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; and 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 (Dist. Ct. Case No. 1:19-cv-00190) (Chasanow, J.)

BRIEF OF AMERICAN PSYCHOLOGICAL ASSOCIATION, MARYLAND PSYCHOLOGICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, MARYLAND STATE MEDICAL SOCIETY, NATIONAL ASSOCIATION OF SOCIAL WORKERS WITH NATIONAL ASSOCIATION OF SOCIAL WORKERS MARYLAND CHAPTER, AND AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES AND AFFIRMANCE

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IDENTITY AND INTERESTS OF *AMICI CURIAE* [1]

Amici submit this brief to provide the Court with context regarding the state of scientific knowledge about the efficacy and safety of sexual orientation change efforts ("SOCE").

The American Psychological Association ("APA") is a scientific and educational organization dedicated to increasing and disseminating psychological knowledge; it is the world's largest professional association of psychologists, with over 120,000 members. Among the APA's major purposes are to increase and disseminate knowledge regarding human behavior, and to foster the application of psychological learning to important human concerns.

From 2007 to 2009, the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (the "Task Force") conducted a systematic review of the peer-reviewed studies on SOCE, which culminated in a comprehensive Report (the "Report," JA63-200)[2] on the state of the scientific literature. As discussed in detail below, the Report "concluded that efforts to change sexual orientation are

[1] No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person—other than *amici*, their members, or their counsel—contributed money that was intended to fund preparing or submitting this brief. *See* Fed. R. App. P. 29(a)(4)(E). All parties have consented to the filing of this brief.

[2] "JA" refers to parties' joint appendix. "AOB" refers to the Appellant's opening brief and "AAB" refers the Appellees' answering brief.

unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates." JA69. The APA Council of Representatives, the Association's policymaking body, later voted to adopt a Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (the "Resolution," JA189-92), which reflects the findings of the Report. The Resolution states that "there is insufficient evidence to support the use of psychological interventions to change sexual orientation" and that "elected officials" should "seek areas of collaboration that may promote the well[-]being of sexual minorities." JA190, JA192.

The APA's Report and/or Resolution were discussed at length in the text of Senate Bill 1028 (JA1169-70); Appellant's Complaint (JA17-21); Appellant's motion for a preliminary injunction (JA220-31); the district court's Order denying the preliminary injunction (JA1023-24); and in the parties' merits briefs in this Court (AOB 9-22; AAB 9, 24, 27). In light of the attention the parties have devoted to the Report and Resolution, and in light of Appellant's mischaracterizations of several of the Task Force's key findings, the APA has a distinct interest in this case.

The Maryland Psychological Association ("MPA") is the professional membership association for psychologists in the State. The mission of the association is to support psychologists by advancing the science and practice of psychology for the health and welfare of the general public.

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state, including Maryland. The AMA has adopted a formal policy opposing SOCE and "agrees with medical experts that the lack of regulation on conversion therapy opens the door to fraud, harm and trauma for many adults and children in the U.S." Am. Med. Ass'n, *AMA Adopts New Policies During First Day of Voting at Interim Meeting* (Nov. 19, 2019), https://perma.cc/3VUE-E2MJ.

The Maryland State Medical Society ("MedChi") is a statewide, non-profit association of Maryland physicians. It is the largest physician organization in Maryland. MedChi, formally known as The Medical and Chirurgical Faculty of Maryland, was founded in 1799 by an act of the Maryland General Assembly. Today, MedChi's mission is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health.

The AMA and MedChi submit this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each State and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

The National Association of Social Workers ("NASW") is the largest association of professional social workers in the United States, with nearly 120,000 members and 55 chapters throughout the United States and its territories (including the Maryland chapter, which has approximately 3,000 members). As part of its mission to improve the quality and effectiveness of social work practice, NASW promulgates professional standards and the *NASW Code of Ethics*, conducts research, provides continuing education, and advocates for sound public policies (including by filing *amicus* briefs in appropriate cases, such as this). The NASW National Committee on LGBT Issues develops, reviews, and monitors programs of the Association that significantly affect LGBT individuals. NASW and its members are particularly committed to improving the lives of children, the most vulnerable members of the family unit. NASW policies support adolescent health programs that "respect confidentiality and self-determination needs of adolescents and are provided in a culturally appropriate manner" and that "offer specialized training to staff on working with vulnerable populations, including LGBT teenagers." Nat'l

Ass'n of Social Workers, Social Work Speaks, *Adolescent and Young Adult Health* 3, 6 (NASW Policy Statement) (10th ed. 2015). As a matter of national policy, NASW "encourages the development of supportive practice environments for [lesbian, gay, and bisexual] clients" and has taken a public stance against "treatments designed to change sexual orientation [SOCE]" and "practitioners or programs that claim to do so." Nat'l Ass'n of Social Workers, Social Work Speaks, *Lesbian, Gay, and Bisexual Issues* 198, 203 (10th ed. 2015).

