Tingley v. Ferguson Filings

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,

Defendants.

Case No. 3:21-cv-5359

VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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INTRODUCTION

1. Plaintiff Brian Tingley is a licensed Marriage and Family Therapist practicing in Fircrest, Washington. For over twenty years, Mr. Tingley's clients have looked to him for support in pursuing meaningful and positive change in their lives.

2. Plaintiff finds great fulfillment in working with clients to identify their objectives and encouraging them to achieve the goals that they set for themselves, consistent with their own moral values and religious beliefs. In close relationships built on a strong foundation of trust and openness, Plaintiff has seen adults, couples, teenagers, and children achieve great improvements in relationships as well as in personal stability and happiness simply by talking through the personal challenges that they face.

3. Plaintiff works with couples, individual adults, family groups, and individual children and teenagers, depending on the need. Among the wide range of issues that Plaintiff addresses from time to time with minor clients are issues relating to gender and sexual attractions and behaviors. Needless to say, these are among the most sensitive and private conversations possible.

4. Yet in passing Senate Bill 5722, codified at Wash. Rev. Code §§ 18.130.020 and 18.130.180 (the "Counseling Censorship Law," or "the Law"), Washington State seeks to insert itself into the privacy of Plaintiff's counseling room and censor his discussion and exploration of certain ideas with his young clients. The Law threatens severe sanctions—including substantial fines, suspension from practice, and even loss of his license and livelihood—if Plaintiff speaks ideas, and assists his clients towards goals, of which the State disapproves.

5. Through the Counseling Censorship Law, Washington State seeks to impose uniformity and silence dissent on topics about which both clients and

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counselors hold differing views motivated by ideology, faith beliefs, and differing interpretations of science.

6. Specifically, the Counseling Censorship Law prohibits—in vague and expansive terms—any conversation or exchange of ideas between a counselor and his minor client in pursuit of a goal to "change" that young person's gender identity or sexual attractions, orientation, or behaviors.

7. The Law is not aimed at any particular practices. Amendments to limit the law to physically abusive practices were rejected. Instead, and by design, the Law sweeps in even simple conversation, within a voluntary counseling relationship between a minor client and his chosen counselor, in pursuit of personal goals set by the client.

8. Worse, the Counseling Censorship Law intrudes and censors with a decidedly biased and unbalanced hand.

9. For a minor client who seeks the assistance of a counselor to pursue a personally chosen goal of achieving comfort with a gender identity congruent with the client's biological sex, or a goal of reducing same-sex attraction and increasing sexual attraction to the opposite sex, the Law steps in to deny that young person the professional help that he or she desires.

10. For a minor client of faith who seeks the assistance of a counselor who shares his faith, to help him align his thoughts and his conduct with the teachings of his faith, the Law again says "No," denying that young person professional help towards his goal.

11. Meanwhile, however, the Law imposes no barrier to a counselor supporting a client in "exploring" or "developing" any other sort of gender or sexual identity—or even guiding a minor towards permanently sterilizing treatments and procedures to alter that young person's body to more closely match a perceived gender identity.

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12. In short, through the Counseling Censorship Law, the State of Washington seeks to impose its own new orthodoxy concerning sexual morality, human nature, personal identity, and free will. And it seeks to do all this at expense of the freedom, beliefs, and even religious convictions of both counselors and clients.

13. But our Constitution does not permit government to impose any orthodoxy in thought, belief, or speech. The First Amendment and Fourteenth Amendment strongly protect the rights of both counselors and clients to speak freely between themselves on any topic, in pursuit of any personal goal, and guided by any religious or moral convictions.

14. Under our system, the government has no power to censor ideas and speech with which it disagrees, even if it believes those ideas to be wrong, offensive, and potentially harmful.

15. As a result, the Washington State Counseling Censorship Law is unconstitutional and unenforceable in its entirety.

16. Because the Law violates the rights of Plaintiff Brian Tingley and of his clients, and because it threatens Plaintiff with the loss of his livelihood, Plaintiff brings this lawsuit to obtain a declaration that the Counseling Censorship Law is unconstitutional both on its face and as applied, and to enjoin its enforcement.

I. JURISDICTION AND VENUE

17. This civil rights action pursuant to 42 U.S.C. § 1983 raises federal questions under the United States Constitution, particularly the First and Fourteenth Amendments.

18. This Court has original jurisdiction under 28 U.S.C. §§ 1331 and 1343.

19. This Court has authority to award the requested declaratory relief under 28 U.S.C. §§ 2201-02 and Federal Rule of Civil Procedure 57; the requested

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injunctive relief under 28 U.S.C. § 1343 and Federal Rule of Civil Procedure 65; and costs and attorneys' fees under 42 U.S.C. §1988.

20. Venue is proper in this Court under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims occurred in this District and the Defendants are located in relevant part in this District.

II. PARTIES

A. Plaintiff

21. **Plaintiff Brian Tingley** is a licensed Marriage and Family Therapist in the State of Washington. He resides in Tacoma, Washington and practices in Fircrest, Washington.

22. Mr. Tingley obtained his Master of Science in Marriage and Family Therapy from Seattle Pacific University in 2001, and has gained 20 years of experience in active practice since that time. Previously, he had an award-winning career in video and news production for local network affiliates, during which he took on many assignments focusing on the needs of youth, family, and the community.

23. Mr. Tingley is an Approved Supervisor by the State of Washington and the American Association for Marriage and Family Therapy, as well as a Clinical Fellow Member of the American Association for Marriage and Family Therapy. He has maintained a private practice of counseling since 2002, working with adolescents, adults, and couples on a wide variety of matters. He also has experience in crisis intervention and has worked alongside child protective services and law enforcement where children have been placed in protective custody.

24. Mr. Tingley has taught college courses in Psychology and Human Relations, and has facilitated training seminars and workshops at the request of local therapist groups.

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25. He has provided both in-person and written testimony to the Washington State Legislature on issues pertaining to teenage sexuality and identity on several occasions, including in connection with the bill that was ultimately passed as the Counseling Censorship Law.

26. Mr. Tingley is a committed Christian who also has theological training, having received a Diploma in Ministry and Biblical Studies in 1984. He is regularly asked to provide seminars and workshops to local churches on challenges facing children and families that take into account a biblical perspective as well as his professional expertise.

27. While Mr. Tingley does not impose his Christian faith on anyone, his faith informs his views concerning human nature, healthy relationships, and what paths and ways of thinking will enable his clients to achieve comfort with themselves and live happy and satisfied lives.

28. Mr. Tingley works with both Christian and non-Christian clients, and he approaches counseling of any clients who choose his services in a consistent way. However, many of his clients are referred to him by local churches, and the majority of his clients share his Christian faith.

B. Defendants

29. **Defendant Umair A. Shah** is the Secretary of Health for the State of Washington, having been appointed by Governor Jay Inslee on December 21, 2020.

30. By virtue of his position as Secretary of Health, Dr. Shah has jurisdiction and disciplinary authority over a number of licensed professions pursuant to Wash. Rev. Code ("RCW") § 18.130, including licensed marriage and family therapists under RCW § 18.130.040 (2)(a)(x).

31. Dr. Shah is authorized under RCW § 18.130.050 to "investigate all complaints or reports of unprofessional conduct" and to conduct any associated hearings. He is further authorized under RCW § 18.130.185 to bring an action

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against any regulated professional to enjoin him or her from violating the Counseling Censorship Law.

32. Dr. Shah is named in his official capacity only.

33. **Defendant Kristin Peterson** is the Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health.

34. Under the direction of Ms. Peterson, the Health Systems Quality Assurance team within the Department of Health claims the right to investigate and prosecute complaints against healthcare providers licensed by the State of Washington further to RCW § 18.130.[1]

35. Complaints against healthcare providers and facilities in the State of Washington are to be directed to the Health Systems Quality Assurance group, which considers the substance of the complaint and determines what action is to be taken.

36. Ms. Peterson is named in her official capacity only.

37. **Defendant Robert W. Ferguson** is the Attorney General for the State of Washington.

38. As Attorney General, Mr. Ferguson is the first person identified by RCW § 18.130.185 as authorized to bring an enforcement action to enjoin a person from violating the Counseling Censorship Law.

39. On information and belief, the Attorney General works with the Health Systems Quality Assurance team to identify potential violations and evaluate evidence concerning alleged violations of the Counseling Censorship Law.[2]

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[1] Health Systems Quality Assurance, WASHINGTON STATE DEPARTMENT OF HEALTH, https://www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance (last visited April 29, 2021).

[2] Health Professions Complaints Process, WASHINGTON STATE DEPARTMENT OF HEALTH, https://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsComplaintProcess (last visited April 29, 2021).

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40. Mr. Ferguson is named in his official capacity only.

III. FACTUAL BACKGROUND

A. The Counseling Censorship Law

41. In March 2018, Washington Governor Jay Inslee signed Senate Bill 5722 into law, which came into effect on June 7, 2018, and was codified at RCW § 18.130.020 and 18.130.180.

42. The Counseling Censorship Law added "performing conversion therapy on a client under age eighteen" to the list of conduct, acts, or conditions that would constitute "unprofessional conduct" for a "license holder."

43. Marriage and Family Therapists are among those deemed to be covered "license holders" under the definitions outlined in RCW § 18.120.020.

44. "Conversion therapy" is defined in terms that are vague, content-based, and biased against one perspective or point of view:

> "Conversion Therapy" means a regime that seeks to change an individual's sexual orientation or gender identity. The term includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. The term includes, but is not limited to, practices commonly referred to as "reparative therapy."
>
> "Conversion therapy" does not include counseling or psychotherapies that provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development that do not seek to change sexual orientation or gender identity."

45. The Counseling Censorship Law provides no definitions of the terms "gender identity", "gender expressions", "identity exploration", and "identity development." It provides no information at all as to what "behaviors" a therapist may not help a client attempt to change.

46. The Law provides no explanation on how an individual can engage in "exploration and development" relating to sexual orientation or gender identity

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without undergoing "change," or where the boundary between "exploration and development" and "change" might be.

47. The Law does not state whether the violative intent to "seek" change is the intent of the therapist, or the client, or both.

48. The Law contains no language concerning "sexual or romantic attractions or feelings towards individuals" of the opposite sex.

