by doing what the client asks, is that conversion therapy?

MS. ELLIS: Objection.

A And my answer is going to continue to be the same, that is legislative intent, that is judicial review. I cannot render an opinion on that.

Q. And so again just for the sake of completeness, is your answer the same if I asked about a minor who presented to a practitioner requesting help to change gender expression and the practitioner responds by doing what the client asks, would that be conversion therapy under SB 1028?

MS. ELLIS: Objection.

A And my response would be the same.

Q. That you are unable to tell me?

A Correct.

(Plaintiff's Exhibit 17 was marked for

purposes of identification.)

Q. All right. I am marking a document as Exhibit 17. Because of its size I've only made one copy but I'll identify it for the record. It is Exhibit B to the complaint filed in this case, Document 1-2 on the docket. It is the report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Have you seen this document before, Dr. Lang?

A I have not.

Q. Have you heard of this document before?

A I have.

Q. What have you heard about it or do you know about it?

A I know that the document exist.

Q. Are you familiar with the American Psychological Association?

A By name.

Q. Do you agree that the APA is considered a credible or mainstream organization?

MS. ELLIS: Objection.

A I have no ability to decide that.

Q. Are you aware that this report is specifically cited in SB 1028?

A I am.

Q. Are you aware that this report is cited by many of the other reports or statements that are cited in SB 1028?

A I'm aware of that.

Q. Would it be fair to say based on that that the state relied on the conclusions and the information in this report in enacting SB 1028?

MS. ELLIS: Objection. Legislative privilege, instruction not to answer.

Q. Would it be fair to say that the legislature trusted the conclusions of the APA in enacting SB 1028?

MS. ELLIS: Same objection and instruction.

Q. Would it be fair to say that the state agrees with the APA's conclusions with respect to what's defined as conversion therapy in enacting SB 1028?

MS. ELLIS: Same objection and instruction.

Q. Are there any conclusions of the APA in this report that the state disagrees with regarding SOCE or conversion therapy?

MR. GANNAM: To the extent that -- could you clarify the time period that you are talking about? Are you talking about during up until the time SB 1028 was enacted? Are you talking about the executive branch of, or the identified defendants in their official capacities?

Q. So I will, I'll break it up. In connection with the enactment of SB 1028 are there any statements or any information in Exhibit 17 that the legislature disagreed with?

MS. ELLIS: Objection. Covered by legislative privilege. Instruction not to answer.

Q. And are there any statements in the APA report marked as Exhibit 17 that the governor of the state of Maryland disagrees with?

MS. ELLIS: Objection. If you're talking up through the enactment, legislative privilege and

instruct the witness not to answer. If you're talking about afterwards, I would say that it's, I would object that it's irrelevant.

Q. So I'm asking that as of March 28, 2019 are there any statements in the 2009 APA report marked as Exhibit 17 that the governor of the state of Maryland disagrees with?

MS. ELLIS: Objection. Irrelevant.

MR. GANNAM: You can answer.

A I would simply refer to the statement that is found in the bill that became law where they refer to the document.

BY MR. GANNAM:

Q. So do you know whether the governor has reached any conclusion about any statement or information in the exhibit marked as 17 since the enactment of SB 1028?

MS. ELLIS: Objection, irrelevant.

A I'm not aware.

Q. And same question for the attorney general of the state of Maryland?

A I'm not aware.

MS. ELLIS: And the same objection.

Q. All right. I want to ask you to look at -- well, first, do you agree that this report marked as Exhibit 17 was limited to sexual orientation change efforts and did not include gender identity change efforts?

A I'm not familiar enough with the report to render a decision on that.

Q. If the state had wanted to ban, for example, only coercive or involuntary SOCE as opposed to voluntary SOCE, does the state have the authority do that?

MS. ELLIS: Objection. What timeframe are you talking about? Who are you talking about?

Q. I'm talking about instead of enacting SB 1028 as it was enacted, could the state have enacted a counseling ban that only banned coercive or involuntary therapy as opposed to all therapy?

MS. ELLIS: Objection. You can go ahead and answer.

A I would assume as long as there's nothing unconstitutional that a legislature would be allowed to consider that.

Q. And are you familiar with the difference between aversive and non-aversive therapy?

A No.

Q. In the context of SOCE?

A No.

Q. I want to go back to the notice of taking deposition which is Exhibit 2 and just ask you to look at page 3. And item number 1 under matters for examination reads: "The state of Maryland's purported interest in banning SOCE counseling for minors including without limitation any complaint or other evidence of alleged harm in the legislative record of SB 1028." Did I read that correctly?

A Yes.

Q. And also I want to ask you about, to look at number 6. It reads: "The state of Maryland's efforts to narrowly tailor SB 1028 including without limitation any alternative to SB 1028 which defendant

considered prior to enactment of SB 1028 and all reasons for rejecting such alternative." Did I read that correctly?

A You did.

Q. And you are the designee for these topics today, correct?

A Yes.

MS. ELLIS: And I would reiterate my statement that I made at the beginning of this deposition that it's our position that the legislative record as has been defined, and we've extensively discussed, public legislative record, is the only thing, only topic on which this witness is available to testify, that to the extent any questions or information that you are seeking goes beyond that record it's covered by the legislative privilege and we're not responding to those.

MR. GANNAM: And I'll just respond for the record that no motion for protective order to enforce that asserted objection has been filed to this point.

MS. ELLIS: No, because you recommended in

our conversation that we do it on a question-by-question basis.

BY MR. GANNAM:

Q. I want to go back to Exhibit 8, the enacted version of Senate Bill 1028, and look at the first page.

A Yes, sir.

Q. The second whereas clause reads: "The American Psychological Association convened a task force on appropriate therapeutic responses to sexual orientation that conducted a systematic review of peer-reviewed journal literature on sexual orientation change efforts and concluded in its 2009 report that sexual orientation change efforts can pose critical health risks to lesbian, gay and bisexual people including" -- I'll stop right there. Have I read that correctly up to this point?

A You have.

Q. Then after "including" it reads: "confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidal

intentions, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame towards parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, the loss of faith and a sense of having wasted time and resources." Did I read all that correctly?

A You did.

Q. In connection with the enactment of SB 1028, did the legislature reach any conclusions as to the level of risk of -- let's just start with the first outcome here -- confusion resulting from conversion therapy as defined in the bill?

MS. ELLIS: Objection. The Exhibit 8 speaks for itself and the question you've asked calls for information covered by the legislative privilege and I instruct the witness not to answer.

Q. Does the public record reveal any

conclusion reached by the legislature regarding the level or percentage of increased risk caused by conversion therapy as defined in the statute for the outcome of confusion?

MS. ELLIS: Objection. Relevance.

A In the public record, no.

Q. Same question for the outcome of depression.

MS. ELLIS: Same objection.

A Same response. In the public record, no.

Q. What about guilt?

BY MS. ELLIS: Same objection.

A The public record, no.

Q. Would the answer be the same for all of the outcomes listed in the remainder of the paragraph?

A Correct.

Q. In connection with passing SB 1028 did the legislature undertake to determine what level of risk of these various bad outcomes is involved with counseling in general that does not involve conversion therapy as defined in the bill?

MS. ELLIS: Objection. It's covered by the legislative privilege and I instruct the witness not to answer.

Q. So does the public record, public legislative record of SB 1028 reflect any determination by the legislature of the level of risk of bad outcomes from counseling in general that does not involve conversion therapy as defined in the statute?

MS. ELLIS: Objection. Relevance.

A In the public testimony from what I listened to, no.

Q. And so isn't it also true then that the public record does not reflect any comparison of the relative risk of bad outcomes from what's defined as conversion therapy as compared to bad outcomes from therapy in general?

MS. ELLIS: Objection. Relevance.

A In comparison?

Q. Correct.

A You're looking for quantitative?

Q. That's correct.

A No.

Q. And so isn't it true that the state cannot determine the relative difference in risk for bad outcomes from what's defined as conversion therapy compared to therapy in general?

MS. ELLIS: Objection. Form and relevance.

A That's speculation. I couldn't answer that.

MR. GANNAM: All right. We've been going about an hour so let's take a break.

(There was a break in the proceedings from 2:21 p.m. to 2:35 p.m.)

BY MR. GANNAM:

Q. Going back to Exhibit 17, the APA report, I'm going to read a couple of statements out of it and just ask questions about the public legislative record in relation to those statements. So let me go to, let's look at page 12 and the footnote's number 5, the lower left. The print is a little small. I apologize. Do you see the footnote there?

A I do.

Q. It reads: "In this report we use the term sexual orientation change efforts, SOCE, to describe methods that aim to change a same-sex sexual orientation, e.g. behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches 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." Did I read that correctly?

A You did.

Q. Does the legislative record for SB 1028 indicate any discussion or attempt to differentiate SOCE performed by licensed professionals from SOCE performed by non-licensed persons with respect to any of the conclusions that are reached in the APA report?

MS. ELLIS: Objection.

A The bill itself which has become law applies only to professionals.

Q. So my question is, within the legislative record, the public legislative record, is there any

indication of a discussion or consideration by the legislature that differentiated between conclusions in this APA report based on SOCE performed by licensed professionals and SOCE performed by non-licensed professionals?

MS. ELLIS: Objection.

A I believe during the floor hearing there was a discussion.

Q. Of the difference between licensed and non-licensed professionals -- or not -- licensed professionals and non-licensed persons?

A Concerning to whom the bill, become law would apply to.

Q. And apart from, and that would have been one of the audio or video?

A I believe so.

Q. Apart from that that you recall, is there anything else in the public legislative record that you know of?

A Not of which I'm aware.

Q. I next want to draw your attention to page

9. And in the left column, the end of the second full paragraph, there's a sentence that begins "Due to our." Do you see that?

A I do.

Q. It reads: "Due to our charge, we limited our review to sexual orientation and did not address gender identity because the final report of another APA task force, the Task Force on Gender Identity and Gender Variance was forthcoming." Did I read that correctly?

A Correct.

Q. Now, is there anything in the public legislative record indicating that the legislature considered the fact that this 2009 APA report did not address gender identity but only addressed sexual orientation?

MS. ELLIS: Objection.

A I don't believe so.

Q. Is there any reference in the public legislative record to consideration by the legislature of this other document that's identified, the, what's

called the forthcoming Task Force on Gender Identity and Gender Variance?

A I'm not aware of that, no.

Q. Now will you flip to page 42 of the report. On page 42 on the left column under the heading recent studies, do you see that?

A I do.

Q. I'm going to read the first sentence and just so you know I'm going to skip over the citations as I read it and just read the text. It reads: "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 just as other recent studies document that there are people who perceive that they have benefitted from it." Excluding these citations did I read that correctly?

A Yes, sir.

Q. And going back to the first part of the statement, where it says "The recent studies do not provide valid causal evidence of the efficacy of SOCE

or of its harm," just focusing on that statement, is there any reference in the public legislative record of SB 1028 to a discussion by the legislature where it disagreed with that statement that the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm?

MS. ELLIS: Objection.

A I believe during floor debate there was consideration given but specifically to this, no.

Q. And then looking over in the second column, or the right-hand column under the heading summary, do you see that?

A I do.

Q. The first sentence reads: "We conclude that there is a dearth of scientifically sound research on the safety of SOCE." Did I read that correctly?

A Yes, sir.

Q. And are you aware of any statement in the legislative record, the public legislative record of SB 1028 that discusses or finds disagreement with that statement?

MS. ELLIS: Objection.

A I'm not aware of any.

Q. And then moving down to about halfway down that same passage, there's a sentence that begins with the word "Thus". Do you see that?

A I do.

Q. It reads: "Thus we cannot conclude how likely it is that harm will occur from SOCE." Did I read that correctly?

A You did.

Q. Are you aware of any reference in the public legislative record of SB 1028 that refers to or disagrees with that statement?

MS. ELLIS: Objection.

A Again, I believe during floor debate there was discussion about the issue but referring to this line specifically, no.

Q. And do you recall what was, what were the contents of that discussion that you recall about the issue?

A If I remember the context, counselor, I

believe it was a discussion to clarify if this would only apply to professionals.

Q. As opposed to unlicensed persons?

A Correct.

Q. So you don't recall any discussion about the inability to conclude how likely it is that harm will occur from SOCE?

A I don't.

Q. And isn't it also true that the state of Maryland cannot conclude how likely it is that harm will occur from SOCE or conversion therapy?

MS. ELLIS: Objection.

A I can't render an opinion on that.

Q. Just to clarify for the record then, are you saying that you don't know if the state of Maryland can conclude how likely it is that harm will occur from SOCE?

MS. ELLIS: Objection. Asked and answered.

A Correct.

MR. GANNAM: We have no further questions.

MS. ELLIS: I have to go get one document

and then I have a few questions for the witness.

(There was a break in the proceedings from 2:44 p.m. to 2:48 p.m.)

EXAMINATION BY MS. ELLIS:

Q. Right after the first break we took this morning Mr. Gannam was asking you a series of questions about the process for getting testimony to the committee offices. And I think it was unclear. You said that the administrative assistant in the committee offices received the testimony, correct, the written testimony?

A Oh, the legislature, yes.

Q. Okay.

A That there was someone in that capacity.

Q. Right. And how does the testimony get to the committee offices?

A In my experience physically someone walks it over.

Q. And the person preparing the testimony or offering the testimony provides it to the committee office?

A Typically, yes.

Q. The administrative assistant or comparable person doesn't go around and collect it?

A Not in my experience, no.

Q. Okay. It wasn't quite clear. Then you also right after that made a reference to testimony available on the Internet. Was that the oral testimony in front of the committee that you were referring to?

A That's correct.

Q. Are you aware whether the written testimony or the contents of the bill files are on the Internet?

A I believe that's how it would be requested, yes.

Q. So you think the bill files themselves are on the, available on the Internet?

A I believe so. I don't know.

Q. Showing you what we marked as Exhibit 10 or Mr. Gannam marked as Exhibits 10 and 11. And he asked you whether this, these two exhibits showed all of the oral and written testimony that was presented to the various committees. Is it, with respect to written

testimony, could there be written testimony in the bill files that did not appear on these lists?

A I think it's possible.

Q. If you could pull up Exhibit 12. Exhibit 12 is -- you don't have it? Thank you. And the Exhibit 12 is a series of documents that were identified in one of the defendants' answers to interrogatories. If you could look at the next to last paragraph on the first page of this exhibit and look at it and read it to yourself.

A Okay.

Q. Does that paragraph suggest that the, or state that the writer of this testimony has concerns about the effects on minors of conversion therapy?

MR. GANNAM: Objection. Leading.

THE WITNESS: Am I allowed to answer?

MS. ELLIS: Go ahead and answer.

A Yes.

BY MS. ELLIS:

Q. And why do you say that?

A It would be the, appears to be the final

sentence. "We need this bill and we need it now because as we have seen from testimony today our kids are still being subjected to this conversion therapy and we need a law to stop it."

Q. If you could look at MD 0063, which is The Trevor Project lawyer.

A Yes.

Q. Could you read the first sentence of the third paragraph?

A "I am a survivor of the dangerous and discredited idea that a therapist could change my sexual orientation or gender identity."

Q. Thank you. And in the last paragraph on the page it identifies and you were asked questions about the sentence that states that there were more than 1200 youth that called The Trevor Project's hotline. If you could read the sentence beginning with "not all" I would appreciate it.

A "Not all of these youth are victims of conversion therapy but all have been wounded by a culture that allows the idea of the choice of one's

sexual orientation to permit violence, bullying and family rejection."

Q. Thank you. And does this letter, what if anything does this letter say about Mr. Brinton's connection if any to Maryland?

A It appears his future spouse works in Maryland.

Q. And then if you could look at the last, well, the last two pages. And on the last page of Ms. MacShane's memo, could you read the first sentence, please?

A Starting with "I support"?

Q. Uh-huh.

A "I support the Youth Mental Health Protection Act because every day in my practice I see first hand the grievous emotional harm that can be done to LGBTQ young people who are forbidden, discouraged or otherwise made afraid to be themselves by adults in positions of authority."

Q. And does the, does this, do these two pages indicate where Ms. MacShane practices?

A Maryland.

Q. Thank you. And I'm sure you recall the many questions you got asked about interpretation of Senate Bill 1028. What if any understanding do you have of what entity is responsible for interpreting -- strike that. Let me start here. What understanding if any do you have of what entity is responsible for determining whether a particular set of facts violates the practice act of a particular board?

A The boards themselves.

Q. And what do they base that decision on?

A On the information that is presented either in the complaint that begins the process or in the investigation if it goes to that stage.

Q. So in that sense what is your understanding if any of who is responsibile for interpreting a statute that defines a particular treatment as a violation of the practice act?

A The boards themselves.

Q. And how do the boards accomplish that interpretation?

A We're speaking of five boards specifically. In general it would be either through their committees or through consultation among the board, the wider board.

Q. And do they generally do that, is that decision-making generally on a case-by-case basis?

A It is.

Q. And if you look at Exhibit 17, what page was that footnote on that you were asked questions about?

A It was footnote 15, if I remember.

MS. ELLIS: What page?

MR. GANNAM: Twelve. And I think it's footnote 5. Well, that's -- yeah.

MS. ELLIS: Yeah. Okay. That's right.

BY MS. ELLIS:

Q. And you were asked questions about whether there was anything in the legislative record about laypersons or non-professionals. Do you recall that?

A Yes.

MS. ELLIS: Can you mark this as

Defendants' Exhibit 1?

(Defendants' Exhibit 1 was marked for purposes of identification.)

BY MS. ELLIS:

Q. I'm showing you, Dr. Lang, what's been marked as Defendants' Exhibit 1, which is MD 0004 through 5. Take a minute and look at that, and when you're ready for me to ask questions.

A I have seen this and I do remember.

Q. Does this refresh your recollection that there was information in the legislative record that the bill would not apply to religious counseling?

A I do remember. And if I can clarify my earlier statement, I thought the question was does it specifically say so in the bill. I understand now more about it.

MS. ELLIS: Okay. That's it. Thank you.

RE-EXAMINATION BY MR. GANNAM:

Q. To follow up, while you have Defendants' Exhibit 1 in front of you from the Office of the Attorney General to the Honorable Bonnie Cullison --

did I state that recipient correctly?

A Yes, sir.

Q. Who is Bonnie Cullison?

A She's a delegate.

Q. And does the attorney general provide legal interpretations or opinions to, for example, the Board of Professional Counselors and Therapists that they requested?

A The boards each have counsel and in the discussion we had earlier like some executive directors or some investigators, counsel is sometimes shared among different boards and these folks come through the AG's office.

Q. So are these various counsel employed by the AG's office and made available to the boards?

MS. ELLIS: I suspect she doesn't know the structure. We are all employees of the, technically employees of the attorney general although we are paid by our clients. So it's a dual relationship.

