No. 19-10604

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, and JULIE H. HAMILTON, PH.D. LMFT, individually and on behalf of her patients,
Plaintiffs-Appellants,

v.

CITY OF BOCA RATON, FLORIDA, and
COUNTY OF PALM BEACH, FLORIDA,
Defendants-Appellees.

On Appeal from the United States District Court for the
Southern District of Florida (Dist. Ct. Case No. 9:18-cv-80771)

MOTION OF AMERICAN PSYCHOLOGICAL ASSOCIATION, FLORIDA PSYCHOLOGICAL ASSOCIATION, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION OF SOCIAL WORKERS FLORIDA CHAPTER, AND AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES AND AFFIRMANCE

Nathalie F.P. Gilfoyle
Deanne M. Ottaviano
AMERICAN PSYCHOLOGICAL ASSOCIATION
750 First Street NE
Washington, DC 20002
(202) 336-6100

Counsel for American Psychological Association

Jessica Ring Amunson
Counsel of Record
Emily L. Chapuis
James T. Dawson
JENNER & BLOCK LLP
1099 New York Avenue NW
Washington, DC 20001
(202) 639-6000
jamunson@jenner.com

Counsel for All Amici Curiae

Additional Counsel Listed on Inside Cover

Anne B. Camper
NATIONAL ASSOCIATION OF
SOCIAL WORKERS
750 First Street NE, Suite 800
Washington, DC 20001
(202) 336-8799

Counsel for National Association of Social Workers and National Association of Social Workers Florida Chapter

Otto v. City of Boca Raton, Florida
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Yasko, Jennifer A.

Pursuant to Federal Rule of Appellate Procedure 26.1 and Eleventh Circuit Rules 26.1-1 through 26.1-3, each proposed *amicus curiae* hereby certifies that it has no parent corporation and that no publicly held corporation owns 10% or more of its stock.

/s/ *Jessica Ring Amunson*

Jessica Ring Amunson
JENNER & BLOCK LLP
1099 New York Ave. NW
Washington, DC 20001
(202) 639-6000
jamunson@jenner.com

Counsel for All Amici Curiae

MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE*

Pursuant to Federal Rule of Appellate Procedure 29(a)(3) and Circuit Rule 29-1, the five organizations listed below ("proposed *amici*") respectfully submit this motion for leave to file a brief as *amici curiae* in support of the Appellees and affirmance. Proposed *amici*'s brief has been filed in conjunction with this motion.

Proposed *amici* have endeavored to obtain the consent of all parties to the filing of this brief. Appellees consented to this filing. Counsel for Appellants advised proposed *amicus* the American Psychological Association by email that their "willingness to consent was conditioned upon [Appellants] seeing the brief before filing." Because proposed *amici* were not willing to share this brief with Appellants before filing, they did not receive Appellants' consent to file.

Under Federal Rule of Appellate Procedure 29(a)(3), a motion for leave to file an *amicus* brief must state "the movant's interest" and "the reason why an amicus brief is desirable and why the matters asserted are relevant to the disposition of the case."

Movants' interest. Proposed *amici* are five organizations: the American Psychological Association, the Florida Psychological Association, the National Association of Social Workers, the National Association of Social Workers Florida Chapter, and the American Association for Marriage and Family Therapy.

Collectively, proposed *amici* represent tens of thousands of psychologists and health professionals.

Proposed *amici* are dedicated to the dissemination of psychological and medical knowledge. They share a commitment to improving the health and mental health of all Americans and to informing and educating lawmakers, the judiciary, and the public regarding issues that may affect public health. Several of the proposed *amici* have submitted *amicus* briefs in cases that touch on issues that either affect their members or affect patients who are or may be in the care of mental health professionals.

Proposed *amici* are concerned about the use of sexual orientation change efforts ("SOCE") with minors. As explained in the brief filed with this motion, scientific research has shown that SOCE is unlikely to be effective and may result in harm to patients. As a result, proposed *amici* have a particular interest in this case.