49. The prohibitions of the Counseling Censorship Law seek to enforce the Washington legislature's particular viewpoint concerning human sexuality, identity, and morality. Under this view, feelings of identification with the opposite sex, or sexual or romantic attractions or feelings toward individuals of the same sex, are the highest value, and must only be "affirmed," regardless of the wishes, personal life goals, and religious beliefs of the individual affected.

50. It is well known that many religious faiths have for countless generations taught a different view concerning sexual morality and the proper place of sexuality in relation to one's identity, conduct, and relationships. Nevertheless, the Counseling Censorship Law contains no meaningful religious exemption to protect the freedoms of counselors and clients to hold, speak and act on such faith-based views of human nature, healthy relationships, and morality.

51. Instead, the Counseling Censorship Law provides a sham exemption that is in fact no exemption at all. The Counseling Censorship Law states that it does not apply to "religious practices or counseling under the auspices of a religious denomination, church, or organization that do not constitute performing conversion therapy by licensed health care providers on clients under age eighteen." However, as the Counseling Censorship Law prohibits nothing *except* "performing conversion therapy by licensed health care providers on clients under age eighteen," this does not exempt religious providers and clients from anything at all. Instead, it indirectly asserts the right and power to prohibit even "religious . . . counseling" by

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a license holder "under the auspices of a . . . church," if the counsel that is given disagrees with the viewpoint enshrined in the Counseling Censorship Law.

52. Similarly, the Counseling Censorship Law states that it does not apply to "nonlicensed counselors acting under the auspices of a religious denomination, church, or organization." But this again is a sham and empty exception, since the Law never applies to "nonlicensed counselors," whether religious or not.

53. The Counseling Censorship Law threatens severe sanctions against any therapist or counselor found to have violated its vague and viewpoint-based prohibitions. It threatens these penalties based on nothing more than private conversations and counsel that is desired by clients and their parents.

54. As stipulated in RCW § 18.130, in the event of a violation of the Counseling Censorship Law, the Secretary "must" impose one of a number of sanctions listed in RCW § 18.130.160 that range from "censure or reprimand," to fines of $5,000 for each violation, to permanent revocation of the professional's license—destroying that professional's very means of earning a living and supporting a family.

55. Further, the Law authorizes not just the Secretary or responsible disciplinary bodies, but "any other person" to file a lawsuit accusing a counselor or therapist of violating the Counseling Censorship Law, RCW § 18.130.185, exposing professionals who do not agree with the State's approved viewpoint on these matters of sexuality and identity to harassment and attack by private activists.

56. Restrictions on so-called "conversion therapy" are often justified by claims that unscrupulous practitioners have resorted to electroshock therapy or physical restraint, and the bill's primary sponsor Senator Liias asserted that the law is directed against "barbaric practices." The Senate Bill Report behind SB 5722 expressed concern about supposed practices that "induce nausea, vomiting, and other responses from youth, while showing them erotic images."= No specific

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instances are documented in the Report. The House Report asserted that problematic practices include "physical abuse of children." However, the legislative record of the Counseling Censorship Law did not contain any testimony or evidence that such practices have *ever* been engaged in by "license holders" in the State of Washington.

57. In reality, the Counseling Censorship Law is directed against specific ideas and personal goals, not against specific practices. During consideration of the Law, the Washington legislature rejected an amendment that would have limited the proscribed conduct to "aversion therapy" that involved "electrical shock, extreme temperatures, prolonged isolation, chemically induced nausea or vomiting, assault" or other procedures intended to cause "pain, discomfort, or unpleasant sensations."

58. Likewise, the Washington legislature rejected an amendment that would have limited the definition of prohibited "conversion therapy" to mean "aversive or coercive" regimes that would include physical restraints, "use of pornographic material, and electroconvulsive therapy conducted outside of medically accepted use."

59. It is revealing to note that the Washington legislature also rejected an amendment that would have specifically exempted counseling that would have been "consistent with the client's affirmatively stated goals or objectives."

60. Instead, Senator Liias, one of the sponsors of the bill, argued in debate that in his view counseling consisting of mere talk could be "just as pernicious" as abusive practices, and affirmed that the bill was directed to "use [of] words."

61. This legislative history confirms that the intent of the Counseling Censorship Law is to suppress ideas and advice that the government of Washington State frowns on, and instead to restrict counseling in this State to viewpoints and advice that reflect certain values.

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62. Further, it is well known to both advocates and practitioners in the field, and on information and belief, was well known to the legislative sponsors of the Counseling Censorship Law, that most of those who seek counseling to change sexual orientation are motivated by religious convictions.

63. Thus, in 2013 the American Counseling Association issued a statement declaring that "Conversion therapy as a practice is a religious, not psychologically-based, practice…. The treatment may include techniques based in Christian faith-based methods…." In other words, according to the ACA, what the Counseling Censorship Law seeks to prohibit is "a religious . . . practice."

64. Another of the Bill's sponsors, Senator Maureen Walsh, implicitly admitted this while advocating passage of the Bill when she denounced those who (in her words) might seek to "pray the gay away."

65. The Human Rights Campaign organization, which is active nationally in promoting counseling censorship laws and ordinances, in its website accuses "right-wing religious groups" of "promot[ing] the concept that an individual can change their sexual orientation or gender identity."

66. In a booklet published by the Human Rights Campaign and National Center for Lesbian Rights titled "Protecting our children from the harms of conversion therapy," the introduction blames "churches, synagogues, mosques and temples around the world" for telling LGBTQ people that "they are sinful," and the booklet refers to religious faith and religious leaders and institutions on almost every page.

67. In a report published in 2009, a task force of the American Psychological Association reported that "most SOCE ["sexual orientation change efforts"] currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs." The Task Force further reported that those who seek

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counseling with a goal of moving away from same-sex attractions are "predominately . . . men who are strongly religious and participate in conservative faiths."[3]

68. Leading authors in the field have made the same observation repeatedly over the last two decades. In 1999, psychology professor and prominent advocate of counseling censorship laws Douglas Haldeman wrote that "Historically, most conversion therapy occurred in religious settings." In 2004, Prof. Haldeman again wrote that "the vast majority of those seeking sexual orientation change because of internal conflict have strong religious affiliations." Douglas C. Haldeman, *When Sexual & Religious Orientation Collide: Considerations in Working with Conflicted Same-Sex Attracted Male Clients*, 32 THE COUNSELING PSYCHOLOGIST 691, 693 (2004). And in an important paper in 2016, internationally prominent authors Prof. Lisa Diamond and Prof. Clifford Rosky cited multiple peer-reviewed papers to conclude that "[T]he majority of individuals seeking to change their sexual orientation report doing so for religious reasons rather than to escape discrimination." Lisa M. Diamond & Clifford J. Rosky, *Scrutinizing Immutability: Research on Sexual Orientation & U.S. Legal Advocacy for Sexual Minorities*, 52 J. OF SEX RESEARCH, 1, 6 (2016).

69. In sum, through the Counseling Censorship Law, the State of Washington is not only seeking to censor and suppress ideas and personal goals with which it disagrees; it is targeting ideas and motivations well known to be primarily associated with and advocated by people of faith, for reasons of faith.

[3] American Psychological Association, *Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009), http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html (last visited April 29, 2021).

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B. The Plaintiff's clients and his practice

70. Plaintiff Tingley founded his own private therapy practice in 2002, and since that time has offered a wide range of therapy services to adolescents, adults, couples, and families addressing interpersonal and family conflict, communication issues, marital and post-divorce issues, individual identity challenges, emotional management including depression and anxiety, anger management, and adult Attention Deficit Hyperactivity Disorder, among many other matters. The practice web page states that the practice group consists of Christian counselors, who share a goal of helping clients achieve "personal and relational growth as well as healing for the wounded spirit, soul, and body through the healthy integration of relational, psychological, and spiritual principles with clinical excellence."[4]

71. While Plaintiff is a committed Christian, his services are available to anyone, regardless of whether they have a different faith background or no faith at all. Nevertheless, Mr. Tingley's clients are frequently referred to him by local churches, and the majority are Christians. Many of them come to Plaintiff because they desire a counselor who shares and so will understand and respect their Christian beliefs. Often, Plaintiff's clients express the belief that alignment between their actions and feelings on the one hand, and their religious convictions on the other, will be important to helping them to heal from past trauma, as well as to pursuing their personal goals and the lives that they wish to lead going forward.

72. Plaintiff's counseling approach is to provide a safe environment for each client to allow for his or her own self exploration. Plaintiff's first priority is ensuring that he establishes trust with his clients, so that they feel safe in opening up to discuss all kinds of sensitive issues. Once rapport is established, Plaintiff can

[4] *See* Family Foundations Counseling, https://www.familyfoundationscounseling.com/ (last visited April 29, 2021).

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help clients identify their own objectives and then, through discussion over time, work together to accomplish those objectives.

73. Because Mr. Tingley is a Christian himself, he is able to engage with his Christian clients in a manner that is particularly understanding and respectful of, and informed by, shared faith convictions and the personal goals of the client that may be guided by the client's faith convictions, or by the client's desire to live a life of integrity within his or her family.

74. Where clients have a strong faith, Mr. Tingley has recognized that it can be of particular importance to them to know that there are no unspoken concerns or suspicions about their beliefs on the part of their counselor. This is because of the central role that faith plays in their lives—touching on all aspects of their lives—as well as their prior experiences of varying degrees of opposition to their faith from those who do not share their beliefs. Consequently, in many cases he is specifically sought out by clients because they want to speak with a counselor who shares their Christian worldview about the issues that are affecting their lives.

75. However, Plaintiff is not a pastor, and does not consider it part of his role to rebuke clients, or to tell them how they should live their lives.

76. Working with his clients, all Mr. Tingley does is listen and talk with them. He spends time listening to their stories, their fears, and their hopes—at times probing with questions to aid their own self-discovery. Through thoughtful discussion, ideas are exchanged and positions are queried. This process allows clients to reflect on their identity and their beliefs, as well as enabling them to identify personal goals and objectives which are not immediately clear to them.

77. Plaintiff provides counseling concerning a wide array of issues that arise in personal, marriage, and family life. Issues relating to gender identity and sexual attractions and behaviors are simply some of the many issues that clients bring into his counseling room and about which they ask his assistance.

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78. Given his expertise and his family-oriented practice, a significant part of Mr. Tingley's practice is dedicated to counseling minors. He works with minors on a wide variety of issues as they transition into adulthood, but his basic approach to them as clients remains the same.