The American Association for Marriage and Family Therapy ("AAMFT"), founded in 1942, is a national professional association representing the field of marriage and family therapy and the professional interests of over 62,000 marriage and family therapists in the United States. It joins this brief for the reasons expressed in its 2004 *Statement on Nonpathologizing Sexual Orientation* and related statements.[3]

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Local Rule 26.1(b)(2), *amici* hereby disclose that they have no parent corporations and that no corporation holds 10% or more of an ownership interest in any of the *amici*.

[3] Am. Ass'n for Marriage and Family Therapy, *Statement on Nonpathologizing Sexual Orientation* (2004); *see also* Am. Ass'n for Marriage and Family Therapy, *Position on Reparative/Conversion Therapy* (2009); Am. Ass'n for Marriage and Family Therapy, *Position on Couples and Families* (2005).

SUMMARY OF THE ARGUMENT

The APA's findings in the Report and Resolution—and the state of the scientific evidence regarding the efficacy and safety of SOCE more broadly—are at the center of this case. At all stages of this dispute—from the passage of the relevant Maryland statute to the Order now on appeal—the parties have expressed divergent views about the effectiveness and risks of SOCE for minors. *Amici* respectfully submit this brief in order to clarify and describe the scientific evidence surrounding this type of therapeutic approach.

As discussed in detail below, SOCE developed in the middle of the nineteenth century as a mode of ridding patients of homosexual desires, which were then viewed as a mental illness. By the 1970s, however, the APA and other professional organizations had reached the conclusion that homosexuality was not a pathology. Mainstream mental health professionals began to view SOCE as unethical and potentially harmful, and studies on SOCE became less common. By the 1980s, however, some mental health providers within religious communities began to reassert a mental-disorder conception of homosexuality and to claim that SOCE was safe and effective for people whose religious beliefs were perceived as being in conflict with their sexual orientation. In response to the emergence of advocacy for SOCE, APA adopted its first resolution on SOCE in 1997, identifying concerns with

SOCE, including the ethical issues of bias, deception, and informed consent. Several other mental health associations also adopted resolutions at this time.

As further concerns were raised about advocacy of SOCE for children aimed at parents and schools, APA decided to establish a Task Force to advise the APA on this issue. Before proposing the second Resolution that APA adopted in 2009, the APA Task Force conducted a comprehensive multi-year survey of the scientific literature on SOCE. The Report reached two key conclusions. *First*, it found that SOCE is unlikely to be effective. At the time of the Report—and continuing through the present—there is a scientific consensus that SOCE is unlikely to reduce same-sex attractions. With respect to minors specifically, there is no scientific evidence that any form of childhood therapy can alter adult sexual orientation. *Second*, the Report concluded that SOCE poses a risk of harm to patients. Multiple scientific studies suggest that SOCE may lead to depression, suicidal ideation, anxiety, substance abuse, impotence and sexual dysfunction, nightmares, gastric distress, dehydration, social isolation, deterioration of relationships with friends and family, and an increase in high-risk sexual behaviors, as well as a number of indirect harms such as loss of time and money. In the absence of data showing that SOCE is safe

for children and adolescents, the potential for psychological risks of SOCE for minors are especially concerning.

In his challenge to Maryland's ban on SOCE for minors, the Appellant has attempted to discredit or minimize the Report by (1) noting the lack of published research on SOCE; (2) suggesting that the Report does not indicate evidence of harm; and (3) claiming that the Report notes important evidence of SOCE's purported benefits. Each of these claims is inconsistent with the Report itself, and with the available scientific evidence regarding SOCE.

Contrary to the Appellant's suggestion (and consistent with the best available evidence), the APA recommends "provid[ing] multiculturally competent and client-centered therapies to children, adolescents, and their families ***rather than SOCE***." JA150 (emphasis added). *Amici* urge this Court to reject the Appellant's mischaracterizations of the scientific evidence and to affirm the decision below.