Consistent with "the classic role of amicus curiae"—"assisting in a case of general public interest," *Miller-Wohl Co. v. Comm'r of Labor & Industry*, *State of Mont.*, 694 F.2d 203, 204 (9th Cir. 1982) (per curiam)—the proposed *amici* desire to submit a brief to inform the Court of several issues uniquely within their expertise. In particular, proposed *amici* seek to bring to the Court's attention the findings of peer-reviewed, scientific studies concerning the safety and efficacy of SOCE.

Proposed *amicus* 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," 1 Appx. Tab 85-5)[1] on the state of the scientific literature. The APA later voted to adopt a Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (the "Resolution," *id.* at 119-24), which reflects the findings of the Report. The APA's Report or Resolution were discussed in the challenged ordinances at issue in this appeal (2 Appx. Tab 121-1 (Palm Beach); 8 Appx. Tab 126-27 (Boca Raton)); Appellants' Complaint (1 Appx. Tab 1 at 10-12 ¶¶ 38-54); Appellants' motion for a preliminary injunction (1 Appx. Tab 8 at 11-12); the preliminary injunction hearing (10 Appx. Tab 129 at 11-13, 48, 57-

[1] "Appx." refers to Appellants' appendix, and the preceding numeral refers to the applicable volume of that appendix. "AOB" refers to Appellants' opening brief, "PBAB" refers to Palm Beach County's answering brief, and "BRAB" refers to the City of Boca Raton's answering brief.

60, 64-71, 125-30); the Order denying the preliminary injunction (11 Appx. Tab 141 at 21 n.8, 34-35, 37 n.12, 38, 41); and in the parties' merits briefs in this Court (AOB 12-13, 15-25, 47-48, 54-55, 57; PBAB 5-6, 11-12; BRAB 5-6). In light of the attention the parties have devoted to the Report and Resolution, and in light of Appellants' mischaracterizations of several of the Task Force's key findings, the APA has a distinct interest in this case.

In addition to the APA, proposed *amici* include several other national organizations of professionals focused on mental health or children's health.

The Florida Psychological Association is the sole professional association for psychologists in the state of Florida. The mission of the association includes promoting health and human welfare, increasing psychological knowledge, and the application of research findings to the promotion of health and public welfare.

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 Florida chapter, which has 4,300 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). 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 reparative therapies and treatments designed to change sexual orientation" 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.[2]

[2] Am. Ass'n for Marriage and Family Therapy, *Statement on Nonpathologizing Sexual Orientation* (2004); *see also* Am. Ass'n for Marriage and Family Therapy,

Why an amicus brief is desirable and relevant. "Even when a party is very well represented, an amicus may provide important assistance to the court." *Neonatology Associates, P.A. v. C.I.R.*, 293 F.3d 128, 132 (3d Cir. 2002) (Alito, J.). "Some friends of the court are entities with particular expertise not possessed by any party to the case. Others argue points deemed too far-reaching for emphasis by a party intent on winning a particular case. Still others explain the impact a potential holding might have on an industry or other group." *Id.* (quotation marks and citation omitted).

In this case, proposed *amici*'s brief fulfills all three of these functions. First, proposed *amici* have "particular expertise." *Id.* Proposed *amici* are professional organizations whose members and staffs have expertise on the questions at issue in this appeal. Moreover, proposed *amicus* the APA published the Report in 2009. In addition to being one of the leading publications concerning the efficacy and safety of SOCE, the Report and its findings are at issue in this appeal.

Second, proposed *amici* raise "points deemed too far-reaching for emphasis by a party intent on winning a particular case." *Id.* Each of the parties to this case discusses the state of the scientific literature on SOCE and the APA's Report or Resolution. But the additional detail and context provided by proposed *amici*—

Position on Reparative/Conversion Therapy (2009); Am. Ass'n for Marriage and Family Therapy, *Position on Couples and Families* (2005).

including information concerning various peer-reviewed studies that have analyzed SOCE—may prove useful to this Court as it considers the important questions raised in this case.

Third, proposed *amici* "explain the impact a potential holding might have on an industry or other group." *Id.* As previously described, proposed *amici* have a unique capability to describe how SOCE may affect children and adolescents—as well as the mental health professionals who treat them. Thus, proposed *amici*'s perspective may prove helpful to the Court as it considers the legality of the Appellees' bans on SOCE for minors.

CONCLUSION

Proposed *amici* believe that their input may be of assistance to the Court, and respectfully urge this Court to grant leave to submit the attached brief.