79. Although the wishes of the parents may often overlap with those of their children, Mr. Tingley's approach is to support the minor in his or her own personal exploration and development. As he works with the minors over the course of continued discussion, he seeks to offer them the support and encouragement that they need to achieve the goals and objectives that they set for themselves.

80. While in most cases the minor will initially attend on the prompting of their parent or parents, Mr. Tingley will only continue to see a minor as a client if the minor is willing to work with him, and participates voluntarily.

81. Topics about which Plaintiff has counseled minors include depression, anxiety, anger management, and other issues of emotional management. They also include concerns or confusion about gender identity, unwanted same-sex attraction, and other unwanted sexual behaviors such as addiction to pornography.

82. In these cases, as with any other, Mr. Tingley does nothing but talk with his clients. He simply listens to what his clients say, asks them questions, and talks with them.

C. Plaintiff's counseling relating to gender identity

83. "Gender identity" is not defined in the Counseling Censorship Law.

84. Gender dysphoria is defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5"), in adolescents and adults, as "A marked incongruence between one's experienced/expressed gender and assigned gender [i.e., biological sex], of at least 6 months duration," along with certain other indicators, and resulting in "clinically significant distress or impairment in social, occupational, or other important areas of functioning."

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85. In recent years, rapidly increasing numbers of minors have been referred to gender clinics for diagnosis for potential gender dysphoria, with one noted clinic reporting a more than eight-fold increase between 2002 and 2013, M. Aitken et al., *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, 12 J. OF SEXUAL MEDICINE, 756, 757 (2015), and a more recent paper recognizing that "most studies" demonstrate a "clear trend" of "growth in the proportion of [transgender] self-identifying individuals over time." Ian Nolan et al., *Demographic and Temporal Trends in Transgender Identities and Gender Conforming Surgery*, 8 TRANSITIONAL ANDROLOGY AND UROLOGY, 184, 185 (2019).

86. Nolan et al. report that transgender identification "appears to be more common among younger age groups," with noticeable geographic concentrations. In particular, a 2016 survey of 9th to 11th graders in Minnesota reported "exceptionally high rates of [transgender] identities," reaching 2,700 per 100,000 youths, or almost 3%. *Id.* at 185.

87. Of particular concern, across the last 20 years the proportion of adolescents referred to gender clinics who are biologically female—girls—has changed rapidly, *doubling* at one clinic from about 30% during the 1999-2005 time period to more than 60% during the 2006-2013 time period. Aitkin et al. at 758. Academics and practitioners in the field have described evidence that many of these girls appear to have been strongly influenced by internet contacts, or by local friend groups. Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 13 PLoS ONE, e0202330 (2018).

88. Rapid changes in numbers and sex ratios of individuals reporting concerns about gender identity, as well as striking geographic variations, strongly suggest that social and cultural factors are affecting many adolescents' sense of comfort with—or distress about—their natal sex.

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89. The widely urged path of "affirming" a transgender identity for girls includes the use of puberty blockers beginning as young as eight; cross-sex hormones a few years later which build muscle mass, cause growth of facial hair and a deepened voice; "social transition" including adoption of a male name and male pronouns and dress; breast-binding to conceal their developing female biology; and ultimately double mastectomy and hysterectomy, followed by life-long administration of cross-sex hormones.

90. Obviously "sex reassignment surgery," which removes testicles or ovaries, permanently sterilizes the affected individual. However, it is generally recognized by practitioners that cross-sex hormones, which are increasingly prescribed even for minors, may also irreversibly sterilize a child for life. A Harvard Medical School professor and her co-authors, who are active in medically transitioning minors, admit that "cross-sex hormones . . . may have irreversible effects," and describes infertility as "a side effect" of these drugs. Carly Guss et al., *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, 26 CURR. OPIN. PEDIATRICS, 421, 424-5. Another team of prominent practitioners in the field caution that there is evidence that cross-sex hormones administered to minors will permanently and irreversibly sterilize at least some of these youths, both male and female. Yet these practitioners also recognize that "research suggest[s] some of these individuals may desire genetic children as adults." Amy Tishelman et al., *Health Care Provider Perceptions of Fertility Preservation Barriers and Challenges with Transgender Patients*, 36 J. OF ASSISTED REPRODUCTION AND GENETICS, 579, 580 (2019).

91. In addition to permanent sterilization, accepting and living in a transgender identity carries a number of known or likely lifetime costs and risks for a young person.

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92. Any individual whose testicles or ovaries are surgically removed through so-called "sex reassignment surgery" requires life-long medical hormonal therapy. In general, the use of cross-sex hormones, once begun, will be continued for life.

93. As a result of chemical or surgical impacts on their sexual development and organs, some transgender adults experience diminished sexual response, and are unable ever to experience orgasm.

94. Multiple authors have cautioned that administration of cross-sex hormones to biological males increases the individual's risk of blood clots and resulting strokes, heart attack, and lung and liver failure.

95. It is often asserted that transgender youth attempt suicide at much higher rates than the general adolescent population. This is true. But it is not true that there is any statistically significant evidence that "affirmation" in a transgender identity substantially reduces actual suicide attempts. Instead, multiple studies report that adolescents and adults who adopt and live in a transgender identity continue to suffer severely negative mental health outcomes—including suicide and attempted suicide—throughout their lives, and this remains true even if they undergo the ultimate "gender-affirming" step of extensive surgery to reconfigure their body to conform in appearance to their desired gender identity.

96. A long-term study in Sweden found that *after* sex-reassignment surgery transgender individuals exhibited a rate of completed suicide 19 times higher than the control group, suicide attempts at a 7.6 times higher rate, and hospitalization for any psychiatric condition at a 4.2 times higher rate. These researchers concluded that "[t]he most striking result was the high mortality rate in both male-to-females and female-to-males, compared to the general population." C. Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS ONE, e16885, 5-6 (2011).

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97. Similarly, a study in the United States found that the death rates of transgender-identifying veterans are comparable to those who suffer from schizophrenia and bipolar diagnoses—dying 20 years earlier on average than a comparable population.

98. Many academics and practitioners and even transgender activists have observed that gender identity is not necessarily either binary or fixed for life. Indeed, in formally promulgating a rule in 2016, the United States Department of Health and Human Services defined "gender identity" as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth," and disparaged "the expectation that individuals will consistently identify with only one gender" as an inaccurate "sex stereotype." *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31,376 (May 18, 2016) at 31,384 and 31,468.

99. In addition, at least for pre-adolescents who experience gender dysphoria and receive therapeutic support but do *not* socially transition, "*every* follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." J. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. OF SEX &MARITAL THERAPY, 1, 1 (2019). In fact, multiple studies have documented that for pre-pubertal children who suffer from gender dysphoria, the very large majority—estimates range between 80%-98% percent—will grow into comfort with a gender identity congruent with their biological sex by young adulthood, so long as they are *not* affirmed as children in a transgender identity. S. Adelson & American Academy of Child & Adolescent Psychiatry, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY, 957, 963 (2012).

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100. It is not surprising, therefore, that increasing numbers of young women are speaking up who for a time transitioned to live in a male gender identity, and underwent varying degrees of hormonal and surgical "transition," but who later regretted those decisions, and reclaimed a female gender identity. These women are publicly expressing regret about the harm done to their bodies and minds, and anger against the too-hasty counsel and medical advice they received as minors which steered them into that transgender identity and those medical choices.

101. While many of these women had previously detailed their experiences on internet blog websites pseudonymously, in recent years they have become more visible, writing under their real names, posting videos online, and forming support groups for those in similar situations.[5] In 2018, *The Atlantic* profiled several high-profile "detransitioners" who have been raising awareness of their own stories as a warning to those who are promoting or hearing only positive narratives about the impact of gender transition on affected individuals.[6]

102. For example, Max Robinson, who has been featured at length in both *The Atlantic* and *The Economist*[7], became convinced that her internal discomfort needed to be resolved by a sex "transition" after discovering the "world of online gender-identity exploration" at age 15. A doctor prescribed cross-sex hormones for her beginning at age 16, and at age 17 she underwent a double mastectomy. While Max was initially pleased with the results, it wasn't long before she realized that

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[5] *See* Pique Resilience Project, https://www.piqueresproject.com/ (last visited April 29, 2021); Detrans Canada, https://detranscanada.com/ (last visited April 29, 2021); and Lost in Transition, https://lostintransition.info/ (last visited April 29, 2021), among others.

[6] *See* Jesse Singal, *When Children Say They're Trans*, The Atlantic, July/August 2018, https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/, attached as Exhibit A.

[7] *See* Charlie McCann, *When girls won't be girls*, The Economist, Sept. 28, 2017, https://www.economist.com/1843/2017/09/28/when-girls-wont-be-girls, attached as Exhibit B.

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she had made a mistake and began the process of "detransitioning" at age 19. She lives with permanent physical changes—a deep voice, a beard, and a flat chest—that cannot be reversed. *See* attached Exhibits A and B.

103. Similarly, Cari Stella was prescribed cross-sex hormones by a doctor at age 17, and underwent a double mastectomy at age 20. According to Cari, from the time she first saw a therapist, no professional ever suggested or helped her explore alternatives to a "transition."[8] Already by age 22, Cari realized that she had been led into a mistake, and "detransitioned." Cari maintained a blog[9] and YouTube channel[10] reflecting on her experiences, and in a video posted in 2016 said: "I'm a real-live 22-year-old woman with a scarred chest and a broken voice and a 5 o'clock shadow because I couldn't face the idea of growing up to be a woman."

104. In the United Kingdom, 23-year-old Keira Bell successfully sued the Tavistock and Portman NHS Trust—the leading British clinic responsible for administering puberty blocking drugs—after her own experience culminated in the realization that she had been rushed "down the wrong path."[11] As a teenager, Keira went through a regimen of puberty blockers and cross-sex hormones, before undergoing a double mastectomy at age 20. She initially believed that the measures would help her achieve happiness, but "detransitioned" shortly after having the double mastectomy. Keira has become an outspoken campaigner for reform, stating that her doctors had failed her as a confused and distressed adolescent by failing to

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[8] *See In praise of gatekeepers: An interview with a former teen client of TransActive Gender Center*, 4th Wave Now, April 21, 2016, https://4thwavenow.com/2016/04/21/in-praise-of-gatekeepers-an-interview-with-a-former-teen-client-of-transactive-gender-center/

[9] *See* Cari Stella, Guide on Raging Stars Blog, https://guideonragingstars.tumblr.com/ (last visited April 29, 2021).