ARGUMENT

This brief primarily reports the conclusions of a systematic review[4] of peer-reviewed empirical research on the efficacy of SOCE completed and published by the APA in 2009. The systematic review was conducted by the APA Task Force,

[4] The Institute of Medicine has defined a systematic review as "a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies." Institute of Medicine, *Finding What Works in Health Care: Standards for Systematic Reviews* 1 (2011).

which was established by the APA in 2007 to address several concerns that had been raised in the professional literature and by advocacy organizations about the use of SOCE on children and adolescents. Although the APA did not explicitly charge the Task Force to review the efficacy literature on SOCE, the Task Force decided that such a review was necessary in order to provide a context for the larger Report and its conclusions.

The APA's systematic review attempted to answer three questions: (1) whether SOCE can alter sexual orientation; (2) whether SOCE is harmful; and (3) whether SOCE may result in any outcomes other than changing sexual orientation. The review considered only peer-reviewed empirical research on treatment outcomes published from 1960 to the time of the Report. *See* JA163-87 (references).

The 2009 Report presented an accurate summary of the state of scientific knowledge on the efficacy of SOCE up to that time. For this brief, *amici* have made a good faith effort to review and report the findings of all valid, empirical studies published on the efficacy of SOCE since the completion of the Report.

The Report also conducted narrative reviews of the larger body of studies on SOCE that did not meet the scientific standards necessary to be a valid study of efficacy. These studies are useful in understanding the motivations and experiences of those who have participated in SOCE (including whether they look back on those experiences as harmful or helpful), but they are not valid bases for conclusions

regarding efficacy. The Task Force's conclusions regarding those studies (and the results of similar studies that have been published since the Report was completed) will be reported in this brief when they are pertinent to important questions other than the question of efficacy.

It is important to note that the lack of recent scientifically valid efficacy studies of the broad range of SOCE that have been used in recent decades is due in part to the ethical barriers to such research. To conduct a random controlled trial of a treatment that has not been determined to be safe—and for a condition that is not a disorder—is not ethically permissible. Doing such research with vulnerable minors who cannot themselves provide legal consent would be out of the question for institutional review boards to approve.

Before citing a study, *amici* have critically evaluated the study's methodology, including the reliability and validity of the measures and tests the study employed and the quality of the study's data-collection procedures and statistical analyses. Scientific research is a cumulative process, and no empirical study is perfect in its design and execution. Accordingly, *amici* base their conclusions as much as possible on findings that have been replicated across studies rather than on the findings of any single study. Even well-executed studies may be limited in their implications and generalizability. Many studies discuss their own

limitations and provide suggestions for further research. This is consistent with the scientific method and does not impeach these studies' overall conclusions.

I. History of "Conversion Therapy" and *Amici*'s Positions on SOCE.

SOCE developed in the mid-nineteenth century to "cure" homosexual desires, which were then viewed as a mental illness. *See* JA91. Because homosexuality was seen as a consequence of either "psychological immaturity" or pathologies such as genetic defects and hormonal exposure, early SOCE "treatments attempted to correct or repair the damage done by pathogenic factors or to facilitate maturity." *Id.*

These erroneous perspectives on homosexuality persisted through much of the twentieth century. *Id.* Indeed, "efforts to alter sexual orientation through psycho-analytic and behavior therapy were prevalent" by the mid-twentieth century. JA92. These techniques included inducing nausea and paralysis; providing electric shock therapy; providing shame-aversion therapy; and attempting "systematic desensitization." *Id.* Some therapists also used non-aversive treatments such as assertiveness and dating trainings, so-called "satiation therapy," or hypnosis. *Id.*

At the same time, "countervailing evidence was accumulating" against the proposition that homosexuality was a pathology. *Id.* In the 1940s and 1950s, Alfred Kinsey showed that homosexuality was more prevalent than previously assumed, and Evelyn Hooker cast doubt on the notion that homosexuality was a mental disorder. JA92-93. By 1973, the American Psychiatric Association had removed

homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"). JA93. In 1975, the APA adopted a policy reflecting the same conclusion. JA93-94. Over the course of the next several decades, professional health and mental health organizations increasingly adopted the view that homosexuality is "a normal variant of human sexuality." JA82.