BY MR. GANNAM:

Q. And I won't ask you questions on the record

as to the -- do you know the structure other than what your counsel has just said?

A The thumbnail sketch she explained that, yes, their funding, if you will, comes from the boards.

Q. We talked about earlier how SB -- or actually, strike that. Before we go there. Right before I asked you that last question you had just answered a series of questions from your counsel following the end of my questioning, is that correct?

A Yes.

Q. And prior to your answering that series of questions from your counsel, did you discuss with your counsel today any of those questions and their answers?

A No.

Q. We looked at SB 1028 and the fact that it specifies that conversion therapy is to be considered an instance of unprofessional conduct by the five boards that are covered by that statute, correct?

A I'm sorry?

Q. Let me just, I'll just read it. Looking at Exhibit 8 on page 6, and Exhibit 8 is the final version

of SB 1028. And actually I'm looking at the bottom of page 5, subsection C. It reads: "A mental health or child care practitioner who engaged in conversion therapy with an individual who is a minor shall be considered to have engaged in unprofessional conduct and shall be subject to discipline by the mental health or child care practitioner's licensing or certifying board." Did I say that correctly?

A Yes, sir.

Q. So here we have SB 1028 is identifying a specific instance of something it deems to be unprofessional conduct, is that correct?

A Yes.

Q. And that would apply to the five practitioners boards or occupational boards that are covered by this statute, correct?

A It would.

Q. Are there any other statutes in the state of Maryland that specify what is unprofessional conduct for those five boards?

A I believe we'll go back to the Health

"occs," to the Health "occs" articles.

MR. GANNAM: Okay.

MS. ELLIS: Do you know whether there are?

THE WITNESS: I don't know. I would assume they're there.

BY MR. GANNAM:

Q. And just so I'm clear, apart from a statute saying you may be disciplined for unprofessional conduct, are there any other statutes that apply to these five boards that specify what constitutes unprofessional conduct like SB 1028 specifies that conversion therapy is unprofessional conduct?

A No.

MR. GANNAM: That's all I have.

MR. MIHET: Just for the record, we are not concluding the deposition but adjourning it for the purpose of seeking an order from the court with respect to the privilege objections that were made that we believe are improper and also with respect to what we believe has been an unprepared witness on several topics, the most concerning of which is the state's

enforcement, application and interpretation of the challenged statute.

It is our belief particularly in a case such as this one where the plaintiff is bringing a pre-enforcement as applied challenge, that the plaintiff is entitled to know how the state would enforce and apply the challenged statute in a particular situation under a particular set of facts. We have litigated this issue, this exact issue in other contexts and have prevailed. We have authority that we intend to bring to the court on that. And so just, you know, for the record, we're not concluding the deposition but merely adjourning it for the purpose of seeking relief from the court.

MS. ELLIS: And I am sure you're not surprised to hear that we will vigorously contest your right to continue the deposition because of an unprepared witness. Regardless of what other courts may have found, in Maryland administrative bodies adjudicate on a case-by-case basis and can't say in advance what will or will not constitute a particular

violation of the practice act.

MR. MIHET: Okay.

THE WITNESS: May we hold up for a second? I want to ask counsel a question.

MS. ELLIS: I mean, is it something related to the deposition?

THE WITNESS: Yes.

MS. ELLIS: Okay.

THE WITNESS: Can I do that in private?

(The witness and Ms. Ellis left the deposition room and returned.)

MS. ELLIS: Okay. So we're done.

MR. GANNAM: We're done. Good.

(Signature reserved.)

(Deposition adjourned at 3:08 p.m.)

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary will be made on the Errata Sheet.

_____

Kimberly Christine Lang

_____

Date

(If needed, make additional copies of the Errata Sheet on the next page or use a blank piece of paper.)

Job #3277170

ERRATA SHEET

Case: Doyle v. Hogan, et al.

Witness: Kimberly Christine Lang, Ph.D.

Date: 3-28-19

PAGE/LINE	SHOULD READ	REASON FOR CHANGE

Job #3277170

State of Maryland

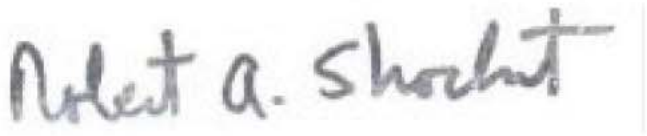
Baltimore County, to wit:

I, ROBERT A. SHOCKET, a Notary Public of the State of Maryland, County of Baltimore, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and after having been duly sworn by me, according to law, was examined by counsel.

I further certify that the examination was recorded stenographically by me and this transcript is a true record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand this 2nd day of April, 2019.



Robert A. Shocket, Notary Public

My Commission Expires:

November 23, 2022

UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC, individually and on behalf of his clients,	)	
Plaintiff,	)	Civil Action No. 1:19-cv-00190-DKC
v.	)	**INJUNCTIVE RELIEF SOUGHT**
LAWRENCE J. HOGAN, JR., Governor of the State of Maryland, in his official capacity, and BRIAN E. FROSH, Attorney General of the State of Maryland, in his official capacity,	)	
Defendants.	)	

PLAINTIFF'S ANSWERS AND OBJECTIONS
TO FIRST SET OF INTERROGATORIES

Plaintiff CHRISTOPHER DOYLE, LPC, LCPC ("Doyle"), pursuant to Fed. R. Civ. P. 26 and 33, and L.R. 104, provides the following answers and objections to Defendant Brian E. Frosh's First Set of Interrogatories. Doyle hereby reserves all objections to the relevance, use, or admissibility of any of these interrogatories and responses. Subject to the foregoing, Doyle objects and otherwise responds as follows:

INTERROGATORY NO. 1: Identify all persons who are likely to have personal knowledge of any fact alleged in the pleadings, and state the subject matter of the personal knowledge possessed by each such person. (Standard Interrogatory No. 1)

Objection: Doyle objects to this interrogatory to the extent it seeks patient-identifying information subject to the psychotherapist–patient privilege or which is otherwise confidential. Doyle's investigation and discovery continue, and Doyle reserves the right to supplement this response as permitted by applicable rules. Subject to and without waiver of this objection, Doyle answers as follows:

Answer: At this time, Doyle is aware of the following persons who may have personal knowledge of facts alleged in the pleadings:

Plaintiff, **Christopher Doyle**, LPC, LCPC. May be reached through counsel.
Subject matter: All matters alleged in the Complaint (Doc. 1).

Defendant **Lawrence J. Hogan, Jr.**, Governor of the State of Maryland.
Subject matter: Drafting, sponsoring, consideration, debate, passage, interpretation, application, and enforcement of SB 1028.

Defendant, **Brian E. Frosh**, Attorney General of the State of Maryland.
Subject matter: Drafting, sponsoring, consideration, debate, passage, interpretation, application, and enforcement of SB 1028.

Peter Sprigg, Senior Policy Analyst, Family Research Council, 801 G Street NW, Washington, D.C. 20001, 1-800-225-4008.
Subject matter: May 14, 2018 conference call involving Peter Sprigg, Doyle, and Christopher Shank (see below), on which call Doyle shared his perspective on and opposition to SB 1028.

Christopher B. Shank, Chief Legislative Officer for Governor Hogan.
Subject matter: Drafting, sponsoring, consideration, debate, and passage of SB 1028; May 14, 2018 conference call with Doyle and Peter Sprigg (see above).

INTERROGATORY NO. 2: For each witness that you may use at trial to present evidence under Federal Rule of Evidence 702, 703, or 705, provide a complete statement of the opinions to be expressed and the basis and reasons for those opinions. (Standard Interrogatory Nos. 8 & 9)

Answer: Doyle objects to this interrogatory as premature. Doyle's discovery and investigation continue. Doyle will provide his expert disclosures as and when required by the applicable rules and the scheduling orders of the Court.

INTERROGATORY NO. 3: Identify all locations in the State of Maryland at which you provide or have provided counseling as a licensed clinical professional counselor; the dates on which you provided such counseling from January 1, 2017 to the present, the number of individuals to whom you provided such counseling in the State of Maryland from January 1, 2017 to the present who were (1) under 16 years of age at the time of the counseling and (2) 16 or 17 years of age, and state whether the counseling was performed in a group or individually, whether

you were physically present in the State when providing such counseling, and whether the counseling was provided in person, via audio, or via audio and visual means.

Objection: Doyle objects to this interrogatory as vague, ambiguous, and overly broad, and on the grounds that it seeks information which is neither relevant nor proportionate to the needs of the case, to the extent it seeks information regarding Doyle's counseling in Maryland which is not subject to the restrictions of SB 1028. Doyle further objects to this interrogatory to the extent it seeks patient-identifying information subject to the psychotherapist–patient privilege or which is otherwise confidential. Subject to and without waiver of any objection, Doyle answers as follows:

Answer:

Client 1: 17-year-old male, St. Mary's County, MD

- Audio/visual counseling beginning July 10, 2017. Engaging in weekly individual and family counseling for approximately 1.5 years in St. Mary's County, MD.
- In-person group therapy for parents in Washington County, MD September 15–17, 2017 (physically present).
- In-home family therapy in St. Mary's County, MD December 9–10, 2017 (physically present).
- In-person group therapy for parents in Washington County, MD on November 3–5, 2017 (physically present).

Client 2: 15-year-old male, Montgomery County, MD

- Audio/visual counseling beginning September 9, 2018. Engaging in bi-weekly individual and family counseling for approximately six months in Montgomery County, MD.
- In-person group therapy for parents in Washington County, MD September 28–30, 2018 (physically present).
- In-home family therapy in Montgomery County, MD December 1–2, 2018 (physically present).
- In-person group therapy for parents in Washington County, MD November 16–18, 2018 (physically present).

Client 3: 17-year-old male, Carroll County, MD

- Audio/visual counseling beginning August 8, 2016. Engaged in individual and family counseling for approximately 1.5 years.
- In-person group therapy for parents in Washington County, MD September 17–19, 2016 (physically present).
- In-home family therapy in Carroll County, MD October 22–23, 2016 (physically present).
- In-person group therapy for parents in Washington County, MD November 4–6, 2016 (physically present).

Client 4: 16-year-old male, Prince George's County, MD.

- Audio/visual counseling beginning November 5, 2016. Engaged in individual and family counseling for approximately ten months.

Client 5: 16-year-old male, Montgomery County, MD.

- Audio/visual counseling beginning May 3, 2016. Engaged in individual and family counseling for approximately 1.5 years.

INTERROGATORY NO. 4: For the individuals between 16 and 18 years of age to whom you provided counseling in the State of Maryland during the period January 1, 2017 to the present, state how many initiated counseling on their own and how many participated in counseling at their parents' direction.

Objection: Doyle objects to this interrogatory as vague, ambiguous, and overly broad, and on the grounds that it seeks information which is neither relevant nor proportionate to the needs of the case, to the extent it seeks regarding Doyle's counseling in Maryland which is not subject to the restrictions of SB 1028. Doyle further objects to this interrogatory to the extent it seeks patient-identifying information subject to the psychotherapist–patient privilege or which is otherwise confidential. Subject to and without waiver of any objection, Doyle answers as follows:

Answer: This interrogatory is premised on a false dichotomy, for it excludes the most common situations where minors voluntarily present for counseling with their parents' input, cooperation, or guidance, in which cases the concepts of who "initiated" or "directed" counseling are inadequate to describe the realities of therapy. In my therapeutic work at the Institute for Healthy Families, counseling around sexual and gender identity conflicts for minors and/or dependents always includes a family therapeutic approach. I will not work with minors and/or dependents in individual therapy if parents are not willing to participate in family therapy (this also includes individual and group therapy components for parents in therapy). Additionally, I never work with a minor or dependent simply at a parent's direction. Therapy is always client-centered and revolves around the client's goals, including the minor, parents, and/or family. If the minor or dependent does not wish to receive counseling, I work with the parents alone. If the parents are unwilling to engage in family counseling that includes themselves, I will not work with their minor child. I never tolerate any coercion or manipulation of a minor in the therapeutic process.

INTERROGATORY NO. 5: State the facts on which you base your request for relief against the governor of Maryland.

Objection: Doyle objects to this interrogatory on the grounds that it is overly broad, unduly burdensome, impracticable, and disproportionate to the needs of the case, as it improperly seeks Doyle's statement of his entire case rather than disclosure of facts supporting particular allegations. Some facts upon which Doyle bases his request for relief are stated in the Verified Complaint (Doc. 1). Doyle's investigation and discovery continue.

INTERROGATORY NO. 6: State the facts on which you base your request for relief against the Attorney General of Maryland.

Objection: Doyle objects to this interrogatory on the grounds that it is overly broad, unduly burdensome, impracticable, and disproportionate to the needs of the case, as it improperly seeks Doyle's statement of his entire case rather than disclosure of facts supporting particular allegations. Some facts upon which Doyle bases his request for relief are stated in the Verified Complaint (Doc. 1). Doyle's investigation and discovery continue.

INTERROGATORY NO. 7: Identify all documents that support your answers to interrogatory nos. 1 through 6.

Objection: Doyle objects to this interrogatory on the grounds that it is vague, overly broad, unduly burdensome, impracticable, and disproportionate to the needs of the case. Doyle further objects to the interrogatory because it seeks information subject to the psychotherapist–patient privilege or which is otherwise confidential. The interrogatory places no limitation on how a document may "support" an interrogatory answer, seeks a virtually endless identification of every possible article, research paper, report, etc. that may "support," for example, Doyle's approach to therapy for minors described in his answers to interrogatories 3 and 4, and would require identification of confidential client treatment records that may "support" the times and locations of Doyle's treatment of clients identified in his answers to interrogatories 3 and 4. Construing this interrogatory as limited to seeking identification of non-privileged documents that directly evidence Doyle's answers to the above interrogatories, and subject to and without waiver of the foregoing objections, Doyle answers as follows:

Answer: Pursuant to Fed. R. Civ. P. 33(d), the answer to this interrogatory may be determined by examining my business records produced contemporaneously herewith, in response to Defendant Frosh's First Set of Requests for Production of Documents and identified therein, as follows.

- Interrogatory no. 1 – e-mail correspondence between Peter Sprigg and me, Bates nos. PL000001–PL0000004; and
- Interrogatory nos. 3 and 4 – informed consent forms for Clients 1 through 5, Bates nos. PL000016–PL0000051.

As to answers:

I, Christopher Doyle, verify under penalty of perjury that the foregoing interrogatory answers are true and correct.

/s/ Christopher Doyle
Christopher Doyle

As to objections:

/s/ John R. Garza
(signed by Roger K. Gannam
with permission of John R. Garza)
John R. Garza (D. Md. 01921)
GARZA LAW FIRM, P.A.
Garza Building
17 W. Jefferson Street, Suite 100
Rockville, Maryland 20850
301-340-8200 ext. 100
301-761-4309 FAX
jgarza@garzanet.com

/s/ Roger K. Gannam
Mathew D. Staver (Fla. 701092)†
Horatio G. Mihet (Fla. 26581)†
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407-875-0770 FAX
court@LC.org
hmihet@LC.org
rgannam@LC.org

Attorneys for Plaintiff
† Admitted to appear *pro hac vice*

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this March 22, 2019, I caused a true and correct copy of the foregoing to be served by e-mail on the following counsel of record:

Kathleen A. Ellis
Assistant Attorney General
Maryland Department of Health
Suite 302, 300 West Preston Street
Baltimore, Maryland 21201
kathleen.ellis@maryland.gov
Attorney for Defendants

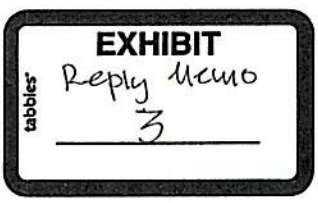
/s/ Roger K. Gannam
Attorney for Plaintiff

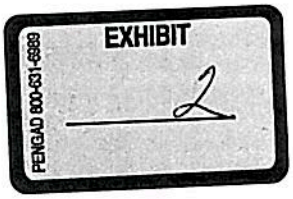
Institute for HEALTHY Families
Restoring Hope in the Hurting Home

PSYCHOTHERAPY AND COACHING SESSIONS INFORMED CONSENT AND LIABILITY WAIVER AND RELEASE FORM

To participate in psychotherapy and/or coaching sessions with Christopher Doyle, LCPC, LPC please read and sign this Informed Consent. Your signature constitutes an understanding and acceptance of all terms mentioned.

1. If this therapy or coaching session is being held outside of the state of Maryland or Virginia, Christopher Doyle, M.A. will facilitate as a coach, not a licensed counselor. All coaching will be provided as part of the therapeutic work of the Institute for Healthy Families, a 501(c)(3) non-profit organization.
2. By signing this Informed Consent, I hereby release, acquit, discharge, and indemnify, and hold harmless the Institute for Healthy Families, its officers, board members, employees, agents, representatives, and/or volunteers from any and all actions, claims, demands, damages, and expenses, including attorney's fees or other legal expenses, arising from and/or in connection with the therapeutic services provided by the Institute for Healthy Families.
3. I understand that if I choose to cancel or change my scheduled session, I will provide 72 hours notice by e-mail or phone call to Christopher Doyle. I also understand that if I do not provide 72 hours notice for this change or cancellation, I will be charged the full session fee, unless this change or cancellation is due to sickness or medical emergency.
4. I understand that Institute for Healthy Families will make every reasonable effort to safeguard my communications with Mr. Doyle and treat them as confidential and privileged information. I further understand that the Institute for Healthy Families will comply with any applicable federal or state laws regarding maintenance and safekeeping of its records pertaining to my therapy sessions and my right to inspect and copy them. Notwithstanding the foregoing, I understand that Mr. Doyle may need to share my confidential information with the appropriate authorities if:
    - 4.1. He suspects that a child, or other person, has been physically abused, neglected, and/or sexually abused;
    - 4.2. He suspects that I have a condition or am engaging in behavior that may require restraint and/or hospitalization to protect me and/or others;
    - 4.3. I have committed or am about to commit a crime or other violation of the law and he or the Institute for Healthy Families is required or permitted to report it;





4.4. A court of law issues a legitimate subpoena for your records; and/or if I provide written consent to release information about me and/or my family members.

If the circumstances described above arise, I will not require the Institute for Healthy Families and Mr. Doyle to obtain a release-of-information form from me designating each person to whom they will be communicating.