[10] *See* Cari Stella, YouTube, https://www.youtube.com/channel/UChCA_LScK33yNsiq0BIAa2g (last visited April 29, 2021).

[11] *See Puberty blockers: Under-16s "unlikely to be able to give informed consent,"* BBC News, Dec. 1, 2020, https://www.bbc.com/news/uk-england-cambridgeshire-55144148.

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"challenge" her oversimplified desires to be male. "I think it's up to these [medical] institutions," Keira has said, "to step in and make children reconsider what they are saying, because it is a life-altering path."

105. Many similar stories are coming to light as more individuals realize that they are not alone in enduring these experiences.[12] It is not surprising, therefore, that increasing numbers of young people who struggle with questions of gender identity, and the parents of such young people, are aware that there are often grave and lasting costs resulting from adopting a transgender identity, and that adoption of or attraction to a transgender identity is not necessarily fixed, unchangeable, or desirable.

106. It is also not surprising, and is entirely reasonable and legitimate, that some young people (and/or their parents) wish to explore whether it is possible for them to escape from gender dysphoria and achieve comfort with their own biological sex, so as to avoid all of these potentially severe lifetime costs of living in a transgender identity.

107. Meanwhile, there are no statistically significant studies that demonstrate that voluntary conversational counseling which aims to help the client towards a personally chosen goal of achieving or returning to comfort with his or her own biological sex is in any way harmful to clients.

108. Mr. Tingley has worked with minors who have expressed discomfort with their biological sex and struggled with questions and feelings around their gender identity.

109. In one incidence since the enactment of the Counseling Censorship Law, parents brought to Plaintiff's clinic their teenage minor daughter who had

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[12] *See* Post Trans, https://post-trans.com/ (last visited April 29, 2021), *Voices*, Sex Change Regret, https://sexchangeregret.com/voices/ (last visited April 29, 2021), among others. *See also* Abigail Shrier, *Irreversible Damage: The Transgender Craze Seducing Our Daughters,* Regnery Publishing (2020).

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been exposed to websites advocating transgender identification for girls, and who had begun expressing unhappiness with her female gender identity, and even asserting a male gender identity. This girl had been previously diagnosed with high-functioning autism and was facing various social difficulties at school with her peers, but in earlier years had appeared comfortable in her identity as a girl.

110. The parents were aware that gender dysphoria is often accompanied by mental health co-morbidities, that gender identity in young people is not necessarily fixed, and that long-term adoption of a transgender identity by their daughter would likely lead to sterilization, lifelong dependence on extraordinary medical care including cross-sex hormones, and an increased risk of physical, social, and mental health difficulties.

111. The parents and child were also Christian. Contrary to basic assumptions of contemporary "gender ideology," many Christians, as well as believers in other historic religions, believe that God intended and designed humanity as "male and female," that God has created each individual as either male or female, and that obedience, well-being, and happiness lie in acceptance of and gratitude for the particular sex that God has given each individual.

112. The parents' desire was thus to find a counselor who would assist their daughter in understanding herself and exploring the reasons for her unhappiness with her sex and identity as a girl, and hopefully enable her to return to comfort with her female body and reproductive potential, and with a gender identity as a female, girl, and in years to come, woman.

113. The parents expressed these thoughts and goals to Mr. Tingley, and sought his professional expertise as a counselor to work with their daughter towards that goal. The daughter also expressed a willingness to meet and talk with Plaintiff. Accordingly, Plaintiff entered into this counseling relationship, taking the girl on as a client.

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114. Plaintiff's counseling of this client mainly consisted of private discussions, consisting for the most part of prompting questions, and sympathetic listening. It also included discussions with the girl and her parents together.

115. At no point did the client indicate that she was talking with Plaintiff against her will, or that she felt that Plaintiff was coercing her in any manner.

116. After several counseling sessions, the girl expressed a desire to become more comfortable with her biological sex, notwithstanding her previous claims of a male gender identity. Plaintiff did not challenge her new goal or the "change" that it would mark, but worked with her toward that goal. Over the course of several years of observing and talking with this girl, Plaintiff saw a notable improvement in her demeanor and self-esteem, and understood the client to be more comfortable identifying herself as a girl and to be much happier with her direction in life.

117. Another recent instance occurred when a Christian family came to Mr. Tingley after their minor daughter had begun expressing discomfort with her biological sex and asserting a male gender identity. This girl had exhibited no signs associated with gender dysphoria as a young child, but had begun to assert a transgender identity only after exposure to online material advocating transgender identification.

118. Her parents were aware that gender dysphoria is often accompanied by mental health co-morbidities, that gender identity in young people is not necessarily fixed, and that long-term adoption of a transgender identity by their daughter would likely lead to sterilization and lifelong medical complications.

119. These parents also sought a counselor who would assist their daughter in understanding herself and exploring the reasons for her unhappiness with her sex and identity as a girl, and hopefully enable her to return to comfort with her female body and reproductive potential, and with a gender identity as a female, girl, and in years to come, woman.

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120. However, while the parents of this minor client expressed their faith-based hopes and goals for their daughter's counseling regarding gender identity, they also discussed the Counseling Censorship Law with Plaintiff, and expressed great fear about what being accused of being involved in a violation of that Law might do to their family, including their fear that it could lead to the intrusion of Child Protective Services between themselves and their daughter.

121. As the daughter was willing to meet and talk with Plaintiff, Plaintiff took her on as a client. However after a few sessions, without expressing any dissatisfaction with Plaintiff's counseling, the parents terminated the counseling relationship, on information and belief due to their fears resulting from the Counseling Censorship Law.

122. Plaintiff has supported several adolescent clients in similar circumstances who have sought his help as a therapist in addressing questions and concerns surrounding their gender identity. In some of those cases, during counseling the client has specifically expressed the desire to accept and achieve comfort with their God-given sex as a faith-driven motivation for their goals in counseling. In others of such cases, neither the parents nor the client have expressed any religious motivation for achieving their chosen goals.

123. Given the rapid and large increase in children and teens who are experiencing gender dysphoria, and given Plaintiff's visible identity as a licensed counselor who is a Christian who has previously and is currently helping clients with these issues, Plaintiff expects with high confidence that parents and minors will continue to come to him for counseling with a goal of helping a child who is exhibiting gender dysphoria or a transgender identity return to comfort with a gender identity aligned with his or her biological sex. Plaintiff wishes to provide such counseling for minors who are willing to engage in such conversational counseling on a strictly voluntary basis.

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D. Counseling and change relating to sexual attractions

124. Individuals who experience same-sex attractions may and do have multiple reasons not to accept those attractions nor to let those attractions define their lives and relationships.

125. A young person may have a personal life goal to enter into a stable marriage in which he or she can raise children who are the natural, genetic children of both spouses. Indeed, the ability to form one's own natural family has been recognized as one of the greatest joys in life, and one of the most fundamental human rights, across cultures and history. Of course, this can only happen in a heterosexual relationship.

126. Further, major historic faiths including Judaism, Christianity, and Islam, have long taught that the only moral context for sexual relationships is within a heterosexual marriage. Individuals who believe any one of these religions may well wish to bring both their desires and their conduct into conformity with the moral teachings of their faith, and what they believe to be the commandments of God. Indeed, recognizing that humans experience wrong or misguided desires in many contexts—not just sexual—and striving to bring not just conduct but desires into line with the moral teachings of the faith, is a central aspect of each of these religions.

127. For example, the Lubavitcher Rebbe Menachem Mendel Schneerson, an internationally famous Jewish teacher, in a well-known letter to a young man who struggled with same-sex attractions, wrote that "Every day children are born with particular natures and innate tendencies or drives, some of them good and some of them bad. . . . The Creator endowed human beings with the capacity to improve, indeed even to change their 'natural' (i.e. innate) traits." Similarly, Christianity teaches that our "natural" desires are often misguided and harmful, but that God can work within an individual to give him a "new heart."(Ezekiel

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26:36.) The Bible's teaching in the New Testament further emphasizes both the necessity and the possibility of profound inner change, for example in the Apostle Paul's instruction to believers: "Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will." (Romans 12:2.) With regard to gender identity, formal teaching of the Catholic Church instructs believers that "man . . . has a nature that he must respect and that he cannot manipulate at will" (*Laudato Si*, No. 1555 (2015)), and that "the young need to be helped to accept their own body as it was created" (*Amoris Laetitia*, No. 285 (2016)).

128. Each of these religions also teaches that, with divine help, individuals *can* make real progress in changing our desires and bringing them into line with the moral teachings of the faith—that is, that we are not mere machines irrevocably destined to be inescapably controlled by chemically programmed desires.

129. Each of these religions also teaches that faith in God and obedience to his moral law is more important to an individual's being and personal identity than are his or her sexual desires. Even noted authors Professors Lisa Diamond and Clifford Rosky, who consider themselves advocates for LGBTQ issues, recognize that assertions that sexual orientation cannot change "fail to adequately serve the interests of sexual minorities [i.e., all who experience anything other than purely heterosexual attractions] from ethnic, cultural, or religious backgrounds that do not share the contemporary Western conceptualization of sexual orientation as a defining status definition. Such individuals may believe that their status as a . . . religious minority is more critical to their sense of selfhood than their status as a sexual minority." Diamond & Rosky (2016) 21.

130. In fact, the historic Western religions do not "share the contemporary Western conceptualization" that sexual orientation defines the individual, and instead contend that belief in and obedience to God is "more critical to [the

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believer's] sense of selfhood" than is his or her sexual desires. Those who adhere to these faiths are fully entitled to believe this, to structure their own lives accordingly, and to pursue their own goals of personal identity and conduct informed by those beliefs.

131. It is often asserted that sexual attractions or orientation are fixed and not subject to change. But this is incorrect, and indeed is unsustainable in the face of modern science. In fact, a much-cited recent review of the relevant scientific literature by prominent LGBTQ-advocate authors concluded that "[A]rguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attractions remain fixed over the life course." Diamond & Rosky (2016) 2. These authors conclude that rather than resting on science, assertions that sexual orientation cannot change "rely on unspoken legal and moral premises whose validity must be questioned." Diamond & Rosky (2016) 11.