After homosexuality was removed from the DSM, experiments and studies concerning SOCE decreased dramatically. *See* JA97-98; *see also* JA97 (noting that most studies on SOCE were conducted before 1981). Behavioral therapists "became increasingly concerned that aversive therapies designed as SOCE for homosexuality were inappropriate, unethical, and inhumane." JA94. By the 1980s, mainstream mental health professionals had rejected SOCE because they saw same-sex sexual orientation as a normal part of the continuum of sexual orientation. However, in the 1990s, a counter-movement led primarily by mental health providers practicing within religious communities began to reassert that homosexuality was a mental disorder and that SOCE was safe and effective for people whose religious beliefs were in conflict with their sexual orientation. In response, APA in 1997 adopted a resolution that highlighted ethical concerns associated with the practice of SOCE.[5] Several other mental health organizations—including the American Counseling

[5] Am. Psych. Ass'n, *Appropriate Therapeutic Responses to Sexual Orientation* (Aug. 14, 1997), https://www.apa.org/about/policy/appropriate.

Association, the American Psychiatric Association, and the American Psychoanalytic Association—also adopted resolutions opposed to SOCE on the ground that "such efforts were ineffective and potentially harmful." JA82.

The resolutions adopted by other associations subsequent to APA's 1997 resolution, the publication of new research on SOCE, and requests (from both opponents and supporters of SOCE) that APA take further action led APA to establish a Task Force to advise APA on the issue, especially with regard to minor children. *See id.* In order to assess the safety and effectiveness of SOCE, the Task Force conducted an extensive review of the literature and published a 124-page Report in 2009. The Report concluded that "the peer-refereed empirical research on the outcomes of efforts to alter sexual orientation provides little evidence of efficacy and some evidence of harm." JA105.

Several states and localities—including Maryland—have relied upon the APA's findings when passing bans on SOCE for minors. *See* JA1169-70. Numerous courts, including the court below, have discussed the Report or Resolution in concluding that bans on SOCE for minors are justified. *See* (JA1023-24) (district court Order); *Pickup v. Brown*, 740 F.3d 1208, 1224, 1232 (9th Cir. 2014) (discussing and citing Report while upholding California's ban on SOCE for minors).

Rather than endorsing SOCE, "mainstream mental health professional associations [currently] support affirmative approaches that focus on helping sexual minorities cope with the impact of minority stress and stigma." JA94.[6]

II. There Is Insufficient Evidence to Support the Efficacy of SOCE.

Based on a systematic review of the literature on the efficacy of SOCE, the Task Force concluded that there is no scientific evidence that SOCE is likely to reduce same-sex attractions. JA111. As the Report observes, a systematic review of the small number of rigorous peer-reviewed empirical studies found little evidence that SOCE decreased same-sex attraction or increased other-sex attraction or behaviors. Moreover, the studies showed little evidence of any enduring changes or changes that generalized from the treatment context into the real world.[7] Some

[6] Affirmative therapy in this context refers to "therapy that is culturally relevant and responsive to LGBQ clients and their multiple social identities and communities; addresses the influence of social inequities on the lives of LGBQ clients; fosters autonomy; enhances resilience, coping, and community building; advocates to reduce systemic barriers to mental, physical, relational, and sexual flourishing; and leverages LGBQ client strengths." Tiffany O'Shaughnessy & Zachary Speir, *The State of LGBQ Affirmative Therapy Clinical Research: A Mixed-Methods Systematic Synthesis*, 5 Psych. Sexual Orientation & Gender Diversity 82, 83 (2018).

[7] The Task Force Report noted that "enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in the[early SOCE] studies showed any credible evidence of reduced same-sex sexual attraction, though some showed lessened physiological arousal to all sexual stimuli. . . . Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life." JA112-13; *see also* Lee Birk et al., *Avoidance Conditioning for Homosexuality*, 25 Archives Gen. Psychiatry 314 (1971); Neil McConaghy, *Is A Homosexual Orientation Irreversible?*, 129 Brit. J. Psychiatry 556 (1976); Barry A.

studies that claimed to find sexual orientation change were not rigorous enough to permit the Task Force to draw any conclusions from those studies about the efficacy of SOCE.[8]

Studies post-dating the Report do not alter the conclusions contained in the Report. The APA has identified only one post-Report study that had a design that could possibly provide valid evidence of change, even though it could not prove that the cause of the change was the treatment.[9] And even that study suffers from methodological flaws.[10] *See* Stanton L. Jones & Mark A. Yarhouse, *A Longitudinal*

Tanner, *Avoidance Training With and Without Booster Sessions to Modify Homosexual Behavior in Males*, 6 Behav. Therapy 649 (1975).