5. I understand that all clients experience healing in different ways and may have varying degrees of success, and that healing and/or success is determined by each individual client. I also understand that reaching my goals for coaching or therapy is not guaranteed by Institute for Healthy Families, and that my success depends on many factors, including my own efforts, keeping my scheduled appointments, my response to the therapy or coaching, and my own desire and/or efforts to heal and grow.
6. I understand that Christopher Doyle and the Institute for Healthy Families does not practice reparative therapy, reorientation therapy, conversion therapy, or any type of sexual orientation change effort (SOCE) therapy. I understand that should I pursue therapy or coaching for sexual or gender identity conflicts, that I will be receiving sexual identity affirming therapy and that Institute for Healthy Families will work to help me resolve internal and external issues that are getting in the way of living out my self-described sexual identity in the way of my choosing. I also understand that I have the right of self-determination – that is, it is my obligation to determine how much therapy or coaching I would like to receive, and that the Institute for Healthy Families does not and will not tell me how long or how much therapy or coaching I should undergo to reach my goals.
7. I understand that all psychotherapy, including sexual identity affirming therapy, has potential risks, including the possibility that I will not meet my goals, or that I might even feel worse or harmed, after I conclude psychotherapy. I consent to these risks under my own volition. I also agree that I am undergoing this therapy or coaching under my own free will, and that I am not being coerced by parents, family, friends, or society to pursue therapy or coaching, and that I voluntarily choose to receive this therapy or coaching.
8. I understand that the American Psychological Association (APA) conducted a Task Force in 2009 and concluded the following (for more information, see pages 1-7 at: http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf):
    8.1. The APA Task Force concluded: "None of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety of non gay-affirming therapy. Given the limited amount of methodologically sound research, claims that recent SOCE is effective are not supported."
    8.2. The APA Task Force concluded: "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 all sexual stimuli."

8.3. The APA Task Force concluded: "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."

8.4. The APA Task Force concluded: "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."

8.5. The APA Task Force concluded: "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). 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 report 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."

8.6. Regarding the treatment of children and adolescents, the APA Task Force concluded that: "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."

9. I also understand that in 2009, the National Association for Research and Therapy of Homosexuality (NARTH) conducted a systemic review of the scientific literature called "What Research Shows" and found that:

9.1. "There is no universal definition of *sexual orientation;* some see it as fixed, while others see it as fluid. According to Schneider, Brown, and Glassgold (2002), sexual orientation is defined in terms of the gender (or genders) of the people to whom individuals are sexually and affectionately attracted and toward whom they experience feelings of love and/or sexual arousal. It is defined as a continuous rather than a dichotomous variable. Most people are primarily oriented toward one gender (their own or the opposite), but some people have some degree of attraction to or history of sexually gratifying behavior with persons of the other gender as well. Other individuals

experience more or less balanced attractions to both women and men (p. 11)."

9.2. "A review of the literature by Whitehead and Whitehead (2007) shows that homosexuals—and, to a much lesser extent, heterosexuals—demonstrate evidence of sexual fluidity, including "spontaneous" as well as "assisted" reorientation. "A summary of these studies . . . is that about half of those with exclusive SSA [same-sex attraction] were once bisexual or even heterosexual. And about the same number changed from being exclusively SSA to bisexual or even heterosexual" (Whitehead & Whitehead, 2007, Chapter 12, p. 3). (p. 11)."

9.3. "In the clinical and scholarly literature over the past 125 years, mental health professionals and researchers document many different ways to assist men and women to successfully change from a homosexual to a heterosexual orientation. Reorientation assistance includes a variety of approaches, such as psychoanalysis, behavior and cognitive therapies, group therapies, sex therapies, hypnosis, pharmacological treatment, and religiously mediated activities. Other incidents of reorientation are attributed to spontaneous change, unknown methods, a combination of therapies, and other factors. There are also anecdotal accounts of change that have not been clinically or scientifically validated (p. 19)."

10. I agree to pay the Institute for Healthy Families a fee of $150 per 50-minute session. I understand that sessions lasting longer than 50 minutes will be pro-rated based on the 50-minute fee of $150 (e.g., 75 minute sessions are $225). I also understand that payment is due at the time of service for all therapy and/or coaching sessions.
11. I understand that I may be required, as a part of my therapy or coaching, to attend at least one group therapy session per month for a fee of $25 per 90 minute group session, and that I will be charged for this session unless I cannot attend due to sickness or medical emergency.
12. This Informed Consent represents the entire agreement between us regarding the therapeutic sessions I will be receiving from the Institute for Healthy Families and shall not be modified unless done so in writing signed by both the Institute for Healthy Families and me for the duration of the services it provides me. There are no other promises, representations, or warranties of any kind not included in this Informed Consent. If any provision is declared void or unenforceable, it shall not affect the validity or enforceability of any other provisions.

My signature demonstrates my understanding of the foregoing points. By signing below, I accept the terms of this agreement.

_____ _____

Name Date

Institute for Healthy Families Updated: January 1, 2016
Tel: 703-367-0894 10620 Crestwood Drive, Suite C Manassas, VA 20109
E-mail: IHFinfo@InstituteforHealthyFamilies.org / Internet:
www.InstituteforHealthyFamilies.org

Institute for HEALTHY Families
Restoring Hope in the Hurting Home

PSYCHOTHERAPY AND COACHING SESSIONS INFORMED CONSENT AND LIABILITY WAIVER AND RELEASE FORM

To participate in psychotherapy and/or coaching sessions with Christopher Doyle, LCPC, LPC please read and sign this Informed Consent. Your signature constitutes an understanding and acceptance of all terms mentioned.

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2. By signing this Informed Consent, I hereby release, acquit, discharge, and indemnify, and hold harmless the Institute for Healthy Families, its officers, board members, employees, agents, representatives, and/or volunteers from any and all actions, claims, demands, damages, and expenses, including attorney's fees or other legal expenses, arising from and/or in connection with the therapeutic services provided by the Institute for Healthy Families.
3. I understand that if I choose to cancel or change my scheduled session, I will provide 72 hours notice by e-mail or phone call to Christopher Doyle. I also understand that if I do not provide 72 hours notice for this change or cancellation, I will be charged the full session fee, unless this change or cancellation is due to sickness or medical emergency.
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    - 4.1. He suspects that a child, or other person, has been physically abused, neglected, and/or sexually abused;
    - 4.2. He suspects that I have a condition or am engaging in behavior that may require restraint and/or hospitalization to protect me and/or others;
    - 4.3. I have committed or am about to commit a crime or other violation of the law and he or the Institute for Healthy Families is required or permitted to report it;
    - 4.4. A court of law issues a legitimate subpoena for your records; and/or if I provide written consent to release information about me and/or my family members.

    If the circumstances described above arise, I will not require the Institute for Healthy Families and Mr. Doyle to obtain a release-of-information form from me designating each person to whom they will be communicating.

EXHIBIT 4

5. I understand that all clients experience healing in different ways and may have varying degrees of success, and that healing and/or success is determined by each individual client. I also understand that reaching my goals for coaching or therapy is not guaranteed by Institute for Healthy Families, and that my success depends on many factors, including my own efforts, keeping my scheduled appointments, my response to the therapy or coaching, and my own desire and/or efforts to heal and grow.
6. I understand that Christopher Doyle and the Institute for Healthy Families does not practice reparative therapy, reorientation therapy, conversion therapy, or any type of sexual orientation change effort (SOCE) therapy. I understand that should I pursue therapy or coaching for sexual or gender identity conflicts, that I will be receiving sexual identity affirming therapy and that Institute for Healthy Families will work to help me resolve internal and external issues that are getting in the way of living out my self-described sexual identity in the way of my choosing. I also understand that I have the right of self-determination – that is, it is my obligation to determine how much therapy or coaching I would like to receive, and that the Institute for Healthy Families does not and will not tell me how long or how much therapy or coaching I should undergo to reach my goals.
7. I understand that all psychotherapy, including sexual identity affirming therapy, has potential risks, including the possibility that I will not meet my goals, or that I might even feel worse or harmed, after I conclude psychotherapy. I consent to these risks under my own volition. I also agree that I am undergoing this therapy or coaching under my own free will, and that I am not being coerced by parents, family, friends, or society to pursue therapy or coaching, and that I voluntarily choose to receive this therapy or coaching.
8. I understand that the American Psychological Association (APA) conducted a Task Force in 2009 and concluded the following (for more information, see pages 1-7 at: http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf):
    - 8.1. The APA Task Force concluded: "None of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety of non gay-affirming therapy. Given the limited amount of methodologically sound research, claims that recent SOCE is effective are not supported."
    - 8.2. The APA Task Force concluded: "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 all sexual stimuli."
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    - 8.4. The APA Task Force concluded: "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."

8.5. The APA Task Force concluded: "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). 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 report 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."

8.6. Regarding the treatment of children and adolescents, the APA Task Force concluded that: "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."

9. I also understand that in 2009, the National Association for Research and Therapy of Homosexuality (NARTH) conducted a systemic review of the scientific literature called "What Research Shows" and found that:

9.1. "There is no universal definition of *sexual orientation:* some see it as fixed, while others see it as fluid. According to Schneider, Brown, and Glassgold (2002), sexual orientation is defined in terms of the gender (or genders) of the people to whom individuals are sexually and affectionately attracted and toward whom they experience feelings of love and/or sexual arousal. It is defined as a continuous rather than a dichotomous variable. Most people are primarily oriented toward one gender (their own or the opposite), but some people have some degree of attraction to or history of sexually gratifying behavior with persons of the other gender as well. Other individuals experience more or less balanced attractions to both women and men (p. 11)."

9.2. "A review of the literature by Whitehead and Whitehead (2007) shows that homosexuals—and, to a much lesser extent, heterosexuals—demonstrate evidence of sexual fluidity, including "spontaneous" as well as "assisted" reorientation. "A summary of these studies . . . is that about half of those with exclusive SSA [same-sex attraction] were once bisexual or even heterosexual. And about the same number changed from being exclusively SSA to bisexual or even heterosexual" (Whitehead & Whitehead, 2007, Chapter 12, p. 3). (p. 11)."

9.3. "In the clinical and scholarly literature over the past 125 years, mental health professionals and researchers document many different ways to assist men and women to successfully change from a homosexual to a heterosexual orientation. Reorientation assistance includes a variety of approaches, such as psychoanalysis, behavior and cognitive therapies, group therapies, sex therapies, hypnosis, pharmacological treatment, and religiously mediated activities. Other incidents of reorientation are attributed to spontaneous change, unknown methods, a combination of therapies, and other factors. There are also anecdotal accounts of change that have not been clinically or scientifically validated (p. 19)."

10. I agree to pay the Institute for Healthy Families a fee of $150 per 50-minute session. I understand that sessions lasting longer than 50 minutes will be pro-rated based on the 50-minute fee of $150 (e.g., 75 minute sessions are $225). I also understand that payment is due at the time of service for all therapy and/or coaching sessions.
11. I understand that I may be required, as a part of my therapy or coaching, to attend at least one group therapy session per month for a fee of $25 per 90 minute group session, and that I will be charged for this session unless I cannot attend due to sickness or medical emergency.
12. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier. I authorize payment to Institute for Healthy Families for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
13. This Informed Consent represents the entire agreement between us regarding the therapeutic sessions I will be receiving from the Institute for Healthy Families and shall not be modified unless done so in writing signed by both the Institute for Healthy Families and me for the duration of the services it provides me. There are no other promises, representations, or warranties of any kind not included in this Informed Consent. If any provision is declared void or unenforceable, it shall not affect the validity or enforceability of any other provisions.

My signature demonstrates my understanding of the foregoing points. By signing below, I accept the terms of this agreement.

_____ _____

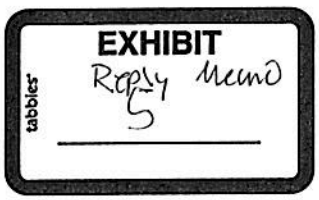
Name Date

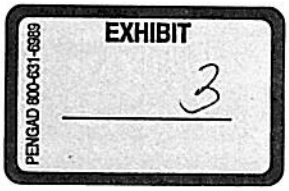
Institute for HEALTHY Families
Restoring Hope in the Hurting Home

PSYCHOTHERAPY AND COACHING SESSIONS
INFORMED CONSENT
AND
LIABILITY WAIVER AND RELEASE FORM

To participate in psychotherapy and/or coaching sessions with Christopher Doyle, LCPC, LPC please read and sign this Informed Consent. Place your initial to the left of each paragraph to show that you have read and consent to each paragraph. Your initials and signature means that you understand and accept each of the terms mentioned.

Initial	*Term*
_____	1. If this therapy or coaching session is being held outside of the state of Maryland or Virginia, Christopher Doyle, M.A. will facilitate as a coach, not a licensed counselor. All coaching will be provided as part of the therapeutic work of the Institute for Healthy Families, a 501(c)(3) non-profit organization.
_____	2. By signing this Informed Consent, I hereby release, acquit, discharge, and indemnify, and hold harmless the Institute for Healthy Families, its officers, board members, employees, agents, representatives, and/or volunteers from any and all actions, claims, demands, damages, and expenses, including attorney's fees or other legal expenses, arising from and/or in connection with the therapeutic services provided by the Institute for Healthy Families.
_____	3. I understand that if I choose to cancel or change my scheduled session, I will provide 72 hours notice by e-mail or phone call to Christopher Doyle. I also understand that if I do not provide 72 hours notice for this change or cancellation, I will be charged the full session fee, unless this change or cancellation is due to sickness or medical emergency.
_____	4. I understand that Institute for Healthy Families will make every reasonable effort to safeguard my communications with Mr. Doyle and treat them as confidential and privileged information. I further understand that the Institute for Healthy Families will comply with any applicable federal or state laws regarding maintenance and safekeeping of its records pertaining to my therapy sessions and my right to inspect and copy them. Notwithstanding the foregoing, I understand that Mr. Doyle may need to share my confidential information with the appropriate authorities if:
_____	4.1. He suspects that a child, or other person, has been physically abused, neglected, and/or sexually abused;
_____	4.2. He suspects that I have a condition or am engaging in behavior that may require restraint and/or hospitalization to protect me and/or others;
_____	4.3. I have committed or am about to commit a crime or other violation of the law and he or the Institute for Healthy Families is required or permitted to report it;
_____	4.4. A court of law issues a legitimate subpoena for your records; and/or if I provide written consent to release information about me and/or my family members.
_____	5. If the circumstances described above arise, I will not require the Institute for Healthy Families and Mr. Doyle to obtain a release-of-information form from me designating each person to whom they will be communicating.
_____	6. I understand that all clients experience healing in different ways and may have varying degrees of success, and that healing and/or success is determined by each individual client. I also understand that reaching my goals for coaching or therapy is not guaranteed by Institute for Healthy Families, and that my success depends on many factors, including my own efforts, keeping my scheduled appointments, my response to the therapy or coaching, and my own desire and/or efforts to heal and grow.





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10. I also understand that in 2009, the National Association for Research and Therapy of Homosexuality (NARTH) conducted a systematic review of the scientific literature of SOCE therapy called "What Research Shows" and found that:

10.1. "There is no universal definition of *sexual orientation;* some see it as fixed, while others see it as fluid. According to Schneider, Brown, and Glassgold (2002), sexual orientation is defined in terms of the gender (or genders) of the people to whom individuals are sexually and affectionately attracted and toward whom they experience feelings of love and/or sexual arousal. It is defined as a continuous rather than a dichotomous variable. Most people are primarily oriented toward one gender (their own or the opposite), but some people have some degree of attraction to or history of sexually gratifying behavior with persons of the other gender as well. Other individuals experience more or less balanced attractions to both women and men (p. 11)."

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13. This Informed Consent represents the entire agreement between us regarding the therapeutic sessions I will be receiving from the Institute for Healthy Families and shall not be modified unless done so in writing signed by both the Institute for Healthy Families and me for the duration of the services it provides me. There are no other promises, representations, or warranties of any kind not included in this Informed Consent. If any provision is declared void or unenforceable, it shall not affect the validity or enforceability of any other provisions.

14. I understand that the Institute for Healthy Families will not accept reimbursement from third parties (e.g., health insurance companies). However, IHF may provide me with a receipt for services, upon request, and I understand that I am responsible for all correspondence with and for documentation requested by third parties and that IHF will not disclose any confidential information on my behalf to third parties.

My signature demonstrates my understanding of the preceding points. By signing below, I accept the terms of this agreement.

_____ _____
Client Printed Name & Signature Date

_____ _____
Parent or Guardian Printed Name & Signature Date

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC,	:	
LCPC,	:	Civil Action No.
Plaintiff,	:	1:19-CV-00190-DKC
vs.	:	
LAWRENCE J. HOGAN, JR.,	:	
et al,	:	
Defendants.	:	

- - - - - - -

DEPOSITION of CHRISTOPHER DOYLE, LPC, LCPC

Baltimore, Maryland

Tuesday, March 26, 2019

9:58 A.M.

Job No: 35259

Pages 1 - 149

Reported by: Barbara A. Conner

EXHIBIT A

Deposition of CHRISTOPHER DOYLE, LPC, LCPC, held at the offices of:

OFFICE OF THE ATTORNEY GENERAL
STATE OF MARYLAND
300 West Preston Street
Suite 302
Baltimore, Maryland 21201
(410) 767-1867

Pursuant to Notice, before Barbara A. Conner, Notary Public of the State of Maryland.

A P P E A R A N C E S

ON BEHALF OF THE PLAINTIFF:

HORATIO G. MIHET, ESQUIRE

ROGER K. GANNAM, ESQUIRE

LIBERTY COUNSEL

Post Office Box 540774

Orlando, Florida 32854

(407) 875-1776

ON BEHALF OF THE DEFENDANTS:

KATHLEEN A. ELLIS, ESQUIRE

BRETT FELTER, ESQUIRE

OFFICE OF THE ATTORNEY GENERAL

STATE OF MARYLAND

300 West Preston Street

Suite 302

Baltimore, Maryland 21201

(410) 767-1867

ALSO PRESENT:

Ellen Rosenberger

P R O C E E D I N G S

CHRISTOPHER DOYLE, LPC, LCPC,

having been duly sworn, testified as follows:

EXAMINATION BY COUNSEL FOR DEFENDANTS

BY MS. ELLIS:

Q Good morning, Mr. Doyle.

A Good morning.

Q My name is Kathleen Ellis, I am the principal counsel for the Maryland Department of Health, and with me is my colleague, Mr. Felter, Brett Felter, who is also an Assistant Attorney General, and our law clerk, Ellen Rosenberger.

A Thank you.

MS. ELLIS: Could you mark this as exhibit 1, please.

(Notice of deposition was marked Exhibit 1 for identification.)

Q I'm showing you what's been marked as exhibit 1, Mr. Doyle. Have you seen that before?

A Yes, I have.

Q Is that the deposition notice pursuant to

which you're appearing here today?

A Yes, ma'am.

Q Thank you.

Have you ever been deposed before?

A Yes, I have.

Q How many times?

A Once.

Q And in what case were you deposed?

A I was an expert witness with the trial for Jews Offering New Alternatives to Healing against the plaintiffs represented by the Southern Poverty Law Center in, I believe it was, 2015.