132. In the past many authors have hypothesized that same-sex attractions are biologically determined. However, no such causes have been found. A 2019 large-scale study by a team of authors from Harvard, MIT, and several other prestigious institutions analyzed the genomes of *almost half a million individuals*, along with self-reported information about heterosexual and same-sex sexual behaviors from these individuals. This massive study found only "very small" correlations between any genes and same-sex behavior. The authors concluded that the impact of genetic factors on sexual orientation were so small that they "do not allow meaningful prediction of an individual's sexual preference." Andrea Ganna et al., *Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior*, SCIENCE, 882 (2019).

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133. Before the extensive genomic work of Ganna et al. published in 2019, some studies had attributed a somewhat higher influence of genetics on the formation of sexual orientation. But even these studies attributed only minority influence to genetics, leaving sexual orientation no more genetically determined than "a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having lower back pain, and feeling body dissatisfaction." Diamond & Rosky (2016) 4.

134. Rather than being biologically predestined, many individuals who identify as other than heterosexual believe that they possessed and exercised choice in their sexual orientation. Surveying the literature again, Diamond and Rosky reject the claims of "[b]oth scientists and laypeople . . . that same-sex sexuality is rarely or never chosen," instead concluding that "individuals who perceive that they have some choice in their same-sex sexuality are more numerous than most people think." Diamond & Rosky (2016) 20.

135. Suggesting there is much left to learn about the complex origins of same-sex attractions and behavior, the American Psychological Association's stance on the biological origin of sexual orientation has shifted over the years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way," asserting that "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, plays a significant role in a person's sexuality." But just ten years later, in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, *no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or*

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factors. Many think that nature and nurture both play complex roles...." (Emphasis added).[13]

136. As to the possibility of *change* in sexual attractions or behaviors; it has often been assumed or asserted in the literature in the past, and is still often asserted by non-scientists or in the popular press today, that sexual orientation is fixed and unchanging. However, this assumption is not just unfounded, but provably false. Diamond and Rosky concluded in 2016, after surveying the scientific literature, that "Studies unequivocally demonstrate that same-sex and other-sex attractions do change over time in some individuals," and that the evidence for this is now so clear as to be "indisputable." Diamond & Rosky (2016) 6-7.

137. Empirically, the frequency of change in sexual orientation is particularly high among those who experience same-sex attraction.

138. Thus, after reviewing and summarizing extensive scientific literature, chapters in the American Psychological Association Handbook of Sexuality and Psychology conclude that "research on sexual minorities [i.e., all those who do not identify as exclusively heterosexual] has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time" (636), and that "Youth who are unsure or uncertain of their identity predominantly transition to a heterosexual identity" (562).

139. Many individual articles and studies reach the same conclusion.

140. A study by authors from the Harvard School of Public Health and other respected institutions examined "gender- and age-related changes in sexual orientation identity from early adolescence through emerging adulthood" in over 13,000 youth from 12 to 25 years of age, examining data collected for each

[13] American Psychological Association, *Answers to Your Questions For a Better Understanding of Sexual Orientation and Homosexuality* (2008), https://www.apa.org/topics/lgbtq/orientation (last visited April 29, 2021).

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participant at four times over a period of seven years. Miles Ott et al., *Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics*, 40 ARCH. SEXUAL BEHAV., 519 (2011). On this sample, Diamond and Rosky note that "Of the 7.5% of men and 8.7% of women who chose a nonheterosexual descriptor at ages 18 to 21, 43% of the men and 46% of the women chose a different category by age 23. Among the same-sex-attracted youth who changed, 57% of the men's changes and 62% of the women's changes involved switching to completely heterosexual."

141. Diamond and Rosky gather the results of the Ott et al. study along with two separate "longitudinal" studies (i.e., studying the same individuals over time), done by different researchers at different times on different samples, and report that, for young adult populations (starting ages from 18 to 26), of those who initially reported "any same sex attractions," every study found that between 40% to 60% of each sex reported a "change in attractions" when resurveyed a few years later. Of those who experienced a "change," at least half and as high as 83% "changed to heterosexuality at the second assessment." Diamond & Rosky (2016) 7.

142. Authors analyzing data collected for approximately 2,500 individuals as part of the National Survey of Midlife Development in the United States found that, of those of any age who identified at the start of the study as bisexual, a decade later approximately 32% identified as exclusively heterosexual, while of those who identified at the start of the study as homosexual (that is, exclusively attracted to the same sex), a decade later 28% identified as attracted to the opposite sex (heterosexual or bisexual). Steven E. Mock & Richard P. Eibach, *Stability and Change in Sexual Orientation Identity Over a 10-year Period in Adulthood*, 41 ARCHIVES OF SEXUAL BEHAVIOR 642 (2011) (Table 2). Heterosexual identity was far more stable: among those who identified as heterosexual at the start of the study,

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only 0.78% of men and 1.36% of women identified a different orientation a decade later. Mock & Eibach (2012) 645.

143. Another often-cited paper by prominent researchers summarized scholarship and cautioned that "there was little evidence of true bipolarity in sexual orientation" and that sexual orientation is instead "a continuous construct." These authors observed that one study found that "Only 38% of exclusive same-sex attracted females stayed in this group [between ages 21 and 26], with the rest moving into 'occasional' same-sex attraction (38%) or exclusive opposite-sex attraction (25%)," while another found that across a multi-year study period "Most (62%) young women changed their identity labels at least once. . . Over time, lesbian and bisexual identities lost the most adherents and heterosexual and unlabeled identities gained the most." In short, this paper's literature review found that "Evidence to support sexual orientation stability among nonheterosexuals is surprisingly meager." Ritch C. Savin-Williams & Geoffrey L. Ream, *Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood*, 36 ARCHIVES OF SEXUAL BEHAVIOR 385, 386 (2007).

144. Savin-Williams' and Ream's own study of adolescents and young adults pointed to the same conclusion, "highlight[ing] the high proportion of participants with same- and both-sex attraction and behavior that migrated into opposite-sex categories between [interview periods]." Savin-Williams & Ream (2007) 388.

145. Meanwhile, other noted scholars argue that the "sexual orientation" categories of "gay" or "straight" are to some extent socially defined, such that surrounding "cultural press" may in essence coerce an adolescent boy who merely experiences "affectional bonding" with another male to categorize and thus understand himself through the rigid binary category of "gay," whereas that same type of affection would not lead the boy to think of himself that way in a different

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cultural setting. Phillip Hammack, *The Life Course Development of Human Sexual Orientation: An Integrative Paradigm*, 48 HUMAN DEVELOPMENT, 267 (2005).

146. In light of these facts and considerations, some individuals who believe that they are experiencing same-sex attractions may want to understand themselves better, to understand relationships and life experiences that may have produced those feelings in themselves, and to examine whether any of those influences, understandings, and feelings can be changed, so that they can happily pursue the life built around a heterosexual relationship that they desire, and that they believe their faith instructs them to pursue. Because self-understanding is difficult, they may wish the assistance of a sympathetic professional counselor to assist them in that inquiry and effort.

147. It is also beyond dispute that there are large numbers of individuals who at one time in their lives have considered themselves gay or lesbian, and who have experienced same-sex attraction and even relationships, but who later, and with the support of secular or religious counseling, developed opposite-sex attractions, and even entered into lasting opposite-sex marriages. For some, this change has been motivated by and assisted by religious conviction; for others, not. Others, while not necessarily succeeding in eliminating same-sex attractions, have changed their behaviors to obey the moral teachings of their faith by abandoning same-sex relationships in favor of a celibate life. Multiple organizations exist made up of individuals who have experienced one of these paths as their own story, and who affirm that their lives are happier and more fulfilled as a result.

148. It is often asserted that "conversion therapy" or other forms of "sexual orientation change efforts" (or "SOCE") are severely harmful. In fact, there is no meaningful evidence that conversational counseling with willing clients to explore possibilities of change in unwanted same-sex attractions is harmful to most or even

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many participants. On the contrary, in a major 2009 report based on a review of many studies, a task force of the American Psychological Association concluded:

> a) "Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE… just as other recent studies document that there are people who perceive that they have benefited from it. . . . . We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE." (42) b) "[I]t is still unclear which techniques or methods may or may not be harmful." (91)

149. Writing in 2021, a group of proponents of "SOCE" bans affirmed that the pertinent research base remains sparse up to the present, providing an insufficient basis on which to make confident judgments about SOCE. As they wrote, "There is limited SOGIECE [sexual orientation and gender identity and expression change efforts]-related research—a critical knowledge gap . . . Rigorous research syntheses to support or refine legislative proposals related to SOCIECE are not available at this time." David Kinitz et al., *The Scope and Nature of Sexual Orientation and Gender Identity and Expression Change Efforts: A Systematic Review Protocol,* 10 SYSTEMATIC REVIEWS, 3 (2021).

150. Specifically with respect to willing participants who are motivated at least in part by religious beliefs and goals, a six year longitudinal study concluded that "The attempt to change sexual orientation did not appear to be harmful on average for these participants. The only statistically significant trends that emerged…indicated improving psychological symptoms." Stanton Jones & Mark

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Yarhouse, *A longitudinal study of attempted religiously mediated sexual orientation change*, 37 J. OF SEX & MARITAL THERAPY, 404, 424 (2011).

151. It is also frequently asserted—despite the extensive evidence that change in the components of sexual orientation is not only possible but frequent—that counseling to assist an individual toward desired change is never effective. Again, the available science does not support this assertion.

152. The same 2009 APA Task Force report acknowledged that "There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation." (120) More specifically:

> "We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective." (43)

153. Plaintiff uses only a "nonaversive," conversational method of counseling.

154. In fact, authors from a variety of perspectives acknowledge that there is evidence that voluntary counseling is effective for at least some individuals who are highly motivated to change sexual attractions and behaviors.

155. The 2009 APA Task Force report stated:

> a) "Former participants in SOCE reported diverse evaluations of their experiences: Some individuals perceived that they had benefited from SOCE, . . . [These] individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom they could identify." (3) b) "For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation, gender identity, sexual behavior, [and] sexual orientation identity…." (49)

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156. The longitudinal study of religiously motivated nonaversive therapy conducted by Jones and Yarhouse found that about half of participants reported progress towards their desired goal, with 23% of study participants reporting substantial reduction in homosexual attraction and substantial increase in heterosexual attraction and functioning, while an additional 30% of participants reported that same-sex attraction remained present only incidentally or in a way that did not seem to bring about distress.