[8] *See* JA152-56.

[9] Peer-reviewed empirical research on SOCE that does not meet the minimum standards for efficacy studies has been published since the Report was released. *See, e.g.*, Kate Bradshaw et al., *Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated with the Church of Jesus Christ of Latter-day Saints*, 41 J. Sex & Marital Therapy 391, 391 (2015) (finding that SOCE efforts for Mormons suggest a "very low likelihood of a modification of sexual orientation"); John P. Dehlin et al., *Sexual Orientation Change Efforts Among Current or Former LDS Church Members*, J. Counseling Psych. (Online) at 1 (Mar. 2014) ("[O]verall results support the conclusion 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."); Elaine M. Maccio, *Self-Reported Sexual Orientation and Identity Before and After Sexual Reorientation Therapy*, 15 J. Gay & Lesbian Mental Health 242, 242 (2011) (reporting "no statistically significant differences in sexual orientation . . . from before SRT [sexual reorientation therapy] participation to the time of participation in this study").

[10] The Jones & Yarhouse study resulted in a high attrition rate, which the researchers do not explain or address; lacks a baseline measure that represents a state of being untreated; did not maintain constancy regarding assessment intervals; had significant variations among participants in terms of the length of exposure to treatment, the nature of treatment, and the amount of time between a person's initial and

Study of Attempted Religiously Mediated Sexual Orientation Change, 37 J. Sex & Marital Therapy 404 (2011); *see also supra* at 12 (noting that SOCE-related studies have become less prevalent in recent years). In the one subgroup of the Jones and Yarhouse study sample that could have shown valid evidence of change in response to treatment, the study found little evidence of decreased same-sex sexual orientation; it could not distinguish to what extent reported changes involved attraction, rather than identity; and it provided no evidence of increase in other-sex sexual orientation. Accordingly, the conclusions of this study are substantially the same as the conclusions of the Task Force. And because the Jones and Yarhouse study related to SOCE conducted by religious ministries—not psychotherapy provided by licensed psychotherapists—it is also irrelevant to the law at issue in this dispute.

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subsequent assessments; and fails to explain significant gaps in data regarding participants. For these reasons, among others, the Jones and Yarhouse study does not demonstrate the efficacy of SOCE by any scientifically valid standard. *See generally* Society for Prevention Research, *Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination* (2005) ("*2005 SPR Standards*").

Another paper released after the Report was published purports to show that SOCE led to shifts in sexual orientation for most participants in the study with no harmful side effects. *See* Paul L. Santero et al., *Effects of Therapy on Religious Men Who Have Unwanted Same-Sex Attraction*, Linacre Q., July 2018, at 1. But that study was recently retracted by the publishing journal due to statistical flaws.

III. SOCE Poses Significant Risks to Patients and Especially to Minors.

A. Some Individuals Report Harm from SOCE.

As the Report explained, there is "evidence to indicate that individuals experienced harm from SOCE." JA73; *see* JA156 (noting that SOCE "has the potential to be harmful"). With respect to aversive SOCE therapies, studies show that "negative side effects includ[e] loss of sexual feeling, depression, suicidality, and anxiety." JA73. Even with respect to so-called "nonaversive" SOCE, research reports that had been published at the time of the Report "indicate[d] that" there are "individuals who perceive that they have been harmed." JA155.

Based on its exhaustive review of the SOCE literature, the Task Force ultimately concluded that, while there was a "dearth of scientifically sound research on the safety of SOCE," the best available evidence suggested that "attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts." JA112. The Task Force also described in detail a number of "studies that report perceptions of harm" and noted that those studies "represent[] a serious concern." *Id.*

As to older, non-experimental studies, the Task Force observed that "negative [side] effects of treatment are reported to have occurred for some people during and immediately following treatment." *Id.* For example, in John Bancroft's 1969 study, SOCE interventions "had harmful effects on 50% of the 16 research subjects who

were exposed to it," including a 20% rate of anxiety, a 10% rate of suicidal ideation, a 40% rate of depression, a 10% rate of impotence, and a 10% rate of relationship dysfunction. JA111-12; *see* John Bancroft, *Aversion Therapy of Homosexuality: A Pilot Study of 10 Cases*, 115 Brit. J. Psychiatry 1417 (1969). Other early studies of SOCE reported "cases of debilitating depression, gastric distress, nightmares, and anxiety," as well as "severe dehydration," and at least one case where a research participant "began to engage in abusive use of alcohol" that required hospitalization. JA112.[11]