June 17, 2019

Respectfully submitted,

/s/ *Jessica Ring Amunson*

Jessica Ring Amunson
Counsel of Record
Emily L. Chapuis
James T. Dawson
JENNER & BLOCK LLP
1099 New York Avenue NW
Washington, DC 20001
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jamunson@jenner.com

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 27(d)(2)(a) because it contains 1,493 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman type style.

/s/ *Jessica Ring Amunson*
Jessica Ring Amunson

Counsel for All Amici Curiae

June 17, 2019

CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of June, 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.

/s/ *Jessica Ring Amunson*
Jessica Ring Amunson

Counsel for All Amici Curiae

June 17, 2019

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OTHER AUTHORITIES

* Authorities upon which we chiefly rely are marked with an asterisk.

STATEMENT OF THE ISSUE

The question for this Court's consideration is whether the district court's Order denying a preliminary injunction to Appellants should be affirmed.

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

[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). Although Appellees consented to the filing of this brief, Appellants' counsel would not consent to the filing of this brief unless they were permitted to review the brief before it was filed. This brief is therefore accompanied by a motion for leave to file. *See* Fed. R. App. P. 29(a)(2)-(3); 11th Cir. R. 29-1.

of the peer-reviewed studies on SOCE, which culminated in a comprehensive Report (the "Report," 1 Appx. Tab 85-5)[2] on the state of the scientific literature. As discussed in detail below, the Report "concluded that efforts to change sexual orientation are unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates." *Id.* at v. The APA later voted to adopt a Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (the "Resolution," *id.* at 119-24), 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." *Id.* at 121-22.

The APA's Report or Resolution were discussed in the challenged ordinances at issue in this appeal (2 Appx. Tab 121-1 (Palm Beach); 8 Appx. Tab 126-27 (Boca Raton)); Appellants' Complaint (1 Appx. Tab 1 at 10-12 ¶¶ 38-54); Appellants' motion for a preliminary injunction (1 Appx. Tab 8 at 11-12); the preliminary injunction hearing (10 Appx. Tab 129 at 11-13, 48, 57-60, 64-71, 125-30); the Order denying the preliminary injunction (11 Appx. Tab 141 at 21 n.8, 34-35, 37 n.12, 38,

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41); and in the parties' merits briefs in this Court (AOB 12-13, 15-25, 47-48, 54-55, 57; PBAB 5-6, 11-12; BRAB 5-6). In light of the attention the parties have devoted to the Report and Resolution, and in light of Appellants' mischaracterizations of several of the Task Force's key findings, the APA has a distinct interest in this case.

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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 reparative therapies and treatments designed to change sexual orientation" 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).

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[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 ordinances to the preliminary injunction 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 claim that SOCE was safe and effective for people whose religious beliefs were perceived as being in conflict with their sexual orientation. This development led several mainstream mental health organizations to adopt resolutions against SOCE.

Before adopting its Resolution, 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 their challenge to the Appellees' bans on SOCE for minors, Appellants repeatedly misstate or mischaracterize the Report's key findings. For example, Appellants attempt to discredit 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 improperly dismisses 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 Appellants' 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***." 1 Appx. Tab 85-5 at 80 (emphasis added). *Amici* urge this Court to reject Appellants' mischaracterizations of the scientific evidence and to affirm the decision below.

ARGUMENT AND CITATIONS OF AUTHORITY

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, 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)

[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).

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* 1 Appx. Tab 85-5 at 93-117 (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 is not ethically permissible and to do 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* 1 Appx. Tab 85-5 at 21. 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. *Id.* at 22. 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. *Id.* at 22-23. By 1973, the American Psychiatric Association had removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"). *Id.* at 23. In 1975, the APA adopted a policy reflecting the same conclusion. *Id.* at 24. 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." *Id.* at 12.

After homosexuality was removed from the DSM, experiments and studies concerning SOCE decreased dramatically. *See id.* at 23-24; *see also id.* at 2 (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." *Id.* at 24-25. 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 assert that SOCE was safe and effective for people whose religious beliefs were in conflict with their sexual orientation.