157. A 2010 study surveyed 117 men who participated in some form of secular or religious counseling or support group activities designed to reduce same-sex attraction. Of these, some were single and some were in heterosexual marriages. 88% were motivated at least in part by what they perceived as conflict between their same-sex desires and conduct and the teachings of their faith. Within the whole study group, responses indicated a "large effect" in decrease of same-sex attractions and behavior, and also a "large effect" in increase of heterosexual attraction and behavior. Elan Karten & Jay Wade, *Sexual orientation change efforts in men: a client perspective*, JOURNAL OF MEN'S STUDIES, Vol. 18 No. 1, 84 (2010).

158. Over the years, Plaintiff Tingley has had multiple clients, including minor clients, who experienced unwanted same-sex attraction and desired Mr. Tingley's help in reducing those attractions so that they could enter into heterosexual romantic relationships and live the family lives which they longed for, and also so that they could live in a manner consistent with the moral teachings of their Christian faith.

159. For example, in recent years Plaintiff counseled an older teen whose parents first brought him to Plaintiff. Over time, this client has himself sought Plaintiff's counsel on a number of topics including attraction to pornography and unwanted same-sex attractions.

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160. Like many young people, this individual first fell into a pattern of repeated access to online pornography. In time, he encountered online pornography depicting same-sex conduct, and believes that this pornography stirred up same-sex attractions in himself that he did not previously experience and would not otherwise have experienced.

161. The client has a personal Christian faith, and desires to live his life in accordance with what he understands to be the teachings of his faith. He is of the opinion that he will flourish—spiritually, emotionally and in relationships—through obedience to the teachings of his faith. He believes that his faith in God is a personal priority over sexual attractions, and that God has determined his identity according to what is revealed in the Bible rather than his own desires and perceptions.

162. In that context, the client has sought Plaintiff's counsel to achieve a personal goal of reducing his same-sex attractions and strengthening his sexual attraction to women.

163. Plaintiff never promises clients that he will be able to solve the problems they bring to him, and he has not done so for this individual. However, he provides sympathetic counseling that is respectful of the client's faith and his personal goals and desires. Through ordinary techniques of counseling including caring listening and questions to help the client understand himself and his personal history, Plaintiff supports this client as he works toward the change he desires to see in his own life. And indeed this particular client feels that he has made, and is making progress towards his goals.

164. This particular client's experience is not unique. Over the years Mr. Tingley has worked with several minors—both male and female—who have revealed similar thoughts and circumstances, and have sought his help in reducing

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same-sex attractions and developing their sense of sexual attraction to the opposite sex.

165. Some former clients who sought Plaintiff's counseling aid on this topic as minors achieved their goals, and as adults are now living stable and happy lives in heterosexual marriages.

166. Mr. Tingley currently works with and will continue to work with clients to these ends, and based on his many years of experience, he expects that he will continue to engage with minor clients with similar goals in future practice.

E. Plaintiff's counseling relating to sexual "behaviors"

167. From time to time, Plaintiff also works with minor teens who have expressed a desire to desist from ongoing sexual behaviors which they consider harmful to themselves and inconsistent with their religious beliefs about sexual morality.

168. Several minor clients have sought Plaintiff's help to break out of a pattern of frequent viewing of pornography for sexual gratification. For example, Plaintiff recently worked with a minor who came for counseling after his mother had initially sought help for him. The client had become obsessed with watching pornography, and despite the efforts of the mother to restrict access to computers and the internet, the client would still find ways to get online and view pornography.

169. The client came from a Christian home and attended church. During discussions with the Plaintiff, the client said that he did not like the fact that he was so drawn to pornography, and personally expressed the belief that it was wrong to look at pornography. He further expressed feeling out of control in his viewing of pornography, and affirmed that he wanted to stop. Plaintiff worked with the client towards a goal of ending his regular viewing of pornography, with the client making good progress toward that end during the time that they spent together.

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170. Plaintiff has supported many other clients in similar circumstances who have sought to stop viewing pornography after expressing a wish to change this behavior that they perceive to be wrong and unhealthy for them to engage in.

171. Plaintiff has also worked with clients who have wanted to cease consensual sexual activity with others of the opposite sex. One example occurred with a teenage client who had initially come to the Plaintiff to address academic difficulties at school. The client was a Christian, involved with his church youth group and with church mission trips to serve other communities. After several counseling sessions with the Plaintiff, the client raised concerns about the way in which he viewed girls, and in particular his relationship with his girlfriend.

172. The client believed that it was not right for him to be sexually involved with his girlfriend, and felt that his thoughts and behaviors were in conflict with his faith and morals. He expressed frustration that he repeatedly fell into conduct that he believed was wrong and harmful to both himself and his girlfriend, and expressed a desire to align his sexual thoughts and actions with his faith. The client worked with the Plaintiff to that end, as part of a wider effort on the part of the client to become a more healthy and stable individual. Over time, the Plaintiff observed the client moving to a much happier place, with better self-esteem and drive, as the client addressed these behaviors that he believed to be wrong and harmful.

173. Similar scenarios frequently arise in Mr. Tingley's practice, and he works with his clients toward goals that enable them to live happier, stabler and more fulfilled lives. Based on his experience and his understanding of adolescents and teens, Plaintiff expects that minor clients will continue to seek his counseling assistance to change sexual behaviors that they believe are harmful and inconsistent with their personal goals and religious convictions.

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174. No client has ever filed any complaint against Plaintiff relating to any counseling that Plaintiff has provided, related to any issue of gender identity, sexual attraction, sexual behaviors, or otherwise.

F. The impact of the Counseling Censorship Law on the Plaintiff's practice and clients

175. For professional, religious, and human reasons, Mr. Tingley desires to continue to support current and future clients who seek his help with issues relating to gender identity, sexual attractions, and sexual behaviors.

176. The Counseling Censorship Law seeks to prevent Plaintiff from providing counsel in these areas that his clients desire, that is consistent with their own religious beliefs and with Plaintiff's, and that is consistent with Plaintiff's professional judgment as to what path will lead his clients into healthy, fulfilled, and stable lives over the long term.

177. If Plaintiff provides such counsel, the Counseling Censorship Law threatens him with harassment, investigation, and severe penalties potentially including the loss of his license and his livelihood. He fears the credible and substantial risk of being subjected to enforcement proceedings under the Counseling Censorship Law for each client that raises these issues with him.

178. While at present Plaintiff continues to provide such counsel to clients who request it, Plaintiff must and does experience a substantial and reasonable fear that hostile activists will maliciously and dishonestly present themselves as clients in an effort to entrap him and accuse him of violating the Counseling Censorship Law. Similarly, even in the case of a client who seeks Plaintiff's assistance in good faith, Plaintiff must and does reasonably fear that some other individual—even an unrelated individual—will learn of the nature of such counseling and file a complaint against Plaintiff, or even initiate a third-party enforcement action as authorized by the Counseling Censorship Law.

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179. In practice, this has meant that conversations with clients on matters of gender, gender expression, sexual orientation, sexual behaviors, or sexual or romantic attractions—particularly at the outset of conversations with a new client, or when these issues are first raised by an existing client—are inevitably more guarded and cautious than would otherwise be the case.

180. Plaintiff is not able to freely and without fear speak what he believes to be true, and his client is therefore denied the right to receive open and uninhibited thoughts from his or her chosen counselor. This chilling is inimical to a healthy counseling relationship, which must be built on openness and trust between client and counselor.

181. In fact, the vagueness surrounding the terms and definitions involved in the Counseling Censorship Law mean that Plaintiff must fear that almost *any* exploratory discussions he has with his clients on matters of gender, gender expression, sexual orientation, sexual behaviors, or sexual or romantic attractions could later be accused as violations of the Counseling Censorship Law, casting a chill over all such conversations. Since these are very common matters of concern for troubled teens, this chill has a grave impact on both Plaintiff and his clients.

182. The prospect of merely going through an investigative process if accused of a violation of the Counseling Censorship Law—regardless of whether a violation is ultimately shown—causes Plaintiff to fear these exploratory discussions, particularly with the likelihood that such a process would be accompanied by hostile and uninformed publicity.

183. Not only does the Counseling Censorship Law chill discussions that Plaintiff has with his clients, but he also is chilled from more actively publicizing the fact that he offers to counsel minors on these issues, as he would otherwise desire to do. Specifically, Plaintiff would advertise on his practice website that he offers counsel on sexual orientation and gender identity issues to adolescents, but is

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currently chilled from doing so because of the explicit prohibitions of the Counseling Censorship Law and the prospect of enforcement proceedings being brought against him.

184. On information and belief, this chilling effect is intentional on the part of the State of Washington because of its clear disapproval of the content of Plaintiff's speech, and the religious beliefs underlying that speech.

185. In fact, for Plaintiff to be in compliance with the Counseling Censorship Law, not only must he actively censor his own speech, but the Law compels him to counsel and speak to his clients on the premise that seeking to reduce same-sex attraction, and achieving comfort with their biological sex *could not* be successful, and would instead harm their physical and psychological well-being. Not only are these viewpoints directly contrary to the beliefs of Mr. Tingley and those of many of his clients, but they are also contradicted by science and by the experience of many of his clients.

186. If Plaintiff—and other license holders in the State of Washington—are successfully barred from working with their clients on matters of gender, gender expression, sexual orientation, sexual behaviors, or sexual or romantic attractions by the Counseling Censorship Law, then those clients are effectively denied access to ideas that they wish to hear, and to counseling that is consistent with their own personal faith, life goals, and motivations. Parents of affected minor clients are likewise deprived of their right to hear such ideas, and to direct the upbringing of their children.

187. Likewise, when Plaintiff—and other license holders in the State of Washington—are caused by fear of the Counseling Censorship Law and loss of their livelihoods to self-censor even in part the messages, ideas, encouragement, and support that they would otherwise offer their clients, then those clients are effectively denied full and unfettered access to ideas that they wish to hear, and to

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counseling that is consistent with their own personal faith, life goals, and motivations. Parents of affected minor clients are likewise deprived of their right to hear such ideas, and to direct the upbringing of their children.

COUNT I

For Denial of Free Speech Rights of Mr. Tingley
That Are Guaranteed by the First Amendment

188. Plaintiff incorporates all paragraphs above by reference.

189. By purporting to censor what Plaintiff may or may not say in the course of his professional counseling work, the Counseling Censorship Law violates Plaintiff's First Amendment rights.