Q And what happened in that case?

A I was -- could you explain more in detail what happened? I mean --

Q I asked you. What happened in the case that you were just telling me that you were an expert witness in?

MR. MIHET: Objection, vague.

A Could you be more specific?

Q What happened in the case? There was a case,

correct?

A Correct.

Q What happened in that case?

MR. MIHET: Objection, vague.

Q Go ahead and answer.

A What happened in the case, VSLC brought suit on behalf of four clients against the Jewish organization and they, the Jewish organization, was found guilty.

Q Was it a criminal case?

A It was --

MR. MIHET: It calls for a legal conclusion.

Q Was it a criminal case?

A No, it was not.

Q So, did you testify at the trial of that case?

A I did not.

Q Why not?

A I was, along with five other experts witnesses, I was dismissed by the judge.

Q You said that the defendants were found

guilty, found liable in a civil case?

A That's correct.

MR. MIHET: Calls for a legal conclusion.

A To my knowledge.

Q Did you know whether the defendants appealed that conclusion?

MR. MIHET: Calls for speculation.

A To my knowledge, an appeal was not filed.

Q Since you've been deposed before, you probably are familiar with these very brief rules that I'll go over, but I feel compelled to go over them anyway.

What's important out of all of this is what the court reporter transcribes onto the record that we will all get copies of, so it works best if we each respect each other and you don't talk until I stop and vice versa.

If you don't understand a question, please ask, please say so, and I will attempt to clarify or attempt to clarify with you what you don't understand, and if there is no such question, I will assume that you

understood the question and are answering it based on that understanding.

This is not an endurance test, although it may feel like that at times, so if you need a break, please tell me. This is a state office building, without a whole lot of amenities, but we do have restrooms down the hall, outside the door that you came into this office from, and so, obviously, if you need a break for that reason, we'll show you how to get to them.

A Thank you.

Q Could you please tell me your full name and address.

A Christopher John Doyle. Would you like my business address or my home address?

Q Both.

A My business address is 10620 Crestwood Drive, Suite C, Manassas, Virginia, 20109. My home address is 19119 Skyfield Ridge Place, Purcellville, Virginia, 20132.

Q Are you employed?

A Yes, I am.

Q Who are you employed by?

A I have three employers. I'm a mental health therapist at Patrick Henry College, in Purcellville, Virginia, I'm the executive director of the Institute For Healthy Families, and I'm a clinical and founder of Northern Virginia Christian Counseling.

Q So, you said you were a counselor at Patrick Henry College. How much time do you spend doing that job?

A During the academic year, approximately six to seven hours a week.

Q And during the rest of the year?

A I don't. They're on break, so I'm not seeing the students.

Q And you said that you were the executive director of the Institute For Healthy Families?

A Correct.

Q What is the Institute For Healthy Families?

A It's a nonprofit organization that was founded to help families and individuals and faith-based

organizations work through sexual and gender identity issues.

Q And how much of your time do you spend as executive director of Institute For Healthy Families?

MR. MIHET: Vague.

A Per week?

Q Yes.

A Anywhere from 35 to 40 hours, sometimes a little bit less, sometimes a little bit more, depending on the caseload and how much work I have.

Q And do you also practice as a professional counselor at the Institute For Healthy Families?

A I do.

Q And if you can estimate for me, how much of your 35 to 40 hours a week is providing services, clinical services, and how much is running the organization?

A Probably about 80 to 85 percent clinical, give or take.

Q How many employees does the organization have?

A We have five, including myself.

Q Are there clinical employees?

A No. We do have two admin. staff and two parents that provide coaching, nonclinical work, and educational activities.

Q And you said that, I believe, that you were the founder of Northern Virginia Christian Counseling?

A That's correct.

Q What role, if any, do you currently have through that organization?

A I'm the clinical director and I'm also a licensed counselor.

Q And, approximately, how many hours a week do you spend with Northern Virginia Christian Counseling?

A 10 to 15.

Q And of that 10 to 15 hours, how much of that time is spent in providing clinical services to individuals and their families?

A 90 percent.

Q So, you provide clinical services at Patrick Henry College, at Institute For Healthy Families and at

Northern Virginia Christian Counseling?

A Correct.

Q Is there any other location that you provide clinical counseling services?

MR. MIHET: Objection, vague, and misstates prior testimony.

Q Is there any other place, other than these three locations, that you provide clinical counseling services?

MR. MIHET: Same objections.

A Not to my knowledge.

Q You mentioned a licensed counselor. Do you have any licenses from any states to practice counseling?

A Yes.

Q And what states do you have?

A Virginia and Maryland.

Q And how long have you been licensed in the State of Virginia?

A I believe five or six years.

Q What's the type of license that you have in

the State of Virginia?

A Licensed Professional Counselor.

Q And you said you're licensed in Maryland as well. How long have you been licensed in Maryland?

A I believe it's eight, and then before that time, I was working under a license during my residency, working under a supervisor's license, I'm sorry, to clarify.

Q For how long did you work under a supervisor's license?

A Roughly, two.

MR. MIHET: You mean years?

THE WITNESS: 2 years.

Q That's a licensure requirement, correct?

A Correct, yes.

Q And what are you licensed as in Maryland?

A Licensed Clinical Professional Counselor.

Q Popularly known as LCPC?

A Yeah.

Q What, if any, communications have you had with the Board of Professional Counselors & Therapists

in Maryland in the last year?

MR. MIHET: Objection, vague, calls for a narrative.

Q Go ahead, you can answer.

A Regarding this issue or at all?

Q What, if any, communications have you had with the Maryland Board of Professional Counselors & Therapists in the last year?

A To my knowledge --

MR. MIHET: Hold on a second.

THE WITNESS: Yeah.

MR. MIHET: Same objections, also overbroad.

Q Go ahead, you can answer.

A To my knowledge, the only communication I have had is renewing my license.

Q And the same question for Virginia. The Virginia board that regulates professional counselors, what communications, if any, have you had in the past year with that group?

MR. MIHET: Same objections.

Q Go ahead.

A I made one phone call to the Virginia Board of Counseling in the spring or summertime.

Q Of 2018?

A Correct.

Q And what was that telephone call about?

A It was regarding requirements for residents on my staff.

Q Residents?

A Resident counselors.

Q Do you mean by resident counselors, counselors in training?

A Correct.

Q To your knowledge, has anybody made any complaints about your practice to the board of Maryland, Board of Professional Counselors & Therapists?

A No.

Q To your knowledge, has anyone made any complaints to the Virginia regulatory agency about your practice?

A No.

(Institute For Healthy Families informed

consent was marked Exhibit 2 for identification.)

Q Mr. Doyle, I'm showing you what's been marked as exhibit 2. It's a document that I received from your counsel and you'll see in the bottom right-hand corner PL 000005 through 8. Do you see those numbers?

A Yes.

Q Could you tell me what this document is, please.

A This is an informed consent document from 2016.

Q Is that an informed consent document that you use or used?

A Yes. Yeah. There is an updated form that you have, but this is one from 2016.

Q And if you direct your attention to paragraph six on the second page, the first line of paragraph six says, "I understand that Christopher Doyle and the Institute For Healthy Families does not practice reparative therapy, reorientation therapy, conversion therapy or any type of sexual orientation change effort, (SOCE) therapy." Do you see that?

A Yes, I do.

Q Is that accurate?

A That's correct.

(Institute For Healthy Families informed consent was marked Exhibit 3 for identification.)

Q I'm showing you now what's been labeled as exhibit 3 and it's PL 000013 through 15. Do you recognize this document?

A I do.

Q And could you tell me what it is, please.

A It's an informed consent document that was updated on May 31, 2018 for my organization, my counseling.

Q And I would ask you to look at paragraph seven on the second page. It says, the first sentence of that says, "I understand that Christopher Doyle and the Institute For Healthy Families does not practice reparative therapy, reorientation therapy, conversion therapy or any type of sexual orientation change effort (SOCE) therapy." Do you see that?

A Yes, I do.

Q Is that statement accurate?

A Yes, it is.

MR. MIHET: Form and vague.

MS. ELLIS: Could you tell me what your objection to form is, please.

MR. MIHET: You failed to define the terms that you're asking Mr. Doyle about and there's no assurance that what he means by those terms is the same thing that the State of Maryland means by those same terms.

MS. ELLIS: That's not what the question was about, Mr. Mihet. Thank you.

MR. MIHET: We can agree to disagree about that.

Q But with your counsel's prompting, we can go there now.

So, it says that you don't do any kind of sexual orientation change effort therapy, correct?

A That's correct.

Q And how do you define sexual orientation change effort therapy?

A I define sexual orientation change effort therapy as a very specific type of therapy, where a client expressly comes in for counseling that wants to change their sexual orientation.

Q And does it include any particular kinds of techniques to attempt to accomplish that client's goal?

A Well, I'm not -- I'm not aware of any specific techniques that a person or a therapist that would necessarily practice, I don't believe there's a standard or uniform definition of SOCE therapy, it tends to be more of a broad umbrella term that doesn't necessarily define the work that I do.

Q But you don't engage in sexual orientation change effort therapy --

MR. MIHET: Form, vague.

Q -- is that correct?

A In that sense, I do not.

Q In what sense?

A In the sense of the fact that it's very broad and ill-defined.

Q What about, how would you define the term

conversion therapy?

A It's even more broad and ill-defined. There is no standard or uniform definition.

Q How do you define it?

A I would define conversion therapy as a practice that is expressly trying to change a client from gay to straight.

Q And, again, you don't engage in that particular kind of therapy, correct?

A I do not.

MR. MIHET: Form.

Q What about reparative therapy, how do you define that?

A Reparative therapy is a clinical term that was coined by Dr. Joseph Nicolosi in the late eighties and early 1990s. It comes from a term from Elizabeth Moberly's book, Homosexuality: A New Christian Ethic, where she defined reparative -- homosexuality as a reparative drive to fulfill unmet love needs. Dr. Joseph Nicolosi took that term -- he's now deceased, by the way -- and coined his specific type of work

reparative therapy.

Q And what specific kind of work did he do that was encompassed by that term, reparative therapy?

A I think you would probably have to ask him.

Q Which would be difficult?

A Yeah.

Q You don't do that, you don't do reparative therapy?

A I do not.

Q How do you define reorientation therapy?

A It's another broad and ill-defined term to help a client go from gay to straight.

Q So, if I understand your testimony correctly, reparative therapy, reorientation therapy, conversion therapy or sexual orientation change effort therapy are all types of therapy, you said they were broadly defined, to change an individual's sexual orientation from homosexual to heterosexual?

A To some extent --

MR. MIHET: Form.

A To some extent, yes. I think it's a little

more complicated than that, but there's a lot of nuance.

Q Well, then, explain to me why it's more complicated and how it's more complicated, please.

MR. MIHET: Form, vague.

A It's overly broad in ill-defined terms.

Q What is overly broad and ill-defined?

A The terms, because in my -- well, outside of reparative therapy, the three other terms really don't have a clear understanding of what's happening in clinical work.

Q What are you asking somebody who signs this form to understand that you're not doing?

A Essentially, the work that I do, I describe it as sexual and gender identity affirming therapy, and what I explain to clients is that they're in the driver's seat, that I'm not imposing a goal on their work. I have a duty and a right to my clients to work with what they want to work on, and clients that may be open to sexual fluidity or change, I'm open to that client's goal.

Q And how do you explain to a client what

reparative therapy, reorientation therapy, conversion therapy or any type of sexual orientation change effort therapy is?

A I, basically, tell them that those are very broad terms that really don't apply to the work that I'm doing because my work is much more client centered. I don't have an objective, stated objective goal, whereas, in my opinion, Dr. Joseph Nicolosi's clinic was expressly a reparative therapy clinic.

Clients that went to seek out his services knew what they were getting, there wasn't any -- in some ways, I guess, it was client centered, but he was expressly known for that. So, in order to not confuse clients with umbrella terms that don't necessarily apply to the work that I do, I try to tell them this is not what I do and this is what I do.

Q Over the eight years that you have been a Licensed Clinical Professional Counselor in the State of Maryland, have you ever engaged in therapy that you would consider to be one of these terms?

MR. MIHET: Form.

Q Go ahead. You can answer the question --

A Yes.

Q -- if you can, and if you can't, tell me what you don't understand and I'll try to amend it.

A I have used those terms in the past over, probably over five years ago to describe the work that I do under another organization that was not mine.

Q So, more than five years ago, you used which of these terms?

A SOCE.

Q And what did you mean by SOCE when you used that to describe your practice five years ago?

A I can't recall exactly where I used that term, but because of the generalizability, I don't know if that's correct, quite the correct word, it's sometimes difficult, when I'm doing media, to use terms that the general population would understand. So, rather than use a term like sexual or gender identity affirming therapy, I might have described my work as SOCE in that regard and I can't recall where, though.

Q And you said that was when you were working

for another organization?

A To my knowledge, yeah.

Q And what organization was that?

A International Healing Foundation.

Q Does the International Healing Foundation still exist?

A No.

Q What was your role with the International Healing Foundation?

A I was the director and a licensed counselor.

Q For how long?

A Approximately, five years.

Q From when to when?

A 2010 to 2015.

Q And why did you leave that position?

A The board of directors voted to dissolve the organization at the end of 2015.

Q Are you aware of any practitioners, counselors, that practice any of the types of therapy that you have listed in this consent in the State of Maryland?

MR. MIHET: Form.

A I don't know if they would call their work that. I am aware of practitioners that may be doing similar work.

Q Similar to what?

A Similar work with over sexual and gender identity conflicts or something of that nature.

Q And who would those be?

THE WITNESS: Do I have to answer that? I feel like I don't want to incriminate someone else.

MR. MIHET: Let me have a discussion with my client for the purpose of determining whether or not a privilege should be asserted.

Q I will make it clear that I'm not asking about minors. Can you please identify any practitioners, counselors, in the State of Maryland, that provide these types of therapies listed in the first sentence of paragraph seven in exhibit 3 in the State of Maryland --

A I have it.

Q -- for adults in the State of Maryland.

MR. MIHET: Okay. And I'm going to object also to the form of the question as mischaracterizing the prior testimony of the witness.

A So, what I'll say is, I don't know specifically of a clinician that identifies their work as these terms.

Q Do you know about any clinician's practice that you would consider to be within those terms?

MR. MIHET: Form.

A That's so vague, you know.

Q Why do you think it's vague?

A I wouldn't want to mischaracterize another clinician's work without knowing specifically what they call it. These are very sensitive terms, they're used in the media pejoratively and inflammatorily, and I would be very sensitive to call another clinician's work one of these without being able to verify that that's what they call it. I'm very careful to not mislabel my work; I wouldn't want to mislabel another person's.

Q If you look at the first page of exhibit 3, it says, paragraph one, "If this therapy or coaching

session is held outside of the State of Maryland or Virginia, Christopher Doyle will facilitate as a coach, not a licensed counselor." Do you see that sentence?

A I do.

Q Could you tell me what the difference between a coach and a licensed counselor in your understanding is.

A In this sentence?

Q A-huh.

A I do work, outside of the State of Maryland and Virginia, some family work with clients, and in that sense, I'm not licensed to practice in that state or commonwealth, so I would not represent myself as a licensed therapist in that context.

Q But you would represent yourself as a coach, is that correct?

A Correct.

Q Tell me what the difference is between the coach and the licensed counselor.

A I'm not operating in a formal therapeutic role.

Q And what does that mean?

A I'm not operating under a license, I don't -- and I don't claim that I am, and I'm careful to inform my clients of that.

Q So, you said you don't represent that you're operating under a license, correct?

A Correct.

Q You don't tell your clients that you are?

A In that sense, outside of Maryland and Virginia.

Q So, what kinds of services would you be providing as a coach?

A Providing guidance, facilitation, discussion, communication with families, educational as well. For example, I do a parents class that, an on-line class where people are in various places around the United States, sometimes internationally, and in that role I would be describing my work as a coach.

MS. ELLIS: Could you please read back, he said guidance, communication, and if you could just read back those things that he described.

(The requested portion was read.)

Q So, when you say you provide guidance, what does that mean?

A Insight, try to help families and individuals understand dynamics within their family, facilitate discussion.

Q Do you provide this coaching with parents, with children, with both?

A Yeah.

Q All three?

A Yeah.

Q I guess, two, I'm sorry, children and families?

A Right. I understood what you meant.

Q So, when you have these discussions in the State of Maryland, or in the State of Virginia, you represent yourself as a licensed counselor then, correct?

A I do.

Q And how does the session in Virginia or Maryland differ from the one in Massachusetts, to pick

another commonwealth?

MR. MIHET: Form.

A It doesn't.

Q Tell me how you would describe your practice, please.

MR. MIHET: Form, vague, calls for a narrative.

A Can you be more specific?

Q Tell me how you would describe your practice to a prospective client.

MR. MIHET: Same objection.

THE WITNESS: I can answer.

A It's client centered, it's based on working with a client to help them resolve distress. In my clinical role, it would be also diagnosing and treating therapeutic issues, possibly mental illness and emotional disorders as well, and also issues and disorders and problems for clients that wouldn't necessarily be clinical or diagnosable.

Q Do you advertise your practice?

MR. MIHET: Vague.

A I do advertise Northern Virginia Christian Counseling. I do not advertise the Institute For Healthy Families and I do not advertise Patrick Henry College.

Q You have a website for Institute For Healthy Families, isn't that correct?

A So, let me amend that answer. I do send out marketing e-mails to our list serve and so that would be a form of advertisement, yup.

Q Would you consider the website a form of advertisement?

A Sure. The distinction I was making was paid advertisements.

Q Approximately, how many clients are you generally serving at any one time?

MR. MIHET: Form, vague.

Q Approximately, how many clients are you serving at any one time, Mr. Doyle?

MR. MIHET: Same objection.

A Can you clarify the question. Are you speaking of how many clients are in -- are under my role

as a therapist or a coach?

Q Well, let's talk about therapist first. When you're performing as a licensed therapist in the State of Maryland or in the State of Virginia, approximately how many clients are you serving at any one time?

MR. MIHET: Same objections.

A I can approximate.

Q Approximately, how many?

A Okay. 30 to 35, maybe. That's an approximation.

Q And that includes both clients that you're serving as a licensed Maryland counselor?

A No, that's just therapy. There's other clients that I serve just in the coaching role and that could be as many as 20. I also consult with parents that are outside the state.

Q So, the 30 to 35 clients are those that you're providing services for which you need a license, is that correct?

A Yes.

Q Of the 30 to 35 therapy clients,

approximately how many are under the age of 18?

MR. MIHET: Form.

A Maybe 10 percent. 10 to 15 percent. It's hard to say.

Q Approximately, how many of those 30 to 35 clients are Maryland residents?