This led mental health organizations—including the American Counseling Association, the American Psychiatric Association, and the American Psychoanalytic Association—to adopt resolutions opposed to SOCE on the ground that "such efforts were ineffective and potentially harmful." *Id.* at 12.

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." *Id.* at 35.

Several states and localities—including Appellees Boca Raton and Palm Beach—have relied upon the APA's findings when passing bans on SOCE for minors. *See* 2 Appx. Tab 121-1 (Palm Beach); 8 Appx. Tab 126-27 (Boca Raton); *see also* BRAB at 30. Numerous courts, including the district court below, have cited and discussed the Report or Resolution in concluding that bans on SOCE for minors are justified. *See* 11 Appx. Tab 141 at 34-38, 41 (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." 1 Appx. Tab 85-5 at 24.[5]

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

[5] 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).

reduce same-sex attractions.[6] 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 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 purports to show

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[6] Mental health and medical organizations now see homosexuality as a normal variant of sexual orientation and not something that needs change, alteration, or cure. Moreover, the current scientific consensus is that theorizing about the nature of human sexuality and sexual orientation should take into account both biological and cultural perspectives. *See generally APA Handbook of Sexuality and Psychology* (Deborah L. Tolman & Lisa M. Diamond eds., 2014).

[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." 1 Appx. Tab 85-5 at 43; *see id.* at 11; *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. Tanner, *Avoidance Training With and Without Booster Sessions to Modify Homosexual Behavior in Males*, 6 Behav. Therapy 649 (1975).

[8] *See* 1 Appx. Tab 85-5 at 37-38.

that SOCE is effective and that meets the minimum standards of an efficacy study,[9] though even that study suffers from methodological flaws.[10] *See* Stanton L. Jones & Mark A. Yarhouse, *A Longitudinal Study of Attempted Religiously Mediated Sexual Orientation Change*, 37 J. Sex & Marital Therapy 404 (2011); *see also supra*

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[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 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.

at 11 (noting that SOCE-related studies have become less prevalent in recent years). The Jones and Yarhouse 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 ordinances at issue in this dispute.

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." 1 Appx. Tab 85-5 at 3; *see id.* at 6 (noting that SOCE "has the potential to be harmful"); *id.* at 43. With respect to aversive SOCE therapies, studies show that "negative side effects includ[e] loss of sexual feeling, depression, suicidality, and anxiety." *Id.* at 43. 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." *Id.* at 3.

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." *Id.* at 42. 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. *Id.* at 41-42; *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. 1 Appx. Tab 85-5 at 42.[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]; *see id.* at 50. Participants in these studies also described "decreased self-esteem and authenticity to others"; "increased self-hatred and

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[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 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 Journal of 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).

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. *Id.* at 50-51.

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. *See id.* at 50. 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." *Id.* at; 3; *see id*. at 50 (noting that some participants in SOCE studies reported "anger at and a sense of betrayal by SOCE providers" or that they "blamed themselves for the failure" of SOCE to work as expected); *id.* at 51 (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 scientifically valid efficacy study published since the Report found significant reduction in psychological distress among the participants in the study over the six to seven years that the participants were followed. *See* Jones & Yarhouse, *supra.*[13] Because the SOCE studied in this 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* 1 Appx. Tab 85-5 at 41. As the Task Force suggests in the

[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 8-9. 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., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (Oct. 2015) ("SAMHSA Report"), https://store.samhsa.gov/system/files/sma15-4928.pdf; 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.

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. *Id.* at 68; *see id.* at 3; 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. *See* 1 Appx. Tab 85-5 at 71-80 (Report Chapter 8). 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.

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.*, SAMHSA Report at 12-13, 20. 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." 1 Appx. Tab 85-5 at 76. Given that "[t]here

is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation" (*id.* at 4; *see id.* at 73), the Report also recommended that LMHPs "provide multiculturally competent and client-centered therapies" to children and adolescents "rather than SOCE" (*id.* at 80). 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." *Id.* at 4.

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. Appellants Misrepresent Various Aspects of the Task Force Report.