190. The Counseling Censorship Law intrudes the censoring hand of government into one of the most private and sensitive spaces—the counseling room where an individual talks with his chosen counselor about his most personal longings, troubles, concerns, and personal goals.

191. Plaintiff's right of free speech protected by the First Amendment includes the right to speak freely with his clients about the problems, questions, and goals that they bring to him. It includes the right to speak the ideas, suggestions, and advice that Plaintiff believes to be true and helpful. And this right to speak freely and honestly is fully protected even if the majority of the Washington State legislature disapprove of the client's chosen goals, and disagree with Plaintiff's views and advice. Indeed, the central role of the First Amendment is to protect the right of individuals to speak beliefs and views that the government disapproves of.

192. The Counseling Censorship Law is not a neutral "time, place or manner" regulation. Instead, it censors the conversations that a counselor and

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client may engage in based on the content of that speech, and based on its viewpoint.

193. This is evident from the fact that determining whether a counselor's or therapist's speech violates the Counseling Censorship Law will necessarily require an inquiry into both the content and the viewpoint of that speech. The Law purports to outlaw and punish only certain speech relating to specifically listed categories of content, including "sexual orientation or gender identity," change to "behaviors or gender expressions," and efforts to "eliminate or reduce romantic attractions or feelings towards individuals of the same sex."

194. As to these topics, the Counseling Censorship Law prohibits only speech promoting a certain viewpoint concerning human sexuality, identity, morality, and indeed free will: that is, the viewpoint that change in an individual's gender identity or sexual orientation to align with their natural reproductive biology is possible, and may be a legitimate and desirable goal for some individuals.

195. The Law is not viewpoint neutral because it prohibits "efforts to . . . eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex," but does not prohibit efforts to reduce sexual or romantic attractions toward a member of the opposite sex, nor does it prohibit efforts to increase attractions toward a member of the same sex.

196. The Law is not viewpoint neutral because it permits counseling that reflects "acceptance" and "facilitation" of any sort of "exploration and development" of gender identity or sexual attractions or behaviors—except "change" to "sexual orientation or gender identity." Meanwhile, it prohibits counseling that does not insist on "accepting" a client's undesired feelings and instead seeks to assist that client toward his chosen goal of changing feelings relating to gender identity or sexual attractions.

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197. Therefore, far from being viewpoint and content neutral, the Counseling Censorship Law actively aims to suppress the dissemination of ideas and information about human sexuality and the human capacity for change in this area that are unpopular with and disapproved by the government of the State of Washington.

198. The Counseling Censorship Law also seeks to compel speech, by demanding that counselors and therapists speak to clients on the premise that seeking to align an individual's sense of gender identity with his or her biological sex, or seeking to align their sexual attractions and relationships with their body's natural reproductive capabilities, is not possible or desirable, and will necessarily harm them, regardless of their own life goals and religious beliefs. This necessarily alters the content of speech for therapists who disagree with the viewpoint of the government on these matters.

199. The Counseling Censorship Law does not adopt the least restrictive means to pursue a compelling government interest.

200. The government has no cognizable interest at all—let alone a compelling interest—in preventing citizens from hearing ideas that those citizens wish to hear from their chosen counselor or therapist.

201. The government has no cognizable interest at all—let alone a compelling interest—in preventing the dissemination of ideas that the government believes are false, offensive, misguided, or even hurtful.

202. The Counseling Censorship Law is overbroad rather than narrowly tailored. Assuming that there are particular physical or pharmaceutical practices that the state may legitimately regulate to safeguard the physical and psychological well-being of a minor, the Counseling Censorship Law makes no attempt at all to identify those practices and target its prohibitions against them. As the large preponderance of mental health counselors engage solely in speech, a substantial

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number of the Counseling Censorship Law's applications are unconstitutional judged in relation to what any possible legitimate application might be.

203. For these reasons, the Counseling Censorship Law is unconstitutional as a violation of the free speech rights of Plaintiff Brian Tingley as well as all other "license holders."

204. This ongoing deprivation of constitutional rights constitutes irreparable injury.

205. Wherefore, Plaintiff Brian Tingley respectfully requests that the Court grant declaratory and injunctive relief against the Counseling Censorship Law pursuant to 28 U.S.C. §§ 20201 and 2202, as set forth in the Prayer for Relief.

COUNT II

For Denial of Free Speech Rights of the Clients of Mr. Tingley That Are Guaranteed by the First Amendment

206. The First Amendment not only protects the right of each individual to speak, but also to *hear* desired information and ideas, free from government censorship. This includes ideas that depart from conventional wisdom, and ideas that the government believes are false, offensive, misguided, or even hurtful.

207. By prohibiting counselors and other "license holders" from talking to minor clients with a view toward helping them achieve their personal goals of changing their feelings of gender identity to align with their biological sex, or reducing same-sex attraction or increasing opposite-sex attraction, the Counseling Censorship Law violates those clients' First Amendment right to hear speech that they and their parents desire them to hear.

208. For the reasons set forth above (¶ 192-197), this infringement of the First Amendment rights of counseling clients including Plaintiff's minor clients is neither content neutral nor viewpoint neutral.

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209. For the reasons set forth above (¶ 199-202), this infringement of the First Amendment rights of counseling clients including Plaintiff's minor clients is not narrowly tailored to serve a compelling governmental interest.

210. Counselors including Plaintiff have standing to assert and seek redress for the First Amendment rights of their clients that are violated by enforcement of the Counseling Censorship Law, and also by the chilling effect that the very existence of that Law has on free and open communications between these clients and their chosen counselors.

211. Counselors, including Plaintiff, enter into an extremely close and intimate relationship with clients who seek their assistance to pursue personal goals relating to the sensitive and important topics of sexual attractions, behaviors, and orientation—a relationship in which openness and candor is crucial.

212. Many clients feel that their discussions with their chosen counselor about sexual attractions, behaviors, and orientation involve the most intimate, difficult, important, and embarrassing topics in their lives. Because of this, it is extremely difficult or even impossible as an emotional and social matter for these clients to step forward to protect their own constitutional rights to engage in the conversations with their counselor that they desire.

213. Further, because the Counseling Censorship Law on its face does not penalize *receiving* counsel of any sort, clients are not themselves subject to any threat of enforcement under the Law, so they risk being denied their right to receive desired counseling while at the same time being denied any forum in which to assert and protect that right.

214. The violation of the protected free speech rights of counseling clients, including minor clients of Plaintiff, constitutes irreparable injury.

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215. Wherefore, Plaintiff respectfully requests that the Court grant declaratory and injunctive relief against the Counseling Censorship Law pursuant to 28 U.S.C. §§ 20201 and 2202, as set forth in the Prayer for Relief.

COUNT III

For Denial of the Due Process Rights of Plaintiff in Violation of the Fourteenth Amendment Because the Prohibitions of the Counseling Censorship Law Are Impermissibly Vague

216. The Fourteenth Amendment's guarantee of Due Process prohibits the government from imposing or threatening punishment based on laws that are so vague that they do not provide fixed legal standards as to what is prohibited and what is not, and so leave room for standardless or discriminatory enforcement.

217. In fact, as detailed below, essentially all of the key terms in the Counseling Censorship Law are undefined in the Law itself, and also undefined in science, and indeed have more in common with slogans than with a fixed standard identifying what counseling speech is prohibited and subject to punishment under the Law, and what is not.

218. As a result, the Counseling Censorship Law is unconstitutional on its face because it does not provide adequate standards or guidelines to govern the actions of those empowered to enforce it—which, as noted above, includes not only the Secretary of Health, the Attorney General, and the Health Systems Quality Assurance team, but also "any other person." Instead, the Law enables and authorizes those who are empowered to pursue enforcement actions in this highly controversial and politicized area to do so based on their personal predilections, rather than on any fixed legal standard, and likewise to pursue discriminatory enforcement.

219. The vagueness and lack of fixed legal standards in the Counseling Censorship Law is all the more impermissible because it impacts a fundamental

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right, in that because of this vagueness and the unbounded discretion that it affords to those authorized to bring enforcement actions, counselors engaging with a client who raises concerns relating to gender identity, same-sex attractions, or sexual behaviors must be all the more fearful that they will be accused of violating the law. As a result, consciously or unconsciously, counselors including Plaintiff inevitably engage in a degree of self-censorship that infringes the freedom of discussion of both counselor and client.

220. The Counseling Censorship Law is unconstitutionally vague because it provides no standards or guidelines defining the line between speech that permissibly seeks to "facilitat[e]" a client's "development" of his or her gender identity or sexual orientation, and speech that unlawfully seeks to "change" that person's gender identity or sexual orientation.

221. Given that "development" necessarily involves "change," the purported distinction is incoherent, and thus leaves those authorized to bring enforcement actions free to do so based on their personal predilections, or for discriminatory purposes including disapproval of the beliefs, viewpoint, or messages of a particular counselor.

222. The prohibition on seeking to "change an individual's . . . gender identity" also fails to provide adequate standards or guidelines to govern the actions of those authorized to bring enforcement actions because the term "gender identity" is undefined in the law and is vague.

223. This vagueness is made worse rather than resolved by consulting Washington State governmental position statements and publications in the field. The Washington State Human Rights Commission "Guide to Sexual Orientation and Gender Identity" published in 2014 asserts that "gender expression or identity" "as defined in the law" means "having *or being perceived as having* a gender identity, self-image, appearance, behavior, or expression . . ." (emphasis added).

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According to this meandering definition, an effort to "change" "gender identity" could include assisting a client to pursue her goal of changing gender-related aspects of her dress, or even of changing how other people *perceive* her gender identity.

224. "Gender identity" has no clearer definition in the wider world. As noted above, in a 2016 rule interpreting Section 1556 of the Patient Protection and Affordable Care Act, the Department of Health and Human Services defined "gender identity" as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth." *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31,376 (May 18, 2016) at 31,384.

225. A publication sponsored by the ACLU, Human Rights Campaign, and National Education Association asserts that gender identity encompasses any "deeply-felt sense of being male, female, both or neither," and can include a "gender spectrum" "encompassing a wide range of identities and expressions." *Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools*, at 6-7.

226. The National Center for Lesbian Rights contends that "Gender is comprised of a person's physical and genetic traits, their own sense of gender identity and their gender expression" and similarly asserts that gender identity "is better understood as a spectrum." That source goes on to say that an individual may have an "internal sense of self as male, female, both or neither," and that "each person is in the best position to define their own place on the gender spectrum."[14] Indeed, the medical text *Principles of Transgender Medicine and Surgery*, declares

[14] Asaf Orr et al., National Center for Lesbian Rights, *Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools* 5, 6 (2015), https://www.nclrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015-Online.pdf (last visited April 29, 2021).