The Task Force noted that more recent studies "document that there are people who perceive that they have been harmed through SOCE." *Id.* Among those studies, "the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction." *Id.*[12] Participants in these studies also described "decreased

[11] *See* J.T. Quinn et al., *An Attempt to Shape Human Penile Responses*, 8 Behav. Res. & Therapy 213 (1970); Steven H. Herman & Michael Prewett, *An Experimental Analysis of Feedback to Increase Sexual Arousal in a Case of Homo- and Heterosexual Impotence: A Preliminary Report*, 5 J. Behav. Therapy & Experimental Psychiatry 271 (1974); Basil James, *Case of Homosexuality Treated by Aversion Therapy*, 1 Brit. Med. J. 768 (1962).

[12] *See* A. Lee Beckstead & Susan L. Morrow, *Mormon Clients' Experiences of Conversion Therapy: The Need for a New Treatment Approach*, 32 Counseling Psychologist 651 (2004); Glenn Smith et al., *Treatments of Homosexuality in Britain*

self-esteem and authenticity to others"; "increased self-hatred and negative perceptions of homosexuality"; "an increase in substance abuse and high-risk sexual behaviors"; and a variety of harms to their relationships, including hostility towards their parents and the loss of lesbian, gay, and bisexual friends and potential romantic partners. JA120-21.

In addition to the *direct* harms posed by SOCE (which may present as mental health issues, physical ailments, sexual dysfunction, or substance abuse), SOCE also has the potential to cause *indirect* harms such as the loss of time, energy, and money. JA120. Moreover, some SOCE patients may suffer an indirect harm in the form of disappointment or psychological damage resulting from the fact that a therapy they thought would be effective turned out not to work. Indeed, the Report found that "[i]ndividuals 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." JA73; *see* JA120 (noting that some participants in SOCE studies reported "anger at and a sense of betrayal by

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Since 1950—An Oral History: The Experiences of Patients, 328 Brit. Med. J. 427 (2004); Ariel Shidlo & Michael Schroder, *Changing Sexual Orientation: A Consumer's Report*, 33 Prof. Psych.: Res. & Prac. 249 (2002); Michael Schroder & Ariel Shidlo, *Ethical Issues in Sexual Orientation Conversion Therapies: An Empirical Study of Consumers*, 131 J. Gay & Lesbian Psychotherapy 131 (2001); Joseph Nicolosi et al., *Retrospective Self-Reports of Changes in Homosexual Orientation: A Consumer Survey of Conversion Therapy Clients*, 86 Psych. Rep. 1071 (2000); Kim W. Schaeffer et al., *Religiously-Motivated Sexual Orientation Change*, 19 J. Psych. & Christianity 61 (2000).

SOCE providers" or that they "blamed themselves for the failure" of SOCE to work as expected); *id.* (noting that some SOCE recipients reported "stress due to the negative emotions of spouses and family members because of expectations that SOCE would work"). Given that SOCE is unlikely to be effective, there is a risk that SOCE poses psychological harms by promising a result that is unlikely to occur.

The one post-Report study that had a design that could possibly provide valid evidence of change found significant reduction in psychological distress among the participants in the study over the six to seven years that the participants were followed, even though it could not prove that the cause of the change was the treatment. *See* Jones & Yarhouse, *supra*.[13] Because the SOCE studied in this

[13] There have been other studies of SOCE published since the Report that do not meet APA's standards for efficacy studies. As discussed above, these studies may nonetheless be useful in understanding the motivations and experiences of those who have participated in SOCE. *See supra* at 9-10. Some participants in more recent studies have reported harmful effects of SOCE. For example, one 2015 study on SOCE efforts for individuals affiliated with the Church of Jesus Christ of Latter-day Saints reported that 37% of study participants found their therapy to be moderately to severely harmful and that there was "clear evidence" that "dutiful long-term psychotherapeutic efforts to change [sexual orientation] are not successful and carry significant risk of harm." Bradshaw et al., *supra*, at 391, 409-10. In another 2018 study that focused specifically on young adults aged 21-25, researchers found that "[a]ttempts by parents/caregivers and being sent to therapists and religious leaders for conversion interventions were associated with depression, suicidal thoughts, suicidal attempts, less educational attainment, and less weekly income." Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*, J. Homosexuality (Online) at 1 (Nov. 7, 2018); *see id.* at 10.