MR. MIHET: Form.

A Roughly, 10 to 15. Maybe 15.

Q And for the Maryland clients, is it still the 10 to 15 percent that are under 18?

MR. MIHET: Form.

A Yes. Yes.

Q So, it would be one or two that would be under 18?

A From Maryland, yeah.

Q From Maryland.

And the 20 that you mentioned that are coaching clients, where do they reside?

A Various places in the United States, some international, yeah.

Q And then you said you consult with parents.

Is that other than the parents that are your therapy clients' or coaching?

A No, they would all be considered clients under the nonprofit. Some are therapy clients, some would be considered coaching clients.

Q Then you said you had a third category, you said you consulted with parents.

A Those could be therapeutic or coaching, yeah.

Q But they're all included in either the 30 to 35 or in the 20?

A Yeah, the 20. The 20. Additional 20 that would be consulting, but not necessarily -- some may be therapeutic, some may be coaching, yeah.

Q So, any of your clients under the age of 16 or 17?

A Yes.

Q How many?

A Currently, one.

Q And is that a Maryland resident?

A Yes.

Q And for your minor clients, what is the

gender mix?

MR. MIHET: Form.

A 95 percent male. Or maybe 90 percent, yeah.

(Complaint was marked Exhibit 4 for identification.)

Q I'm showing you what's been marked as exhibit 4, Mr. Doyle, which is a copy of the complaint minus the exhibits that was filed in this matter. Have you seen this before?

A I have.

Q And if you look at the last page of it, and if you look at the bottom right, where it says, there's a slash S, Christopher Doyle with an asterisk, do you see that?

A I do.

Q Did you actually sign a copy of this complaint?

A I did.

Q If you could look at paragraph 110, please, it says, "Plaintiff does not engage in aversive

techniques." Do you see that?

A Yes.

Q Could you tell me what you consider to be aversive techniques.

A Electric shock, vomit inducing, nausea inducing, any technique or therapy that would cause physical pain.

Q Does anyone, to your knowledge, still engage in those practices?

A Not to my knowledge.

(Answers and objection to first set of interrogatories was marked Exhibit 5 for identification.)

Q I'm showing you what's been marked as exhibit 5. Do you recognize this document, Mr. Doyle?

A I do.

Q And could you tell me what it is.

A These are the answers to your questions that I answered before this deposition and provided to my counsel.

Q And if you look at the page five, again on

the bottom right, there's a slash S and then Christopher Doyle typed. Did you actually sign --

A I did.

MR. MIHET: I'm sorry.

Q Again, if you could wait for me to finish the question.

A I apologize.

MR. MIHET: It's natural to want to anticipate the question, but the record will work a lot better if you work hard to allow counsel to finish.

THE WITNESS: Thank you.

Q It's an effort for both of us.

So, you did actually sign a piece of paper and provide that to your counsel?

A I did.

Q If you could look at page three and four, which is a list of clients that you provided services to who were from Maryland, is that correct?

A That's right.

Q For client number one, are you still providing services to him?

A Yes, I am.

Q Client number two, are you still providing services to him?

A Yes, I am.

Q Clients three, four and five, I believe you are no longer providing services to?

A That is correct, I'm no longer.

Q So, for one and two, it's audiovisual counseling. Where are you located with the audiovisual counseling?

A I'm in that sense, in that sense I'm in Virginia and my client's in Maryland.

Q But you were physically present in December 2017 at your client's home?

A For client one?

Q For client one, yes.

A That's correct.

Q And for client two, you were also in Virginia, while client two was in Maryland?

A For the audiovisual counseling --

Q Yes.

A -- I was in Virginia, and for the family therapy, I was in their home in Maryland.

Q The entries for in-person group therapy for parents, there were no minors involved in that, correct?

A No.

Q Client one did not participate, is that correct?

A No, but these --

Q Wait. Wait.

A Can I clarify?

Q Did client number one, the 17 year old male, participate in the group therapy for parents?

A To provide context, the parents' retreats that I do in-person have a great deal of relevance to my work with the minors and that's why I listed it, but the minors were not present in those retreats.

Q Okay. Thank you.

A Thank you.

Q For the retreats that you do for parents, do they require a professional counselor's license for you to provide those retreats?

MR. MIHET: Form.

A I'm not really sure what that means. That's, in my opinion, vague.

Q What don't you understand?

A When you say require that a licensed counselor.

Q If, in your view, in your understanding, for you to do one of these parents' retreats in Maryland, is it required that you have a license, professional counselor's license, to put on that retreat?

MR. MIHET: Form, calls for a legal conclusion.

A I can't answer that.

Q Why not?

A Because I don't know who is requiring -- who is requiring what.

(Section 17-101 of the Health Occupations Article of the Maryland Annotated Code was marked Exhibit 6 for identification.)

Q I'm showing you what's been marked as exhibit 6, which is Section 17-101 of the Health Occupations

Article of the Maryland Annotated Code. Title 17 is, as it says at the top, Professional Counselors and Therapists. And if you look on page five, which is actually the third page of the exhibit, item V, "Practice clinical professional counseling," could you read that definition.

A "Practice clinical professional counseling means to engage professionally -- "

Q I'm sorry. I'm sorry to interrupt you. You don't need to read it out loud. If you could just read it to yourself.

A Oh sure. Okay.

Q And tell me when you're done.

A I'm done.

Q Do you understand that definition?

A I do.

Q And does whatever you include in your retreats for parents involve activities that come within this definition?

MR. MIHET: Form, calls for a legal conclusion.

A In my opinion, yes.

Q And what kinds of activities are those that come within this definition?

MR. MIHET: Same objection.

A Talk therapy, experiential group therapy, psychoeducation.

Q Do you do these kinds of retreats in states in which you're not licensed?

A No.

Q No, okay.

You do the coaching, correct, in those states?

A Yes, coaching.

Q One of the other rules I forgot to mention, the court reporter has a very hard time interpreting nods, shakes of the head, those kinds of things. It's very important to say yes, no or maybe.

Do you believe homosexuality is a mental illness?

A I do not.

Q Do you believe it's a mental disorder?

A No.

Q Is it normal?

A That would depend on who you're asking.

MR. MIHET: Form.

Q I'm asking you. Do you consider it to be normal?

MR. MIHET: Form.

A Statistically speaking, no.

Q And what does that mean?

A It means that, roughly, 2 to 3 percent of the population identifies LGBT, lesbian, gay, bisexual, transgender, and in that sense it would not be normal.

Q Do you consider it to be a maladaptive condition?

A I do.

MR. MIHET: Form.

A I do.

Q And what does that mean?

A Let me make sure I phrase this correctly.

I believe that there are some issues that individuals experience that would not necessarily be

considered mental illness or disorder, but would also be -- but may be considered a deviation from, I guess you would say, the norm and to me homosexuality would be one of those.

Q So, there's something abnormal about homosexuality?

MR. MIHET: Form.

A Statistically speaking, yes.

Q So, is it your view that because it's a maladaptive condition or abnormal, that it needs treatment?

MR. MIHET: Form, mischaracterizes testimony.

A I -- could you restate the question.

Q You told me that you consider homosexuality to be a maladaptive condition, correct?

And you said, statistically, that means that it's not normal, that it's abnormal. So, does it need treatment?

MR. MIHET: Form, mischaracterizes testimony.

A I'll answer the question.

I don't treat homosexuality.

Q What do you treat?

A I treat the underlying potential causes as to why someone might experience same sex attractions or gender identity, gender dysphoria.

Q And what are those underlying causes, in your view?

MR. MIHET: Form.

A They vary from client to client.

Q So, there's no generalization that you can provide about underlying causes?

MR. MIHET: Form, vague, ambiguous.

A There certainly are similarities with many clients that have some underlying causes, but I wouldn't generalize, necessarily, that every client experiences these attractions for one specific reason. There's always a potential many causes.

Q Well, you've been practicing as a Licensed Professional Counselor, clinical professional counselor for eight years, correct?

A Roughly, yeah.

Q And over those eight years, you've treated

many clients --

A Yes.

Q -- and in those clients, identified what you considered to be underlying causes for their homosexuality?

MR. MIHET: Form.

A Have I identified?

Q Yes.

A I could generalize it to saying that it's, I believe it's trauma, various forms of trauma.

Q And what kinds of trauma do you believe causes at least some people to be homosexual?

A Attachment trauma, emotional trauma, psychological trauma, physical trauma, sexual trauma, relational trauma.

Q Attachment, physical --

A Emotional.

Q -- emotional, relational, I think you said?

A Sexual, relational.

Q Did I miss any?

A There may have been one more, I can't

remember. I think I said five or six.

Q What's attachment trauma?

A Well, let me first state that just because someone has attachment trauma wouldn't necessarily mean that they would develop homosexual feelings.

Q Okay, I understand that.

A Okay.

Q But I'm asking you what attachment trauma is.

A So, in my clinical opinion, the child that doesn't have sufficient attachment with one or more parents or caregivers from an early age, we're talking infancy to childhood, even into adolescence, can experience trauma from that lack of healthy attachment or secure attachment and that has implications for sexual development.

Q Does it matter which parent a particular individual lacks a healthy or secure attachment to?

MR. MIHET: Form.

A It varies, actually.

Q Do you want to explain that, please.

A For some clients it would be the same sex,

for other clients it might the opposite sex, for other clients it might be both. There's no way for me to know until I do assessment.

Q Do you understand that under Maryland law, a minor lacks capacity to consent to treatment if that minor is under the age of 16?

A I do.

MR. MIHET: Objection, form, calls for a legal conclusion.

A I am aware of that.

Q And are you also aware that a 16 or 17 year old minor can't refuse treatment to which his or her parent or guardian consents?

MR. MIHET: Form, calls for a legal conclusion.

A Yes, I am aware.

Q In your interrogatory answers, I think -- let's see -- on page four, the last sentence of answer to interrogatory number four, "I never tolerate any coercion or manipulation of a minor in the therapeutic process." Do you see that?

A I do.

Q And that is your practice, not to tolerate coercion or manipulation of a minor in the therapeutic process?

A That's correct.

Q So, how do you determine whether a minor is participating in therapy with you because the minor wants to be there or because the minor's parents want the minor to be there?

MR. MIHET: Form.

A In most cases, I would interview the minor separately and the parents separately, sometimes for multiple sessions.

Q How do you respond if you find, in the course of your therapy, that the minor really doesn't want to be there?

A Well, there's a variety of ways that could occur, but in a general sense, I'll tell the minor that, "If you really don't want to be here, then you don't have to be here and I really don't want to keep you here," in therapy.

Q Has that ever happened --

A Yes.

Q -- in your practice?

A Yes.

Q And what have you done if the minor no longer wants to be in therapy?

A I inform the parents and I provide an appropriate referral.

Q Now, Chapter 685 or Senate Bill 1028 are both the same thing, you would agree, correct?

MR. MIHET: Form, calls for a legal conclusion.

A I don't know.

Q Well, then, let's --

A I'd have to compare them.

(Senate Bill 1028 was marked Exhibit 7 for identification.)

Q I'll show you what's been marked as exhibit 7 for purposes of this deposition. It's also, as you can see on the bottom right, it says Exhibit A, and across the top it says Document 1-1. Do you see that?

A I'm sorry, I don't know where you're pointing.

Q Across the top, very top, it says, "Case 1 colon -- "

A Yes, I see that.

Q " -- 19-cv-00190-OKC Document 1-1." Do you see that?

A Yes, I do.

Q This was Exhibit A to your complaint. So, this is, you see it says 685?

A I do.

Q "Chapter 685," and then in parens, "Senate Bill 1028." Do you see that?

A I do.

Q This, Chapter 685, only addresses counseling with minors, correct?

A To my knowledge, yes.

Q If you go to page five, and look towards the bottom of the page, B, in parens, do you see that?

A I do.

Q "A mental health or child care practitioner

may not engage in conversion therapy with an individual who is a minor." Do you see that?

A I do.

Q And if you want to take a minute to read page five and the top of page six, why don't you do that. Just look at it, read it to yourself.

A Okay.

Q There's nothing in that part that you just read that applies to the provision of conversion therapy to an individual who is not a minor, is that correct?

MR. MIHET: Form, calls for a legal conclusion, the law speaks for itself.

A The statute applies to clients under the age of 18.

Q Thank you.

Would you agree, Mr. Doyle, that the State of Maryland has a legitimate interest in protecting minors from various kinds of harm?

MR. MIHET: Form, calls for a legal conclusion and misstates the law.

Q Could you please tell me whether in your

understanding, I'm not asking for a legal conclusion, I'm asking whether you understand that the state has an interest in protecting minors from harm. Do you have that understanding?

MR. MIHET: Same objection, also vague and ambiguous.

A I believe the state, under their jurisdiction, has a legal obligation to try to protect minors from harm, in various contexts.

Q Well, tell me what you consider those contexts to be.

A Sure. We want to protect, Maryland wants to protect their minor children from abuse, neglect, from unlawful sexual activity or behaviors, from alcohol use, from substance use, various forms of -- types of harm, harmful activities.

Q In addition to those areas that you listed, child abuse and neglect, alcohol, substance use, folks under the age of 18 are, generally, prohibited from purchasing tobacco, is that correct? Is that your understanding?

MR. MIHET: Objection, calls for a legal conclusion.

A To my understanding, I believe it's under 18, although some, I think, some states are moving that to increasing it.

Q And that may be going on as we speak in the State of Maryland, I don't know.

A I'll try to answer that question accurately. We're in the legislative season.

Q Really.

We distinguish between adults and children or adolescents in terms of ability to purchase tobacco. Is that your understanding?

MR. MIHET: Form.

A Sure.

Q We, actually Congress, attempts to protect children, minors, from indecency, exposure to indecent programming and speech. Is that your understanding?

MR. MIHET: Form, calls for a legal conclusion, speculation, foundation.

A I don't know what programming and speech

means in that context.

Q You're aware that there is something called the Federal Communications Commission?

A Okay. So, you're referring to, you know, for example, children not being able to attend certain films and movies that are -- have different ratings?

Q I wasn't referring to that.

A Okay. That's my understanding of what you were saying.

Q So, you're familiar with the FCC?

A I am, yeah.

Q And that the FCC regulates what can be on the radio and broadcast TV?

A Yes.

MR. MIHET: Form, foundation, calls for a legal conclusion, relevance.

Q And that's another way in which we attempt to protect minors from exposure to indecent material, is that your understanding?

MR. MIHET: Same objections.

A If that's the way that Maryland does it,

sure.

Q Actually, that's Federal law.

And there are child labor laws, correct?

MR. MIHET: Same objections.

A To my knowledge, yes.

Q Yes, okay.

All ways in which a legislature has decided to try and protect children, is that your understanding?

MR. MIHET: Same objections.

A Yes.

Q Do you have any problems with those types of laws trying to protect minors?

MR. MIHET: Form, vague, ambiguous, calls for a legal conclusion.

A I'm not aware of every single foundation under which Federal or the state tries to protect minors from harm, so I don't know if I could answer that adequately.

Q So, of the types of harm that you identified and that we've discussing --

A And those --

Q Let me finish, please.

Of the types of harm that you identified and that we have been discussing in the last few questions, do you have any objection to any of those types of efforts to protect minors from harm?

MR. MIHET: Form, vague, ambiguous, calls for a legal conclusion, lacks foundation.

A Outside of ratings of movies, I don't have a problem with any other types of harm that are prohibited, or whatever the question was. Sorry. I think you have my answer. I think the rating system for movies is fairly arbitrary.

Q There's probably a lot of people who agree with you there.

Now, did you testify at the hearings last year in the Maryland General Assembly against House Bill 902 or Senate Bill 1028?

MR. MIHET: Vague.

A I'll answer the question. I submitted written testimony, I did not testify in-person.

Q Is there any reason that you didn't travel to

Annapolis to testify in-person?

A There is a reason.

Q And what's that?

A I knew the bill would pass.

Q And why did you think the bill would pass?

A Because I'm an expert on this issue and I know exactly what bills will pass and why. I've been following them for eight years.

Q But you took the time to submit written testimony, correct?

A I did. That didn't cost me any money.

(Exhibit 4-33, Exhibit 4-35 and Exhibit 4-58 were marked Exhibits 8, 9 and 10, respectively, for identification.)

Q Can you tell me, by looking at the number at the bottom, which is which exhibit. So, which is exhibit 8?

A Exhibit 8 is 4-33.

Q And what is 4-35?

A Exhibit 9.

Q And then 4-58 is exhibit 10?

A That's right.

Q So, exhibit 8 is an e-mail sent to a number of delegates, Shane Pendergrass and a number of other delegates, Maryland delegates, is that correct?

A That's what it looks like.

Q You sent this e-mail, didn't you?

A I did not.

Q You did not. Who did?

MR. MIHET: Objection, calls for speculation, lacks foundation.

Q If you know, of course, who sent it?

MR. MIHET: Also lacks authentication.

A It's one of two people, yeah. It's either Robin Goodspeed or Daren Mehl.

Q Who is Robin Goodspeed?

A She's listed under number eight. She's an advocate for former homosexuals and for therapy to help those who have these conflicts.

Q And who is the other person?

A Daren Mehl.

Q And could you spell that.

A M-E-H-L.

Q And who is he?

A The same. They both are on my board of directors for Voice of the Voiceless, a 501(c)(3) nonprofit organization.

Q This e-mail --

A I'm sorry. Advisory board, not board of directors.

Q This e-mail says that it's from the National Task Force For Therapy Equality. Do you have any relationship to that task force?

A I do. I cofounded it.

Q And do you continue to have a relationship with it?

A Yes.

Q And what is your role with it?

A I'm the cofounder.

Q And did you play any role in the decision to submit this e-mail with attached testimonies to Delegate Pendergrass?

A I did not.

Q Let's look at exhibit 9. This also is from the National Task Force For Therapy Equality, correct?

MR. MIHET: Objection, foundation, form.

A That's what it looks like.

Q Did you have anything to do with this e-mail being sent to Delegate Pendergrass, et al?

A No.

Q Let's look at exhibit 10. Is this an e-mail that you sent?

A It is.

Q And what is Equality and Justice For All?

A It's a 501(c)(4) nonprofit organization that advocates for individuals who are -- have unwanted same sex attractions and gender identity confusion and is more political in nature.

Q And what is your connection to that organization?

A At one time I was a paid consultant for them and I did educational activities.

Q Do you have any continued connection with that organization?

A I do.

MR. MIHET: Form.

A I do, but it's a volunteer basis.

Q Were you involved in the creation of Equality and Justice For All?

A No, I was not.

Q Do you know who was?

A I can't tell you for sure, no. I mean, I know members of the board.

Q And you said the Equality and Justice For All still exists?

A Yes, to my knowledge.

Q Have you done anything with them recently --

A Can you be more specific?