Both in this Court and below, Appellants have mischaracterized key aspects of the APA's Report and Resolution. Appellants' 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, Appellants make much of the fact that the Report acknowledges the lack of recent research on the harms of SOCE. *See* AOB 13-14, 57; 1 Appx. Tab 1 at 10 ¶¶ 40-43. Although the Report acknowledges that scientifically valid efficacy research on SOCE is limited (*see* 1 Appx. Tab 85-5 at 6-7, 42), Appellants ignore 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* 1 Appx. Tab 85-5 at 91 ("Some authors have stated that SOCE should not be

investigated or practiced until safety issues have been resolved.");[14] *id.* at 24 (noting that, "[f]ollowing the removal of homosexuality from the *DSM* [in 1973], the publication of studies of SOCE decreased dramatically").

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 id.* at 42; *see* 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. 1 Appx. Tab 85-5 at 41; *see* Neil McConaghy & R.F. Barr, *Classical, Avoidance, and Backward Conditioning Treatment of Homosexuality*, 122 Brit. J. Psychiatry 151 (1973).

Thus, the relative lack of empirical studies on SOCE is not evidence of lack of harm, as Appellants appear to suggest. If anything, the lack of studies on SOCE may be indicative of the ***risk*** of harm. The district court correctly recognized this

[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).

fact in its Order. *See* 11 Appx. Tab 141 at 37 n.12 ("Notably, the APA Task Force Report suggests that the lack of rigorous studies is *because* SOCE is harmful.").

Second, Appellants claim that the Report does not indicate clear evidence of harm. *See* AOB 13-14, 47-48, 57; 1 Appx. Tab 1 at 10 ¶ 42); 1 Appx. Tab 8 at 11-12. This is simply mistaken. As explained in detail above, the Report does show evidence of harm. *See supra* § III.A. Moreover, Appellants' suggestion that the Report is deficient because it does not focus on patients who are alleged to have sought SOCE *voluntarily* misses the mark. Even putting aside Appellants' 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." 1 Appx. Tab 85-5 at 69. 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 id.* at 77, 121.

Third, Appellants claim that the Report improperly ignores evidence on the benefits of SOCE, and that the benefits from SOCE that are "at least equivalent to anecdotal evidence of harm." *See* AOB 15-16 (capitalization omitted). Again,

Appellants are incorrect. The Task Force *did* review evidence related to the purported benefits of SOCE. *See* 1 Appx. Tab 85-5 at 36-41.[15] 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.

As a related matter, Appellants appear to suggest that the Task Force used different standards when examining research concerning the harms of SOCE than it did when examining research concerning the purported benefits of SOCE. This suggestion is also incorrect. In conducting their review, Task Force members relied on multiple, well-accepted sets of efficacy criteria, including the standards of evidence for efficacy promulgated by the Society for Prevention Research (SPR). *See 2005 ASR Standards*; *see also* 1 Appx. Tab 85-5 at 28, 114. Furthermore, in reporting on the studies of SOCE that were not valid efficacy studies, the Report did report benefits, as well as harms. *See id.* at 49-50.

In any event, 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

[15] *But see* 1 Appx. Tab 85-5 at 35 ("[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." *Id.* at 42.

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.

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). 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.

CONCLUSION

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

June 17, 2019

Respectfully submitted,

/s/ *Jessica Ring Amunson*

Jessica Ring Amunson
Counsel of Record
Emily L. Chapuis
James T. Dawson
JENNER & BLOCK LLP
1099 New York Avenue NW
Washington, DC 20001
(202) 639-6000
jamunson@jenner.com

Counsel for All Amici Curiae

Nathalie F.P. Gilfoyle
Deanne M. Ottaviano
AMERICAN PSYCHOLOGICAL ASSOCIATION
750 First Street NE
Washington, DC 20002
(202) 336-6100

Counsel for American Psychological Association

Anne B. Camper
NATIONAL ASSOCIATION OF SOCIAL WORKERS
750 First Street NE, Suite 800
Washington, DC 20001
(202) 336-8799

Counsel for National Association of Social Workers and National Association of Social Workers Florida Chapter

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1. This brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) because it contains 6,472 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

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/s/ *Jessica Ring Amunson*
Jessica Ring Amunson

Counsel for All Amici Curiae

June 17, 2019

CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of June, 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.

/s/ *Jessica Ring Amunson*
Jessica Ring Amunson

Counsel for All Amici Curiae

June 17, 2019