Moreover, both the federal government and the United Nations have recently raised concerns about SOCE. *See* Substance Abuse & Mental Health Servs. Admin.,

research was a group ministry, this result is consistent with earlier studies that found some participants reported benefits from the social support of others who shared their concerns about their sexual orientation. *See* JA111. As the Task Force suggests in the alternative therapeutic model it presented, this benefit is not specific to SOCE. Indeed, many of the purported benefits of SOCE (such as stress reduction and experiencing empathy) "are not unique" and may be achieved by talk therapy and/or treatment approaches that do not attempt to change sexual orientation. JA123, JA138; *see* John C. Norcross & Clara E. Hill, *Empirically Supported Therapy Relationships*, 57 Clinical Psychologist 19 (2004).

B. Minors Are Particularly Vulnerable to Harm From SOCE.

Importantly, the Report also discusses the considerable ethical issues with providing SOCE to minors. In the absence of scientifically valid studies of efficacy showing safety of SOCE and in the presence of retrospective reports of harm, the potential for SOCE to harm minors is of great concern to licensed mental health professionals ("LMHPs"), *amici*, and the public.

Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth (Oct. 2015) (JA260-335); Report of the Office of the United Nations High Commissioner for Human Rights, *Discrimination and Violence Against Individuals Based on Their Sexual Orientation and Gender Identity* at 11, 14-15, 20 (May 4, 2015), http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session29/Documents/A_HRC_29_23_en.doc.

Generally speaking, youth may be particularly vulnerable to the potential harms of SOCE because they have been exposed to negative messages about sexual minorities but have not yet developed the resources to reject these messages. *See, e.g.*, JA279-80, 287 (SAMHSA Report). The Report therefore advised LMHPs to "take steps to ensure that minor clients have a developmentally appropriate understanding of treatment" and noted that the APA recommends that LMHPs "support adolescents' exploration of identity." JA146. Given that "[t]here is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation" (JA155; *see* JA143), the Report also recommended that LMHPs "provide multiculturally competent and client-centered therapies" to children and adolescents "rather than SOCE" (JA150). Ultimately, the Task Force concluded in the Report that it had "concerns that [SOCE-type] interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents." JA74.

C. Licensed Mental Health Providers Have a Duty to Avoid Harm to the Members of the Public Whom They are Licensed to Serve.

The charge to "do no harm" has long been a foundational component of practice for healthcare professionals. This means that certain aspirational principles (such as the patient's self-determination) must be balanced against other principles, such as beneficence and non-malfeasance. *See* Am. Psychological Ass'n, *Ethical Principles of Psychologists and Code of Conduct*, at Principles A, E (Jan. 1, 2017),

https://www.apa.org/ethics/code. For this reason, there are a number of patient requests that an ethical psychologist would be required to resist on the grounds that they would harm the patient's health or that there is no evidentiary basis for the requested treatment; for example, a psychologist would decline a request for a weight loss program from a patient with anorexia nervosa. Self-determination, while important, is not the only ethical principal—or even the most important ethical principle—in clinical decision-making. *See* Ariel Shidlo & John C. Gonsiorek, *Psychotherapy with Clients Who Have Been Through Sexual Orientation Change Interventions or Request to Change Their Sexual Orientation, in Handbook of Sexual Orientation and Gender Diversity in Counseling and Psychotherapy* 291 (Kurt A. DeBord et al., eds., 2017). Phrased simply, self-determination does not justify dispensing with other ethical obligations regarding patient care.

IV. The Appellant Misrepresents Various Aspects of the Task Force Report.

Both in this Court and below, the Appellant has mischaracterized key aspects of the APA's Report and Resolution. The Appellant's misleading claims concern the nature of the scientific research on SOCE, the possibility that SOCE may result in harm, and the methodological approaches that the Task Force used when evaluating reports of SOCE benefits.

First, the Appellant makes much of the fact that the Report acknowledges the lack of recent research on the harms of SOCE. *See* AOB 10-11. Although the Report

acknowledges that scientifically valid efficacy research on SOCE is limited (*see* JA76-77, 112), the Appellant ignores the body of research that is not efficacy studies, but which finds that some participants in SOCE do retrospectively report harms.