Q -- in the last year, other than send this e-mail?

MR. MIHET: Form.

A In a general sense, any political activities that I do, that are related to advocacy or politics, I do it from Equality and Justice For All. I try to separate my therapy role from political and advocacy.

Q Would it surprise you to learn that on the website for Equality and Justice For All there's nothing more recent than 2016?

MR. MIHET: Form, foundation, assumes facts not in evidence.

A I don't know if I would characterize it as being surprised.

Q How would you characterize it?

MR. MIHET: Same objection.

A I don't know.

(Homepage for the website Equality and Justice For All was marked Exhibit 11 for identification.)

Q I'm showing you what's been marked as exhibit 11. You can see the date 3/25/2019 in the lower right-hand corner, the date that it was printed.

A Okay.

Q It's the homepage for the website Equality and Justice For All. Do you see anything more recent than 2016 on there?

MR. MIHET: Form, foundation, lacks

authentication, calls for speculation.

A No.

Q So, there's no date that's written on this page that you can see that's later than 2016, is that correct?

A Outside of the time that you printed it, no.

Q Thank you.

So, let's go back to exhibit 10. You sent this e-mail, correct?

A I did, yeah.

Q Was this the testimony, the written testimony, to which you referred when you said that you provided written testimony to the committees considering what became Chapter 685?

MR. MIHET: Form.

A Yes.

Q Did you provide any other written testimony?

A Not to my knowledge.

Q Exhibit 10, in the middle of the page, refers to a letter and report to the Federal Trade Commission. Do you see that?

A I do.

Q And was that a letter and report to the FTC that you were involved in preparing?

MR. MIHET: Form.

A Yes, I was involved in it.

Q Can you tell me what the report was about, please.

A Well, it's quite long. There are, essentially, three sections. The first section is, describes some of the fraudulent activity of certain witnesses sponsored by certain organizations that are pushing these bans on therapy and the report provides evidence that those witnesses are providing fraudulent testimony, the second section describes etiology and development of homosexuality and gender identity confusion or dysphoria, and the third section provides scientific evidence on sexual fluidity and research that suggests that attractions in gender identity is malleable and can change over time with and without therapy.

Q I'm sorry, did you say can change without

therapy?

A With or without therapy.

Q Thank you.

So that according to this e-mail, exhibit number 10, that was submitted to the FTC on May 2, 2017, is that correct?

A Yes.

Q What, if anything, have you heard about that complaint since you submitted it to the FTC?

MR. MIHET: Form, foundation, assumes facts not in evidence.

A Could you clarify that?

Q What don't you understand?

A Have I heard from whom?

Q I said, what, if anything, have you heard about the complaint since you submitted it to the Federal Trade Commission?

MR. MIHET: Same objections.

A The report's been written on and documented in the media.

Q Have you heard anything at all from the FTC?

A I have not.

Q Have you attempted to follow up with the FTC to find out what the status of your complaint is?

MR. MIHET: Form, mischaracterizes the testimony.

A Someone from the organization did, I did not.

Q Who did?

A I don't recall.

Q Did that person who attempted to follow up find out anything from the Federal Trade Commission?

A To my knowledge, no.

MR. MIHET: Could you, when appropriate, I could use a comfort break myself.

MS. ELLIS: Can we do the last exhibit here?

MR. MIHET: Sure.

MS. ELLIS: The last one in this group.

(Attachment to exhibit 10 was marked Exhibit 12 for identification.)

Q I'm showing you what's been marked as exhibit 12, which at the bottom of the page says Exhibit 4-60 and 4-61, also MD 0061 and 62. Do you see that?

A Yes.

Q Do you recognize this document?

A Yeah.

Q Did you write this document?

A I did.

Q And was it attached to your written testimony, exhibit 10, to the committee?

A That was the e-mail and this was the attachment.

Q So --

A Exhibit 10 was the e-mail, exhibit 12 was the attachment.

Q Thank you.

A Yup.

MS. ELLIS: If you want to take a break, that's fine.

MR. MIHET: Thank you.

(Recess.)

Q Could you get your copy of exhibit 4, please, the complaint.

You need to get Chapter 685, which is exhibit

7, as well.

If you could open exhibit 7 to page five, Chapter 685, exhibit 7, prohibits a mental health or a child care practitioner from engaging in conversion therapy with minors, correct?

MR. MIHET: Form, foundation, calls for a legal conclusion, the document speaks for itself.

Q Mr. Doyle?

A Yeah.

Q Is that correct?

A Yes.

Q Thank you.

And according to you, you do not engage in conversion therapy, correct?

MR. MIHET: Form.

A That's correct.

Q So, in what way, then, do you contend that Chapter 685 infringes on your First Amendment rights?

A The reason why this infringes on my First Amendment rights is that the term conversion therapy is overly broad and ill-defined, and while I do not contend

that I perform conversion therapy, the certain way that it's being defined here would affect my practice and some of the things I say to my clients and some of the things my clients say to me and possibly their goals as well and the way that I interpret certain clinical issues and nonclinical issues with the client.

Q So, in what way does the definition of conversion therapy affect your practice?

MR. MIHET: Form, asked and answered.

Q Go ahead.

A I'll let my previous answer be stated for itself.

Q And what previous answer was that?

A What I just said.

Q So, do you engage in practices or treatments that seek to change an individual's sexual orientation or gender identity?

MR. MIHET: Form, foundation, calls for a legal conclusion.

A There are certain therapeutic practices and techniques that I perform with the client that are also

standard psychological practices that may have an effect on a client's sexual identity, gender identity, attractions, behaviors, etcetera.

Q And do you engage in those practices for the purpose of seeking to change an individual's sexual orientation?

MR. MIHET: The same objections.

A If that's the client's desire and they're open to that, then it would be considered, yes.

Q I think you described your practice as sexual orientation affirming?

A Sexual and gender identity affirming therapy.

Q So, wouldn't that therapy come within the exception in (A)(2)(III), "Provides acceptance, support and understanding, or the facilitation of coping, social support, and identity exploration and development"?

A No.

Q No? Why not?

A Because a client's sexual or gender identity may not be the same as their attractions, behaviors, etcetera. Identity speaks as to how someone identifies

himself, and attractions and behaviors are experiences of the client.

Q So, tell me, then, what you mean by sexual identity affirming therapy. And was it sexual orientation --

A Sexual and gender identity affirming therapy.

Q So, tell me what you mean by that, then.

MR. MIHET: Objection, asked and answered.

A I'll answer it.

The client is entitled to identify him or herself as he or she wishes. Whether that corresponds to their behaviors, attractions or feelings is a different experience. So, I affirm their identity as they state and I work with them to resolve issues that may be getting in the way of that identity, which may include behaviors, attractions and feelings.

Q When you say to resolve issues that get in the way of that identity, what do you mean? Can you explain that?

MR. MIHET: Form.

A Resolving would be applying and speaking, in

therapy, certain types of therapy, such as cognitive behavioral therapy or psychodynamic therapy, all which involve speech, to help them, to help them understand and resolve certain unwanted attractions and behaviors or feelings.

Q Do any of your clients have unwanted heterosexual attractions?

A Yes.

Q And you attempt to resolve those?

A I do. Would you like an example?

MR. MIHET: She didn't ask you.

Q Absolutely, I'd love to have an example.

A Pedophilia.

Q Do you believe that pedophilia can be resolved?

A I do.

Q You do?

A I do.

Q Okay.

Is there any evidence that efforts to change a minor's sexual orientation are efficacious?

MR. MIHET: Form, foundation.

A The answer is, no, because there's been no research done on minors who have sought that.

Q Is there any evidence that such therapy may be harmful?

A The answer is, no, because there's not been sufficient research that's actually looked at the outcomes of clients that are minors that are engaged in this type of therapy.

Q Is there anecdotal evidence that conversion therapy may be harmful to minors?

MR. MIHET: Form, vague, ambiguous.

A It's such an overly broad and ill-defined term.

Q Which is? What is?

A Conversion therapy. Lots of problems with that term and definitions.

Q Is there any anecdotal evidence that efforts to practices or treatments to change an individual's sexual orientation or gender identity may cause harm?

MR. MIHET: Form, vague, ambiguous, compound.

A I'm trying to answer the question. There is anecdotal evidence for both, benefit and harm.

Q And if there is anecdotal evidence of both harm and benefit to minors, does the Legislature have the right to select one over the other, to believe harm rather than benefit?

MR. MIHET: Objection, form, speculation, calls for a legal conclusion.

A I'm not a legislator.

Q I understand you're not a legislator. What do you think?

MR. MIHET: Same objection.

A I don't think the Legislature is in the position of making that conclusion and determination.

Q Why not?

A Because I think --

MR. MIHET: Same objection.

A Because I think this issue is highly politicized and they've taken a mental health and emotional issue and politicized it to a point where the facts no longer matter.

Q Because you disagree with the actions that the Legislature has taken?

MR. MIHET: Same objection.

A I disagree with the actions of trying to fight a sexual culture war in a mental health field, which is what I believe is happening.

Q But you also disagree with the Legislature's actions in prohibiting certain treatments for minors, correct?

MR. MIHET: Objection, form.

A Can you be more specific?

Q Well, you object to the prohibition in Chapter 865 on a mental health practitioner engaging in conversion therapy with an individual who's a minor, correct?

A I object to it because I believe the term is overly broad and ill-defined.

Q I understand that --

A In that sense, yes.

Q -- but you object?

A Correct.

Q And you object to the Legislature having made that decision to ban that practice with a minor, correct?

A I don't believe the Legislature should be involved in that.

Q You don't believe the Legislature has the right to define what treatment, what types of treatments should be available to minors and what should not?

MR. MIHET: Form, foundation, calls for a legal conclusion.

A I have opinions.

Q What's your opinion? What's your opinion?

MR. MIHET: Same objections.

A I believe that highly politicized mental health and emotional issues such as this should not be legislated by the Legislature. I think they're better done in a state licensing or regulation board, with people that are objective.

Q Well, and that's what Chapter 685 does, isn't it? It defines the practice of conversion therapy on a minor as unprofessional practice under various practice

acts, correct?

MR. MIHET: Objection, form, calls for a legal conclusion, the law speaks for itself.

A Sure, yes.

Q That's because it says, in part C, "A mental health or child care practitioner who engage in conversion therapy with an individual who is a minor shall be considered to have engaged in unprofessional conduct," is that correct?

MR. MIHET: Same objections.

A That's what it says.

Q "And it shall be subject to discipline by the mental health or child care practitioner's licensing or certifying board," is that correct?

MR. MIHET: Same objections.

A That's what it says.

Q So, in effect, Chapter 685 does what you think it ought to do, it leaves it to the licensing board for professional counselors, for instance, to determine whether there's been unprofessional conduct, correct?

MR. MIHET: Form, mischaracterizes the statute and mischaracterizes the prior testimony.

A If I can comment on that, what I'll say is that because of the overly broad and ill-defined nature of what is called conversion therapy, it's very difficult to know if a counselor has actually violated the statute and whether they would be guilty of this law.

Q Without the statute, do you, in your view, in your understanding of the regulation of professional counseling, would the board of professional counselors have the ability to discipline a professional counselor who engaged in conversion therapy?

MR. MIHET: Form, vague and ambiguous, foundation, calls for a legal conclusion, calls for speculation, incomplete hypothetical.

Q You can go ahead and answer. Would you like the court reporter to read the question back to you?

A Yeah, please.

(The last question was read.)

MR. MIHET: The same objections.

A Without the statute, I don't believe the board would be able to engage in disciplinary action for someone that engaged in something that would be considered conversion therapy in this.

Q Have you agreed to pay attorney's fees for your client for your lawyer's representation in this lawsuit?

MR. MIHET: Objection, form, foundation and irrelevant.

Go ahead.

A No.

Q But your lawsuit is seeking reimbursement of attorney's fees, correct?

MR. MIHET: Objection, form, foundation, misstates the complaint in this case and calls for a legal conclusion.

A In the document, at the end, it does ask for The Court to pay reasonable costs and expenses of the action, including attorney's fees, according to the statute listed here.

MR. MIHET: For the record, Mr. Doyle was

reading from page 45 of the complaint, which has been marked as exhibit 4 in this deposition.

MS. ELLIS: Thank you, Mr. Mihet.

Q As I recall, you agreed that there was anecdotal evidence of harm as well as benefits to counseling seeking to change a minor's sexual orientation or identity. Do I recall correctly?

A You do.

Q Are you familiar with the precept first do no harm?

A Of course.

Q And do you agree that that precept applies to professional counselors?

A Absolutely.

Q If same sex attractions for adolescents frequently changed, and I think you used the word fluid before, why do you need therapy to address the issues related to same sex attractions?

MR. MIHET: Form.

A I don't know what the definition of frequent is in this sense. I think that that would be up to the

research that you look at, up to the population that you're treating.

Q I just used your language that same sex attractions are fluid. Why does one need therapy to address them?

MR. MIHET: Form.

A I think that would be best answered by the client.

Q You don't have any view about that?

MR. MIHET: Form.

A I'm open to a client's goal of experiencing fluidity or possible change in their attractions.

Q If you could turn to page 13 of the complaint, which is exhibit 4. Paragraph 53, SB 1028, which is Exhibit A to the complaint, and exhibit 7 -- is that --

MR. MIHET: Yes.

MS. ELLIS: Yes. Sorry.

MR. MIHET: To the deposition.

Q -- to the deposition, paragraph 53 states that, "SB 1028 falsely asserts that the statute is

necessary to protect minors from the purported harms of counseling to eliminate, reduce or resolve unwanted same sex attractions, behaviors or identity," correct?

A Correct.

Q And if you read through paragraphs 54 through 61, take a minute to read them to yourself and then I'll ask you about them.

A Okay.

Q And in your view, do the legal and ethical obligations imposed my Title 17 of the Health Occupations Article and Title 10, Subtitle 58, of the Maryland Code of Regulations adequately protect minors from any harm that might result from counseling to eliminate, reduce or resolve unwanted same sex attraction?

MR. MIHET: Form, vague, ambiguous and calls for a legal conclusion.

A I can't determine whether this would adequately protect a minor. I think that it does offer protection.

Q So, something more than the practice act and

the regulations governing the conduct of your profession may be required, do I understand that correctly?

MR. MIHET: Form, calls for a legal conclusion, misstates the testimony.

A If -- well, if what I believe that you're asking is that does the statute adequately protect clients from potential harm, is that what you're saying?

MR. MIHET: Which statute?

A The Maryland -- yeah.

Q Your complaint, in paragraph 54, says that you're already subject to obligations imposed by Title 17 of the Health Occupations Article --

A Right.

Q -- and I believe we established earlier that that is the title that governs professional counselors and therapists?

A Correct.

Q And Title 10, Subtitle 58, of the Code of Maryland Regulations, we haven't discussed before, but those are the regulations that govern your practice as a professional counselor, is that your understanding?

A Yes.

MR. MIHET: Form, foundation, calls for a legal conclusion.

A That's my understanding.

Q And you then go on to talk about all of those requirements --

A Right.

Q -- or several of those requirements in paragraphs 55 through 60, is that correct?

MR. MIHET: Objection, form, foundation, calls for a legal conclusion, mischaracterizes the nature of the document.

Q Is that what the complaint says?

A The complaint essentially says that the State of Maryland already protects against minors who may be in potential harm from licensed counselors, there's a regulation already intact before this law.

MR. MIHET: I'm sorry. For the record, when he said this law, the witness pointed to exhibit 7 to the deposition, which is Chapter 685, SB 1028.

MS. ELLIS: Thank you, Mr. Mihet.

Q And I believe that when we started this conversation, you said you weren't sure whether the practice act, Title 17 of the Health Occupations Article, and Title 10, Subtitle 58, of the Code of Maryland Regulations, provided adequate protection to minors, is that correct?

MR. MIHET: Form, asked and answered.

A I believe that the Maryland Code of Ethics before SB 1028 was passed, I believe the Maryland Code of Ethics provided adequate protection.

Q And what code of ethics are you talking about?

A For state licensed professional counselors.

Q Okay.

A Or licensed LCPC.

Q Are you talking about the Code of Ethics that is in the Code of Maryland Regulations?

A This is just definitions. There's an additional form of ethics codes that we have to abide by that I don't have in front of me.

Q It's that code of ethics that you don't have

in front of you --

A I do not.

Q -- you think it's that code of ethics that provides adequate protection?

A Correct.

Q If you could look at paragraphs 61 through 74, just read them to yourself.

A I'm familiar with these.

Q Are those voluntary obligations that a professional counselor might adopt?

MR. MIHET: Objection, form, foundation, calls for a legal conclusion.

A These are practice guidelines from a non-licensed trade organization that I belong to, but they're not ethics code.

Q And they're not binding on licensed professional counselors in the State of Maryland, is that your understanding?

A They're nonbinding.

Q And what is the organization that promulgates these guidelines?

A The Alliance For Therapeutic Choice and Scientific Integrity, formerly known as NARTH, or the National Association For Research & Therapy of Homosexuality.

Q And you're a member of that organization?

A I am.

MR. MIHET: Form.

Q If you could look at paragraph 76, on page 16, that paragraph says, "Thus, existing legal and ethical obligations regulating Licensed Clinical Professional Counselors, both compulsory and voluntary, demonstrate that Maryland's stated rationales for adopting SB 1028 are fallacious, pretextual and unsupported by any governmental interest." Did I read that correctly?

A Yes.

Q And could you please explain that.

A Well, essentially what it says is that SB 1028 is unnecessary, based on the fact that ethics in the State of Maryland already offer sufficient protection for clients that are minors.

Q And that's your opinion, correct?

A Yes.

MR. MIHET: Counsel, for the record, I'm noticing that at least my copy of this exhibit appears to be missing page 17. I'm not sure if the deposition copy --

THE WITNESS: Yeah.

MR. MIHET: -- has the same flaw.

MS. ELLIS: That appears to be the case. I don't quite know where it went, but we will fix that when we take a break for lunch.

Is that page 17?

MR. MIHET: Yes.

Q In paragraph 101, which is on page 21, you say that you have devoted most of your professional life to providing counseling to young people and their parents who are seeking help for unwanted same sex attractions. Senate Bill 1028 does not affect your ability to counsel parents, correct?

MR. MIHET: Objection. Counsel misread paragraph 101 and is now grossly mischaracterizing it.

Q Does Senate Bill 1028 affect your ability to provide counseling to parents?

A Not that I'm aware of.

Q Okay. Thank you.

And I believe that you told me that at any one time you may have three or four minor clients?

MR. MIHET: Form.

A At any time?

Q Yeah.

A Possibly more, sometimes it may be less.

Q You said 10 to 15 percent?

A Yeah. I mean, it varies.

Q Right.

Will you accept a client, a minor client, who does not want to change his or her sexual orientation or same sex attractions even though his or her parents want the minor to change?

MR. MIHET: Form, vague and ambiguous.

A Yes.

Q And has that actually happened?

A Yes.

Q And if you look at paragraph 115, on page 24, the second sentence, "But plaintiff does not begin counseling with any predetermined goals, other than those that the clients themselves identified and set," is that an accurate description of your practice?

A Yes.

Q Do you consider your counseling noncoercive?

A Yes. Let me amend that.

Q Okay.

A The only coercion that I do in my counseling is with parents.

Q And in what way do you do coercion with the parents in your practice?

A If a parent, such as the situation they described, wants their minor to change their sexual orientation or gender identity and the minor does not, I will attempt to persuade the parents to not put pressure on their children and educate them on how better parenting practices would be and how to avoid harming their child and I put much more effort into that than any of the slightest coercion on a minor.

Q If you could look at paragraph 118, on page 25, the last sentence says, "Plaintiff has never publicly stated that he believes homosexuality or same sex attractions is a mental illness in need of a cure." Do you see that?

A Yes.

Q Is that an accurate statement?

A Yes.

Q Have you ever said that privately?

A I don't believe so.

Q Do you believe that?

MR. MIHET: Objection, form.

A Believe what?

Q Do you believe that homosexuality or same sex attractions is a mental illness in need of a cure?

MR. MIHET: Asked and answered.

A I don't believe it.

Q Thank you.

In your understanding, I'm not asking for a legal conclusion, does Senate Bill 1028 prevent you from communicating with the public about conversion therapy

or sexual orientation change efforts?

MR. MIHET: Objection. It does call for a legal conclusion.

A Yes.

Q And why is that?

MR. MIHET: Same objections.

A Because under the statute, under number D, "No state funds may be used for the purpose of conducting, referring an individual to receive conversion therapy, help coverage for conversion therapy, grant or contracting of an entity," etcetera, the state is taking a position that a broadly, ill-defined term that may encompass some of the counseling that I do shall not be in any way a part of state funding or anything education-wise, which is a part of my nonprofit, and that has a direct effect on educational campaigns that I may do and have done in the past.

Q So, do you receive funds from the State of Maryland, government funds, state funds, at this point for any of your activities?

A In the past work that I did, I had an educational anti-bullying campaign that was a part of public education in Prince George's County, and because of the hostile political nature in Maryland and members of the government in Maryland, that program was thrown out. I spent hundreds of thousand dollars out of the nonprofit I was working on to develop that program and so this directly would impact any future efforts to do that kind of work.

Q Because your anti-bullying campaign was somehow conversion therapy?

MR. MIHET: Objection, form, misstates the testimony.

A It discussed therapeutic efforts to help clients resolve unwanted same sex attractions, in the context of bullying.

Q I'm trying to understand your testimony. Subsection D, on page six of exhibit --

A 7.

Q -- 7, says, "No state funds may be used for the purpose of" these three items. How does that affect

your ability to speak about conversion therapy?

MR. MIHET: It calls for a legal conclusion.

A In my opinion, if I wanted to introduce such a program in the State of Maryland again, as I did in 2013, and I would want a public high school to purchase materials to help educate the class through these materials that we invested a lot of money in, the state would be obligated not to allow that to happen, as well as there could be an interpretation that a child or a parent watching this video is just somehow a referral or somehow a referral mechanism by providing information.

And also, I'll also add to this, with the program's website, listed several referral organizations, both pro LGBT and also those who were seeking assistance for unwanted same sex attractions and gender identity, so this would directly impact that.

Q Senate Bill 1028 does not, in your view, affect your ability to speak to a group about, if invited, to speak about conversion therapy, does it?

MR. MIHET: Form, vague and ambiguous, calls for a legal conclusion, lacks foundation.

A I don't know.

Q You don't know?

A No. It's up to the interpretation of those enforcing the regulations and it's very vague. In my opinion, it provides a chilling effect to anyone who has a different opinion than the Legislature.

Q Are there any other prohibitions in Chapter 685? B says, "A mental health or child care practitioner may not engage in conversion therapy with an individual who is a minor," correct?

MR. MIHET: Objection.

A What page are we on?

Q Page five.

A Okay. B says, "A mental health -- " okay.

Q And D says, "No state funds shall be used" for various purposes, correct?

A Those two are correct, yes.

Q Based on your reading of 685, Chapter 685, does it prohibit anything other than engaging in conversion therapy with an individual who's a minor for certain licensed practitioners or state funds being used

for those three purposes?

MR. MIHET: Form, vague and ambiguous, foundation, calls for a legal conclusion, and the law speaks for itself.

A Well, there is a problem with the idea of health coverage. Under D, subsection (D)(2), that could possibly affect, could possibly have an effect, although I can't say for sure.

MS. ELLIS: Can you read back the question, please.

A Oh, so you're -- okay.

MR. MIHET: Sorry. She asked the reporter to read back the question, so let's listen to that.

THE WITNESS: Okay.

(The last question was read.)

MR. MIHET: Let me interpose the same objections that I did to the original question.

Go ahead.

A Not that I can see here.

Q Thank you.

MS. ELLIS: I suggest that we take a break

for lunch. I probably have another hour or so.

MR. MIHET: Are you sure you can't power through?

MS. ELLIS: I get very cranky. I'm sorry, I really do need to eat.

MR. MIHET: That's fine.

(Luncheon recess.)

Q Mr. Doyle, are you currently engaged in doing any research?

MR. MIHET: Form, vague and ambiguous.

A In what capacity?

Q As a licensed counselor, are you doing any research related to counseling?

MR. MIHET: Same objections.

A Not at this time.

Q Have you in the past engaged in such research?

A Yes.

MR. MIHET: Same objections.

Q Would you please tell me about the subject of that research.

A Well, I have a couple of articles published in peer reviewed journals on my therapy, as well as a critique of the APA task force, task force report, and at one time I began a research project looking at the outcomes of youth undergoing therapy around homosexuality, but that research is currently not really proceeding.

Q Why not?

A It's mostly a problem of subjects, trying to find enough subjects that we can sample data and it's been challenging.

Q Did you start that research with any hypotheses that you were hoping to test?

MR. MIHET: Form.

A We wanted to determine what kind of outcomes minors would experience in therapy for conflicts around sexual and gender identity issues to see if there was benefit or harm and determine what would that be and try to figure out -- because there's not really any outcome research based on clients that have really undergone types of interventions that might be open to fluidity or

change.

Q And you said we. Were you doing this research with someone else?

A Yeah, two colleagues.

Q Who is that?

A Dr. Walter Schumm and Dr. James Phelan.

Q And have they also stopped doing research on that topic?

MR. MIHET: Form.

A To my knowledge, they haven't done any more.

Q And so, if I recall correctly, you said that you were having trouble getting a sample big enough?

A That was one problem.

Q Were there other problems?

A Funding, which would also lead to an issue in the sample, because in order to be able to get a sample, you have to have funds to recruit, have more than just word of mouth.

Q So, how would you characterize the progress that you made in doing this research?

A Well, the sample, the questionnaires that we

developed were finished. We also included a separate questionnaire for participant well-being before to determine whether or not the therapy they had received actually increased or decreased their well-being, based on their own levels of what they assessed for themselves before they take the survey. All of those preliminary, you know, mechanisms were done, it was more of an issue of funding and recruitment.

Q Were there any institutional review board issues?

A That was also an issue that we hadn't secured, but it was also due to funding and being able to actually spend time and resources, which is very intensive.

Walter Schumm, he's a professor at Kansas State University, was thinking about putting it through his IRB, but we didn't get that far.

Q How did you spell his last name?

A S-C-H-U-M-M, I believe.

(Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth was marked Exhibit 13 for

identification.)

Q I'm handing you what has been marked as exhibit 13, which is a report dated October 2015 from the Substance Abuse and Mental Health Services Administration, called Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. Are you familiar with this report?

A I am. I haven't read the whole thing, but I'm familiar with the general concepts.

Q If you turn to page two, at the bottom of the left column, it says, "Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the assistance of behavioral health providers." Do you agree with that assessment?

A I one hundred percent disagree with that assessment.

Q And why is that?

A Because in my experience personally and professionally, I have many, many examples where

teenagers, young adults, including myself, were distressed by amorphic attractions and gender confusion without any parental involvement.

Q Has that been your experience in your clinical counseling practice, too?

MR. MIHET: Objection, asked and answered.

A I have experience from children distress, teenager distress, as well as parental distress, both, but this characterizes it as -- let me read this again.

Where does that start, the second paragraph?

Q It starts five lines from the bottom of the left-hand column.

A "Children are rarely if ever distressed about their current or future sexual orientation." Okay. And the interesting thing about that is, it cites the American Psychological Task Force Report from 2009 and that didn't rely on any good research on adolescents or children on this issue. It's merely a political opinion of the APA.

Q Is there an organization for professional counselors analogous to the American Psychological

Association for psychologists?

MR. MIHET: Form.

A Well, I wouldn't say it's analogous, but there are merely -- well, let's just say this. There is the Alliance, there is the American Association of Christian Counselors. The AACC has over 60,000 members, perhaps 65,000, and they support a client's right to, you know, experience fluidity and change in therapy.

Q And could you tell us what the AACC is.

A American Association of Christian Counselors.

Q And the Alliance that you referred to is?

A The Alliance For Therapeutic Choice and Scientific Integrity, and there are other organizations, like the Catholic Medical Association, the Christian medical and dental associations, there's Orthodox Jewish organizations. There's probably, roughly, ten that include therapeutic professionals.

Q Is there an American Counseling Association?

A There is.

Q Are you a member of that?

A I am not.

Q Is there any particular reason?

A Because they're biased towards liberals and don't like me or the work that I do and I won't be subject to their ethics codes in that respect because I don't think they look at all the evidence.

Q Do you think that you ought to have, the therapists, professional counselors, ought to have unfettered choice in the types of treatment that you provide?

MR. MIHET: Form.

A No.

Q Do you think that the type of therapy or type of treatment that you provide is subject to reasonable regulation?

MR. MIHET: Form, calls for a legal conclusion.

A Under the existing ethics code of Maryland for counselors, I think it's subject to enough regulation.

Q Most people do.

But, in general, I understand what you're

saying with respect to the ethics code and the statutes for professional counselors. In general, do you think the Legislature has the right or ought to have the right to regulate treatment provided by therapists?

MR. MIHET: Form, asked and answered, calls for a legal conclusion.

A They have the right, but in my knowledge, the Legislature has never legislated an issue like this from a therapeutic perspective. It's usually done by the regulatory boards. So, it's unprecedented.

Q So, if the regulatory boards, if the professional counselors board said conversion therapy is prohibited for minors, would you think that was okay?

MR. MIHET: Objection, form, calls for speculation, calls for a legal conclusion and it's an incomplete hypothetical.

A The answer is --

Q Subject to all of your counsel's objections.

A The answer is, I wouldn't think it's okay, but I do think the board, regulatory boards, have reasonable regulations on certain types of therapeutic

activities that should be regulated.

Q For instance?

A Well, there are certain types of therapy and practices that are unethical, for example, you know, forming relationships with clients, you know, certain ways of advertising marketing, not misrepresenting yourself, not engaging in practices that you're not trained for. These are all, you know, therapeutic process questions on how to do therapy right.

Q And you think the boards have the right to regulate those?

A I do.

Q Any other kind of regulation that you think is appropriate from the boards?

MR. MIHET: Form, speculation, legal conclusion.

A There are many.

Q Excuse me?

A There are many things that the board regulates, I couldn't list them off by -- I couldn't list them, memorize them.

Q I'm not asking you to repeat some remembered or memorized list, but are there any other areas that you think it's appropriate for, for instance, the Board of Professional Counselors & Therapists to regulate?

MR. MIHET: The same objection.

A I think I'd have to consider that in light of what they were proposing. There's lots of things that could be regulated.

Q Is there anything else that should be regulated that's not?

A Well --

MR. MIHET: Form, speculation --

A -- if you want to know.

MR. MIHET: Let me finish.

Form, speculation, calls for a legal conclusion.

Q In your view as a Licensed Professional Counselor, are there areas that the board of professional counselors should regulate that it does not?

MR. MIHET: Form, speculation, calls for a

legal conclusion.

A I believe that for minors it would be appropriate to, who don't have consent, it would be appropriate to regulate things like aversion therapy, electric shock, physical harming, causing physical pain, things like that, I think that would be appropriate.

But there is one interesting thing about that. No run-of-the-mill counselor that's licensed by the state could engage in that type of work, it's really only done in like a medical hospital. There's really no instances among licensed counselors that they can point to in the last 40, maybe 50 years that have gone through these types of aversion therapies.

Let me amend that statement; that have gone through it for sexual or gender identity.

Q If you could look at exhibit 5, please. If you look at your answer to interrogatory number one on page two, you list Christopher Shank, Chief Legislative Officer for Governor Hogan, as somebody with knowledge about facts alleged in the pleadings, and it says that there was a May 14, 2018 conference call with him. Do

you see that?

A Yes.

Q Did you participation in that conference call?

A Yes.

Q Who else participated?

A Peter Sprigg, for the Family Research Council.

Q Did Delegate Parrot participate?

A I don't recall.

Q Was Mr. Sprigg on the phone or in the office with Mr. Shank?

A I believe he was in the office and I was conferenced in, yeah. I don't know if Delegate Parrot was there or not. I wasn't involved in the whole meeting either.

Q How long were you on the call?

A About 15 minutes.

Q And what happened during those 15 minutes?

A I just explained to the Governor's aide that why I thought this law was bad and how I'd be affected

by it and the problems that I saw with it and how I thought it would curb really just freedom of speech both for counselor and client.

Q Did Mr. Shank ask you any questions?

A He did, but I don't really recall the questions.

Q Did he say anything else?

A He listened. He didn't say much, really. He asked a couple questions. Mostly it was around how you'll be affected, how -- yeah, I think he also may have asked, you know, do you know other licensed counselors in Maryland that'd be affected and I said yes, but I was reticent to give their names, just like I was reticent to give you a name.

Q What did Mr. Sprigg say, if anything?

A He -- not much, really. It was more he wanted Mr. Shank to be able to hear from a prospective therapist that was doing work around that would be affected by this law.

Q And who is Mr. Sprigg?

A He's a policy analyst at the Family Research

Council, in Washington, DC.

Q What's the Family Research Council?

A It's a nonprofit, conservative based research organization that promotes Christian values of variety, Christian values, including sexuality.

Q Did you have any conversations with Mr. Sprigg after the telephone call?

A Maybe --

MR. MIHET: Form, vague and ambiguous.

A There may have been a text message or an e-mail that just I maybe asked him, "How do you think it went?" and that's about it.

Q What did he say?

A He said he thought it went well. I mean, that's -- I'm paraphrasing. But, you know, I think he said something to the nature of, he didn't know, he didn't know if it was going to convince the Governor or not to sign the bill.

Q In fact, it, apparently, did not, correct?

A Another reason why I didn't testify.

Q Did you have any other conversations with

anybody connected, that worked for Governor Hogan, after the bill passed, before he signed it?

MR. MIHET: Form, vague and ambiguous.

A Not that I know of.

Q If you look above the entry for Mr. Shank and Mr. Sprigg, you identify both defendants as having information that identify them as persons likely to have personal knowledge of facts alleged in the pleadings. Could you tell me what information you think the Governor has about drafting of Senate Bill 1028.

A I can only speculate.

Q Can you tell me what information you think that the Governor has about the sponsoring of Senate Bill 1028?

A I could only speculate.

Q Can you tell me what information you believe the Governor has about the consideration by the Legislature of Senate Bill 1028?

A Can I tell you what information I think the Governor has? Well, most likely, he probably has opinions from people that testified, written testimony

and -- but he would have relied on his aides, most likely, for that.

Q Can you tell me what information the Governor may have about the debate of Senate Bill 1028?

A I can't tell you that.

Q Can you tell me what information that the Governor may have about the passage of Senate Bill 1028?

A Well, he signed it.

Q Can you tell me --

A I'm sure he's familiar with the fact since he signed it, so I'm sure he's been briefed on it.

Q Can you tell me what information you think the Governor has about the interpretation of Senate Bill 1028?

A I don't know.

Q Can you tell me what information you think the Governor has about the application of Senate Bill 1028?

A Application in what sense? How the law is carried out?

Q Your answer to interrogatory, Mr. Doyle, says

that, "Lawrence J. Hogan, Jr., Governor of the State of Maryland, is likely to have personal knowledge of facts alleged in the pleadings related to the application of Senate Bill 1028."

MR. MIHET: Objection, form, mischaracterizes the nature of the document.

Q Can you tell me what information that you think Governor Hogan has about the application of Senate Bill 1028.

A The only answer I could give was that if the Governor signed the bill into law, then his staff was familiar with what was going on as far as the bill passing through the Legislature, the debate, the testimony, how it might be applied and so forth. I would be highly surprised if the Governor wasn't aware of any of those things.

Q And what do you base that statement on?

A I think that there were more than one person that opposed that bill, there were people in the Legislature that opposed that bill, and I think that it made some media attention, and I think that that had to

have been heard by Governor Hogan, that he must have had some information on delegates that were opposed to this, including Delegate Parrot, who made his opposition vote vocal. So, I'm sure, I mean, I can't say a hundred percent that he did, but I would say that beyond a reasonable doubt that he did.

Q What information do you think Governor Hogan has about the enforcement of Senate Bill 1028?

A As much as he needs to.

Q Do you think that he has any authority to enforce Senate Bill 1028?

MR. MIHET: Objection, calls for a legal conclusion.

A Well, I'll not a lawyer, but he is the head of the executive in Maryland and he has to oversee that, that's what that governor does.

Q Do you think he has the authority to tell the Board of Professional Counselors & Therapists to enforce Senate Bill 1028?

MR. MIHET: Objection, calls for a legal conclusion.

A Could you state that question again.

Q Do you think that the Governor of the State of Maryland has the authority to tell the Board of Professional Counselors & Therapists to enforce or not enforce, for that matter, Senate Bill 1028?

MR. MIHET: Same objection.

A I think he could.

Q The next entry lists Brian Frosh, who is the Attorney General of the State of Maryland, as having information about drafting, sponsoring, consideration, debate, passage, interpretation, application and enforcement of Senate Bill 1028. What information do you contend Mr. Frosh has about drafting of Senate Bill 1028?

A I can only speculate on all of those.

Q Well, speculate. What do you think he knows?

MR. MIHET: Objection, calls for speculation.

Q What role do you think he played in any of those?

MR. MIHET: Objection, calls for speculation.

A Yeah, I don't know. I can speculate, that's

it.

Q But you contend that he has information about all of those topics, correct?

MR. MIHET: Objection, form.

A I believe he could.