Numerous researchers and LMHPs have concluded that SOCE should be neither studied nor provided precisely ***because it may cause harm to patients***. *See* JA94 (noting that, "[f]ollowing the removal of homosexuality from the *DSM* [in 1973], the publication of studies of SOCE decreased dramatically").[14]

Modern LMHPs' concerns about SOCE find significant support in early studies on SOCE. The Report recognizes that "[h]igh dropout rates characterize early [SOCE] studies and may be an indicator that research participants experience these treatments as harmful." *See* JA112; *see also* Scott O. Lillenfeld, *Psychological Treatments that Cause Harm*, 2 Persp. on Psych. Sci. 53 (2007). To name just one example, a 1973 study on SOCE included one respondent who "dropped out" after "lo[sing] all sexual feeling" and six others who reported some form of depression. JA111; *see* Neil McConaghy & R.F. Barr, *Classical, Avoidance, and Backward Conditioning Treatment of Homosexuality*, 122 Brit. J. Psychiatry 151 (1973).

[14] *See, e.g.*, Gregory M. Herek, *Evaluating Interventions to Alter Sexual Orientation: Methodological and Ethical Considerations*, 32 Archives Sexual Behav. 438 (2003); Gerald C. Davison, *Homosexuality: The Ethical Challenge*, 44 J. Consulting & Clinical Psych. 157 (1976).

Thus, the relative lack of empirical studies on SOCE is not evidence of lack of harm, as the Appellant appears to suggest. If anything, the lack of studies on SOCE may be indicative of the ***risk*** of harm. *See, e.g.*, *Otto v. City of Boca Raton*, 353 F. Supp. 3d 1237, 1261 n.12 (S.D. Fla. 2019) ("Notably, the APA Task Force Report suggests that the lack of rigorous studies is *because* SOCE is harmful.").

Second, the Appellant appears to claim that the Report does not indicate clear evidence of harm. *See* AOB 11-12. This is simply mistaken. As explained in detail above, the Report does show evidence of harm. *See supra* § III.A. Moreover, the Appellant's apparent suggestion that the Report is deficient because it does not focus on patients who are alleged to have sought SOCE *voluntarily* misses the mark. *See* AOB 14, 17. Even putting aside the Appellant's mischaracterization about the risk of harm, SOCE cannot be justified by invoking client autonomy or self-determination. *See supra* § III.C. As the Task Force recognized in the Report, "simply providing SOCE to clients who request it does not necessarily increase self-determination but rather abdicates the responsibility of [LMHPs] to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm." JA139. Moreover, the concept of self-autonomy with respect to minors who "opt into" SOCE is a canard because minors are typically emotionally and financially dependent on adults. *See* JA147, JA191.

Third, the Appellant mischaracterizes the nature of the Report's findings about the purported benefits of SOCE. After reviewing evidence related to the supposed benefits of SOCE (JA105-111[15]) and carefully balancing this scattered evidence against the evidence of harm, the Task Force ultimately concluded that there is evidence of harm from SOCE. *See supra* § III.A. That conclusion comes as no surprise, especially given that there is no documented evidence of benefits of SOCE that are distinct from other forms of talk therapy.

Relatedly, it is incumbent on proponents of a particular type of therapy to show that it is both effective and safe (not on opponents of that method to show that it causes harm).[16] As the SPR standards emphasize, where a study claims to show the efficacy of a therapeutic method, "there must be no serious negative (iatrogenic) effects on important outcomes." *See 2005 ASR Standards* at 5. Here, the available scientific evidence provides no reason to believe that SOCE is effective or safe.

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[15] *But see* JA105 ("[N]onexperimental studies often find positive effects that do not hold up under the rigor of experimentation."). The Task Force pointed to studies showing that some participants in SOCE "described experiencing first the positive effects and then experiencing or acknowledging the negative effects later." JA112.

[16] *Amici* note that it is erroneous to assume that the same standards—or even the same research methods—should be used when interrogating the harms of a proposed therapy and that therapy's purported benefits. Indeed, various mainstream medical groups—including the American Cancer Society—have recognized that different standards do and should apply when examining harm vs. benefit (or effectiveness). *See* Am. Cancer Society, *What Are the Phases of Clinical Trials?* (Feb. 7, 2017), https://www.cancer.org/treatment/treatments-and-side-effects/clinical-trials/what-you-need-to-know/phases-of-clinical-trials.html.

CONCLUSION

For the foregoing reasons, the district court's Order should be affirmed.

December 30, 2019

Respectfully submitted,

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I hereby certify that on this 30th day of December, 2019, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF, which will send notice to all counsel of record in this matter.

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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I certify that on 12/30/2019 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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