Q And do you believe that Mr. Frosh, as the Attorney General of the State of Maryland, has the independent authority to enforce Senate Bill 1028?

MR. MIHET: Objection, calls for a legal conclusion.

A I don't know.

Q Why did you include the Attorney General as a defendant in the lawsuit?

MR. MIHET: Objection, calls for a legal conclusion.

And I'll caution the witness not to disclose any communications that you may or may not have had with your counsel about that. So, answer this question only to the extent that you can without relying upon or disclosing those conversations.

A My opinion would be that the Attorney General

is in charge of carrying out the law.

Q And that was the basis for including him as a defendant?

MR. MIHET: Same objection and same instruction.

A Yeah, I'll just leave it at that.

Q And what was your basis for including the Governor as a defendant in this lawsuit?

MR. MIHET: Same objection and same instruction.

A He signed the law.

Q You've testified on different occasions today about the Alliance of Therapeutic Choice and Scientific Integrity. Is that another organization that you were involved in forming?

A No.

Q But you're a member now?

A I am.

Q And what is the purpose of that organization?

A To further the research and therapeutic assistance of clients that have sexual identity or

sexual conflicts. It's more recently delved into the gender identity issue, but it has not historically been involved in that issue.

Q And does it sponsor research?

A Yes, in an informal sense.

Q What do you mean by an informal sense?

A It has a peer reviewed journal that it publishes annually and seeks members to contribute to that journal. It doesn't, to my knowledge, fund any of the research, usually single practitioners or groups of practitioners would be responsible doing that, but it does dedicate, you know, a significant amount of time and resources in order to publish the document that it publishes.

Q And what's the name of its peer reviewed journal?

A Journal of Human Sexuality.

Q How many members, if you know, does the Alliance have?

A Roughly, a thousand.

Q Are there any membership qualifications?

A There's different tiers of membership. There's clinical membership, there's faith-based membership, there's general public membership.

Q And what is NARTH?

A That is the name National Association For Research & Therapy of Homosexuality, the name the Alliance was previously called until years ago.

Q Why did the Alliance change its name, if you know?

MR. MIHET: Objection, foundation.

A I'm not on the board, I couldn't tell you.

Q You also mentioned Voice of the Voiceless. What is that?

A It's a 501(c)(3) organization I founded in 2013 to advocate for former homosexuals and individuals that have unwanted same sex attractions and gender identity conflicts.

Q And did you choose the name of the organization?

A I did, yeah.

Q And why did you choose that particular name?

A Because I thought that the community that I serve and that I belong to is relatively voiceless and maligned by the media and popular culture and misunderstood and I felt like that we needed to have people advocating for them and give them a voice.

Q Is it a membership organization?

A It's -- no. It has an advisory board.

Q Does it have staff?

A No. All volunteer.

Q How many volunteers does it have?

A 10.

Q And what is your role with the organization since you founded it?

A I was the president for the first few years, now I'm the treasurer.

Q Are you familiar with a documentary called Sunday Sessions?

A Of course. I was wondering when this was going to come up.

Q How are you familiar with that?

A I was in it.

Q You and who else?

A A client of mine.

Q And how did that documentary come to be made?

A A Baltimore filmmaker approached me back in 2015, I believe, maybe it was 2014, and said he was interested in following my work and showing it from a fly-on-the-wall perspective, and I didn't think that I would do it, nor any of my clients would want to do that and so I said, originally, no, and then he kept on bothering me and I vetted him, I thought he was pretty neutral, turns out he wasn't, but the film -- so, basically, that's it. Yeah, that's how it came to be.

Q And a client participated, agreed to participate?

A Yeah, surprisingly.

Q Do you think it is a fair representation of your practices?

MR. MIHET: Objection, form, vague and ambiguous.

A I would say no.

Q Why not?

A Because after I watched the film, after the filming what I realized was that the filmmaker pared down dozens and dozens of hours of therapeutic footage in order to create a narrative and ignored lots of other clinical issues that were discussed in therapy, and the political narrative was, basically, that the client's main goal was to get married to a woman, which it wasn't, that was a peripheral issue, but it pretty much every or almost every therapeutic sequence that he showed between me and the client was this client talking about marriage, when we talked about lots of stuff. So -- and that's since I had no control over the content and I regret that. But nonetheless, the client actually did quite well and is still well-adjusted today.

Q Did you think that the filmmaker had a political agenda?

MR. MIHET: Form.

A I think his bias, I think his bias set the agenda. I wouldn't say it was a political agenda, but he certainly had his own bias, and after the filming was over, he only recruited and marketed the film to the

LGBT activist community and had no interest in really allowing me or the client to -- well, the client didn't want to speak, but allowing me to really be a part of any sort of promotion and marketing or -- and he also mislabelled my work, he also said that I did conversion therapy, when I explicitly said to him that's not what I call my work. He also took a therapeutic sequence out of order, which was in our signed agreement that he wouldn't do that, but I don't have a law firm that was willing to take them to battle, take him to battle for that, nor did I really seriously consider it, but.

Q What do you believe his bias to have been?

A Well, essentially, that sexual attractions are innate and there's no fluidity or change, that people are born LGBT and that therapy is ineffective or unhelpful.

Q I understand that you object to the extent to which he edited the interactions, but what was represented, was that an accurate portrayal of your practice and how you interact with clients?

MR. MIHET: Objection, form, asked and

answered.

A Every client is different and I would not say that the therapy I did with that client was, necessarily, representative of all therapy that I do with clients. There are some similar elements. But client therapy is client centered. What the client needs will determine any number of types of therapeutic tools or any ways of speaking about certain issues, based on my training and my experience, my knowledge. Sometimes clients just ask for advice, it has nothing to do with therapy, and I've experienced that with many populations.

Q Could you tell me about your education. Somehow I missed that in the introduction.

MR. MIHET: We're going backwards.

MS. ELLIS: We're going backwards. I'm filling in the holes here.

A I have a master's degree in professional counseling from Liberty University, and I have an undergraduate degree in political science and an undergraduate degree in history from Grove City College

in Pennsylvania. I also graduated seventh in my high school class, if that matters.

Q It's impressive. Where did you go to high school?

A Springdale High School, in Pennsylvania.

Q What part of Pennsylvania?

A Near Pittsburgh.

I came in second in the elementary spelling bee.

Q I'm glad. Congratulations.

A I should have won.

MS. ELLIS: If I could just to take a few minutes with my colleague here, I think we're probably done, at least done for the purposes of the preliminary injunction.

(Recess.)

(Sexual Orientation Change Efforts Among Current or Former LDS Church Members was marked Exhibit 14 for identification.)

Q Mr. Doyle, I'm showing you what's been marked as exhibit 14, an article entitled Sexual Orientation

Change Efforts Among Current and Former LDS Church Members from the March 2014 Journal of Counseling Psychology. Are you familiar with this?

A Relatively, but not -- not specifically, but I reviewed this before.

Q And according to the abstract, it concluded that sexual orientation is highly resistant to explicit attempts at change and that SOCE are overwhelmingly reported to be either ineffective or damaging by participants?

A That's what the study says.

Q Okay. Thank you.

MR. MIHET: And I object to form and foundation belatedly.

A But there is a problem, though.

MR. MIHET: You weren't asked that.

Q What's the problem?

A To my knowledge, there's no minors that have been included in the sample and it's irrelevant to the law in Maryland. It's a different population.

Q Okay.

Does the fact that this deals with a different population than the population that is subject to the law in Maryland have anything to do with the validity of the study?

MR. MIHET: Objection, foundation.

A The study has a lot to do with the implications of this law and the fact that it's irrelevant to this law, that's my answer. That's my opinion. And I can also point you to studies that have recently come out that have actually looked at a client population that's highly religious, they're adults, that was published just in 2018, from the Leineke -- I can't say it, but it's got a Leineke quarterly -- I might have said that wrong -- but looked at 125 male subjects and the majority of them experience sexual orientation change in therapy.

Q And were those minors?

A They were not.

Q So --

A There's no research that has looked at outcomes in minors in therapy for this issue.

So, what I'm trying to say here is, that this is not generalizable to the population of minors.

Q I simply asked you if you were familiar with it and whether the fact that it doesn't involve minors --

A Sure.

Q -- affects the validity of the study and that's the extent of the questioning.

MR. MIHET: I'm sorry. I object to the mischaracterization of the question that was posed. I think the record will adequately state the questions and the answers that were provided.

MS. ELLIS: That is all I have at this time, although I do reserve the right to resume the deposition if this litigation goes beyond the or when it goes beyond the preliminary injunction stage.

MR. MIHET: So, we would object to that. We think the rules are clear that one person may only be deposed once in the course of an action, whether it's at the PI or merit stage, and so we would encourage you to ask all the questions that you have today because we

will object to the witness being made to come back and that's something that, you know, that we would have to involve The Court if we can't reach agreement, so.

MS. ELLIS: Well, as you said repeatedly in your discovery responses, this is a very early stage of the litigation and we'll agree to disagree on that, Mr. Mihet.

MR. MIHET: Okay.

I do have some questions for the witness myself.

EXAMINATION BY COUNSEL FOR PLAINTIFF

BY MR. MIHET:

Q Mr. Doyle, early on in your deposition today, you were asked about and you identified three entities or organizations that you're affiliated with in the course of your counseling. Do you remember that testimony?

A Yes.

Q And I believe you testified that all three are based physically in Virginia?

A That's correct.

Q And I believe you were asked whether or not you provide counseling at any other location besides those three. Do you recall that question?

A Well, I -- what I recall was that I thought I was asked what organizations are you affiliated with and give counsel with.

Q Okay.

And you only do counseling within the course and scope of your affiliation with these three entities?

A Right.

Q That being the case, though, do you sometimes travel outside of Virginia to provide counseling?

A Yes, including Maryland.

Q Have you traveled to Maryland within the past three years to provide counseling?

A Yes.

Q Do you wish to continue to travel to Maryland in order to provide counseling?

A Yes, because I'm referred clients all the time from Maryland that are including minors.

Q Is it your intention to continue to travel to

Maryland for the purpose of providing counseling once this law that you are challenging is enjoined by The Court?

A Yes.

Q Now, in the course of your counseling, are you sometimes approached by minor clients that present with unwanted same sex attractions?

A Yes.

Q And that present with stress or anxiety that results from their unwanted same sex attractions?

MS. ELLIS: Objection.

A Yes.

Q And are you sometimes presented with clients who come to you because they have unwanted gender identity confusion?

A Yes.

Q And do they present with anxiety or stress resulting from the gender identity confusion?

A Yes.

Q And in both of those cases, do those clients sometimes include minors?

A Yes.

Q And --

A I currently have minors in that situation.

Q And are these minor clients sometimes residents of the State of Maryland or the Commonwealth of Maryland?

A Yes.

Q When you are approached by such minor clients who are residents of the Commonwealth of Maryland --

MS. ELLIS: Correction, it's the State of Maryland.

Q -- the state -- the State of Maryland, do they sometimes identify a goal that they have for themselves to change or reduce or eliminate the unwanted attraction or confusion?

MS. ELLIS: Objection to form.

A Sometimes they do, sometimes they don't.

Q In those cases where the minor clients identify a goal of changing, reducing or eliminating the unwanted attractions or confusion, do you wish to provide them with the counseling that they seek in order

to accomplish their self-chosen goals?

MS. ELLIS: Objection to form.

A Yes, I do, and currently --

Q Well, you've answered my question. Let me ask you another.

Currently, within the State of Maryland, are you able to provide them with the counseling that they seek in those circumstances?

A No, not the counseling they seek, nor the counseling I would like to give. I can't give the full range of services that I would like to give.

Q And why not?

A Because the statute, the statute determines that the work that I do is called conversion therapy, although I object to that title and label.

Q Well, but you don't call that work conversion therapy. I believe that was your testimony, right?

A No.

Q But you believe that the statute subsumes the work that you do within its definition of conversion therapy?

A Yes.

MS. ELLIS: Objection to form.

A Yes. I believe the statute labels and describes my work under that umbrella term of conversion therapy.

Q Now, I believe you also testified that in some states you've engaged in I believe what you called the coaching, where in others you've engaged in therapy.

A Correct.

Q Do you recall that testimony?

A Yes.

Q In the State of Maryland, have you engaged in coaching?

A I have not.

Q Do you engage in coaching?

A No. Anything I'm doing in Maryland is under my therapeutic license.

Q I believe you testified you're licensed by the State of Maryland?

A Correct.

Q Are you able to engage in any counseling

activities that fall outside of that license in the State of Maryland?

A I don't believe that, I believe that would be in direct violation of my license. If I'm operating as a therapist, I have to operate as a therapist and then call myself something else.

Q Okay.

A I'd be misrepresenting myself.

Q You were also asked some time ago today whether or not you would ever accept a client who does not want to change their orientation or identity even though his or her parents want to see a change. Do you recall that testimony?

A Yeah, I do.

Q And I believe I heard you say that you would accept such a client. Did I hear that correctly?

A I would.

Q I think I also heard you testify that in those situations you would apply some pressure, I think the word you used was coerce, the parents to change the expectations and the goals that they have to be more

accepting of the minor's goals and to be more aligned with the minor's goals. Did I hear that testimony correctly?

A Well, counsel was talking about the issue of asking whether I engaged in coercive therapy and I said that I don't for minors, but I would engage in some form of coercive therapy. A better term that I would probably use is persuade, rather than coerce and --

Q And what would you seek to persuade the parents in these kinds of instances?

A Yeah. I would persuade them to allow their child to pursue the goals and the objectives that they want to pursue and not try to influence and push the child into some sort of therapeutic intervention that the child does not want.

Q And what would you do in a situation where your efforts to persuade the parents along the lines that you've just testified about are not successful, where the parents persist in having goals and desires that are at odds with the goals and desires of the minor client?

A Well, there's actually two situations that this would be -- this would come up. Number one is, it's not uncommon for a family with a minor to do a consultation with me before they involve their child in counseling, regardless of the goal of what their child is, and I would speak with those parents and I do speak with those parents before the minor enters counseling and I tell them what my policies are for non-coercion, what my expectations are for family to participate in therapy and for the family and the parents to engage in noncoercive actives and so forth.

So, I speak to them about that and I tell them this is, basically, my therapeutic protocol and what I do and what I expect from you in the process in order for this to be a successful therapeutic experience for the family, and if the family and the parents are not willing to abide by what I've asked them to do, I will never take them on as a client to begin with and I give them a consultation and that's it.

The second one would be if we had started engaging in therapy with the child, as the minor, and

the parents and then I recognize that there was some coercion, subtle as it may be in some instances, going on, I will insist that the parents not do that. I would work with the parents to help them understand how this could be harmful or ineffective, and if they persist in doing that, then I will terminate the relationship and if I can, you know, I'll provide a referral for a therapist that I think may be able to help that family better than me.

Q Would you refer them to a therapist that would be willing to provide a course of counseling that addresses the and seeks to accomplish the parents' goals over the child's goals?

A No. I would refer them to a therapist that I knew that would act ethically and properly in the relationship and keep those goals separately and --

Q What would be your hope or desire in making the referral, what would you hope that the other therapist would be successful in accomplishing?

A Well, mainly that they would be able to persuade the parents to not to try to coerce the child.

Q You were asked about there being anecdotal evidence of harm or benefit from change counseling. Do you recall those questions?

A Yes.

Q Is there any evidence, anecdotal or empirical, that harm may result from psychotherapy or counseling that is outside of the context of sexual orientation or gender identity change efforts?

A Yeah, there is evidence.

Q What do you understand that evidence to be?

A Roughly, that all clients have between 5 and 10 percent risk of, basically, feeling harmed or not achieving their goals or feeling worse after the counseling started, and that goes across all types of counseling, not simply efforts to resolve or reduce same sex attractions.

Q To your understanding, is the evidence you just described anecdotal or empirical?

A Empirical.

Q Is there any evidence, anecdotal or empirical, that the prevalence of harm in the context of

sexual orientation or gender identity change counseling is higher or greater than the prevalence of harm in the general psychotherapy or counseling context?

A No. In fact, there's research and documents that actually list certain specific types of therapies that have been found to be harmful and whatever you want to call it, conversion, SOCE, is not listed in that research.

Q Is there any evidence, empirical, anecdotal or otherwise, that suggests minors who undergo change counseling are X many times more likely to experience depression than minors who did not undergo change counseling?

A There is one study that was published in 2018 by Dr. Caitlin Ryan, at the San Francisco Acceptance Project, Family Acceptance Project, and that study was political in overtones because it did not look at the population of client, minor clients that have unwanted same sex attractions or gender identity conflicts. It also did not verify that the clients -- the study was called Parent Initiated Sex Orientation Change Effort

Therapy, and it did not actually verify what type of therapeutic conversion intervention and what they described it to be, nor did they verify whether the clients were seeing a licensed therapist or a religious advisor, how many sessions they went to, etcetera, and did not look at -- basically, it was looking at a population that wasn't really the population that I work with in that sense and was poorly designed.

Q Now, the anecdotal evidence of harm from change counseling that you were being asked about and that you testified about earlier today, is that evidence of correlation or causation between the change counseling and the resulting harm?

A Correlation or association, yeah.

Q Is it evidence from which one can say that the counseling caused the harm?

A No, it's not causation. They can't determine that. It could be spurious factors.

MR. MIHET: Those are all the questions that I have for you, Mr. Doyle.

Are there any recross questions?

No?

MS. ELLIS: I have no further questions, subject to what I said before.

MR. MIHET: Okay. Subject to the same objection that we had, at this time we consider the deposition complete.

Mr. Doyle, you have the right to receive a copy of the transcript to read and verify that it is accurate and to sign it and I advise you to avail yourself of that right.

THE WITNESS: Okay. Thank you.

MR. MIHET: So, the witness will read and sign.

THE WITNESS: I will.

MR. MIHET: Thank you.

(Signature not waived.)

(Deposition concluded at 4:23 P.M.)

ACKNOWLEDGMENT OF DEPONENT

I, CHRISTOPHER DOYLE, LPC, LCPC, do hereby acknowledge that I have read and examined the foregoing testimony and the same is a true, correct and complete transcription of the testimony given by me and any corrections appear on the attached errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

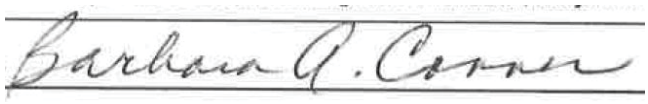
CERTIFICATE OF NOTARY PUBLIC

I, Barbara A. Conner, Registered Professional Reporter, the officer before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 4th day of April 2019.

My commission expires:

January 11, 2020



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(Attached)

CERTIFICATE OF SERVICE

I hereby certify that, on this November 26, 2019, a copy of the foregoing was electronically filed through the Court's CM/ECF system, which will effect service on the following counsel and parties of record:

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