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that "Gender identity can be conceptualized as a continuum, a Mobius, or patchwork."[15]

227. An individual who is unhappy with or uncertain about his or her "sense of being male, female, both or neither," or who wishes to evaluate and "define their own place on the gender spectrum," or who does not wish to live life with an identity as amorphous as a Mobius strip or a "patchwork," may well wish the aid of a professional counselor or therapist. But what conversation will comprise permissible "development" of that individual's place on that disorienting Mobius strip, and what will be condemned as an unlawful effort to "change" the individual's "gender identity," is unknowable.

228. Because the Counseling Censorship Law fails to define "gender identity," and that term has no consistent definition in the wider law or medical science, the Counseling Censorship Law leaves those authorized to bring enforcement actions free to do so based on their personal predilections, or for discriminatory purposes including disapproval of the beliefs, viewpoint, or messages of a particular counselor.

229. The prohibition on seeking to "change an individual's sexual orientation" also fails to provide adequate standards or guidelines to govern the actions of those authorized to bring enforcement actions, because the term "sexual orientation" is undefined in the Law and is vague.

230. There is no definition of the term in the Counseling Censorship Law itself. The Washington State Human Rights Commission elsewhere states that "As defined in the law, 'sexual orientation' means heterosexuality, homosexuality, bisexuality, *and gender expression or identity*," bringing into the term "sexual

[15] *Principles of Transgender Medicine and Surgery* 43 (Randi Ettner, Stan Monstrey & Eli Coleman eds., 2nd ed. 2016).

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orientation" all the vagueness and ambiguity that is embedded in the term "gender identity."

231. There is equally no agreement in the scientific literature as to the definition of "sexual orientation," or to what extent "orientations" may overlap or blend from one to another. The APA Handbook of Sexuality and Psychology cautions that "Sexual orientation is usually considered a multi-dimensional construct" in which "aspects of sexual orientation . . . are not necessarily concordant." (556). Diamond and Rosky (2016) warn that "it is important to note that sexual orientation is not easy to define or measure," and "is a multifaceted phenomenon" which cannot be simplified to mere "sexual attractions," but instead incorporates (among other components) "sexual attractions, . . . sexual behavior, and sexual identity," while "identity and behavior are structured by social context, social constraints, and social opportunities." (3) This, say Diamond and Rosky, "obviously poses a problem for research on the causes of sexual orientation." (3) It also poses a severe problem for a counselor, therapist, or client who wishes to know what type of counseling or therapeutic goals might be condemned as seeking to change "sexual orientation."

232. Because the Counseling Censorship Law fails to define "sexual orientation," and that term has no consistent definition in the wider law or medical science, the Counseling Censorship Law leaves those authorized to bring enforcement actions free to do so based on their personal predilections, or for discriminatory purposes including disapproval of the beliefs, viewpoint, or messages of a particular counselor.

233. The Counseling Censorship Law is further impermissibly vague because it prohibits any "regime that *seeks* to change . . ." sexual orientation or gender identity. The Law fails to provide any standards or guidelines as to whether this refers to the subjective intent of the client, or that of the counselor, again

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leaving unfettered discretion on this critical question to any person authorized to bring an enforcement action, and inviting discriminatory enforcement.

234. Indeed, a client's personal intention in raising a subject relating to sexuality may or may not be known to the counselor, and may change from one meeting to the next. Consequently, a counselor might face sanctions on the basis of the shifting subjective thoughts and goals of his client that are beyond the counselor's knowledge.

235. The Counseling Censorship Law further fails to provide adequate standards or guidelines to govern the actions of those authorized to bring enforcement actions because it provides no definitions of terms "gender expressions", "identity exploration", and "identity development," and provides no information at all as to what "behaviors" a therapist may or may not help a client attempt to change.

236. In the absence of any clarity on these terms, almost any counseling conversation that relates to gender, intimate relationships, or sexuality could be accused of seeking to "change . . . sexual orientation or gender identity." Thus, the failure of the Counseling Censorship Law to define these terms additionally leaves those authorized to bring enforcement actions free to do so based on their personal predilections, or for discriminatory purposes including disapproval of the beliefs, viewpoint, or messages of a particular counselor.

237. Meanwhile, the sanctions faced by therapists for violating the Counseling Censorship Law are severe, ranging up to the revocation of their licenses and the loss of their livelihoods.

238. For these reasons, the Counseling Censorship Law is so vague on its face that it deprives counselors and other "license holders" of Due Process rights protected by the Fourteenth Amendment.

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239. The deprivation of these rights constitutes irreparable injury.

240. Wherefore, Plaintiff respectfully requests that the Court grant declaratory and injunctive relief against the Counseling Censorship Law pursuant to 28 U.S.C. §§ 20201 and 2202, as set forth in the Prayer for Relief.

COUNT IV

For Denial of Free Exercise Rights of Mr. Tingley
That Are Guaranteed by the First Amendment

241. Plaintiff incorporates all paragraphs above by reference.

242. Mr. Tingley's rights of free exercise protected by the First Amendment include the right to use his professional skills to assist his clients to live in accordance with their own religious beliefs, and equally to speak in the course of his professional work in a manner that is consistent with his own religious beliefs.

243. The Counseling Censorship Law is premised on the belief that volitional change away from transgender identification, or away from same-sex attractions, is not possible or desirable, and that any attempt to make such a change is harmful.

244. On the contrary, Plaintiff, like many adherents of Christianity and other historic religions, believes based on his faith (as well as based on science) that this "unchangeable" view of human nature is mistaken, that such change is possible, that God can and does work profound changes in individuals who desire and seek to change, and that change to a gender identity or sexual orientation aligned with an individual's reproductive biology can and does increase well-being at least in individuals who pursue this goal in obedience to their own religious convictions.

245. Further, Plaintiff believes that as a Christian he has a religious obligation to use his time and professional skills to help fellow Christians who seek

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his assistance to live consistently with the teachings of their shared faith. For clients who share his beliefs, he offers a safe harbor where they can be assured that their Christian worldview will not be subject to doubt, or even hostility, that they frequently experience in their daily lives.

246. As applied to Plaintiff, the Counseling Censorship Law substantially burdens his religious beliefs by requiring him to practice and speak in a manner that is contrary to his religious beliefs, prevents him from sharing his religious beliefs about the possibility of change with his clients in the course of discussions, and subjects him to a risk of severe sanctions for speaking to clients consistently with his religious beliefs.

247. Because the Counseling Censorship Law was aimed against counseling goals and speech which are well known to be primarily associated with counselors and therapists of faith, the Law is not neutral or generally applicable.

248. The Counseling Censorship Law is also not neutral or generally applicable because it imposes a viewpoint-based restriction on speech, directed against a viewpoint which is well known to be primarily associated with individuals of faith.

249. The Counseling Censorship Law does not represent the least restrictive means of furthering a compelling state interest as it is both overbroad and underinclusive.

250. By depriving Plaintiff of the right to practice his religious beliefs by speaking to clients on topics of gender identity and sexual attractions and change in a manner consistent with the teachings of his faith and that of his clients, the Counseling Censorship Law denies Plaintiff his rights of free exercise guaranteed by the First Amendment.

251. The deprivation of these rights constitutes irreparable injury.

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252. Wherefore, Plaintiff respectfully requests that the Court grant declaratory and injunctive relief against the Counseling Censorship Law pursuant to 28 U.S.C. §§ 20201 and 2202, as set forth in the Prayer for Relief.

COUNT V

For Denial of Free Exercise Rights of Clients of Mr. Tingley That Are Guaranteed by the First Amendment

253. Plaintiff incorporates all paragraphs above by reference.

254. The right of free exercise under the First Amendment protects an individual's right to live in accordance with his or her religious beliefs.

255. Based on the teachings of their Christian faith, some of Plaintiff's clients believe that they have a moral obligation to strive to bring their sense of gender identity into alignment with the biological sex that God gave to them, and/or to bring their sexual attractions and relationships in line with their reproductive biology—that is, into a heterosexual orientation, and/or to change their sexual behaviors by abstaining from sexual relationships outside the context of a heterosexual marriage.

256. By threatening Plaintiff and all counselors, therapists, or other "license holders" with severe penalties including loss of their license and livelihood if they assist clients to pursue these faith-directed personal goals, the Counseling Censorship Law does, and was intended to, interfere with these clients' free exercise of their religion, in violation of the First Amendment.

257. Because the Counseling Censorship Law was aimed against personal goals and goals for counseling which are well known to be primarily associated with individuals of faith, the Law is not neutral or generally applicable.

258. The Counseling Censorship Law is also not neutral or generally applicable because it imposes a viewpoint-based restriction on speech, directed

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against a viewpoint which is well known to be primarily associated with individuals of faith.

259. The Counseling Censorship Law does not represent the least restrictive means of furthering a compelling state interest as it is both overbroad and underinclusive.

260. Accordingly, the Counseling Censorship Law denies Plaintiff's Christian clients their rights to free exercise guaranteed by the First Amendment.

261. The deprivation of these rights constitutes irreparable injury.

262. Plaintiff has standing to assert and seek redress for the First Amendment rights of his clients that are violated by the enforcement of the Counseling Censorship Law, including his clients' free exercise rights.

263. Wherefore, Plaintiff respectfully requests that the Court grant declaratory and injunctive relief against the Counseling Censorship Law pursuant to 28 U.S.C. §§ 20201 and 2202, as set forth in the Prayer for Relief.

PRAYER FOR RELIEF

Plaintiff respectfully requests that this Court enter judgment against Defendants and grant the following relief:

(A) A declaration that—both facially and as applied—the Counseling Censorship Law violates the First Amendment right to free speech of Plaintiff Mr. Tingley and of his clients who seek his professional assistance to achieve comfort with a gender identity congruent with the client's biological sex, or to reduce unwanted same-sex attraction and/or develop or increase opposite-sex attractions, or to change sexual behaviors of any sort;

(B) A declaration that—both facially and as applied—the Counseling Censorship Law violates the free exercise rights of Plaintiff Mr. Tingley and of his clients who seek his professional assistance to achieve comfort with a gender identity congruent with the client's biological sex, or to reduce unwanted same-sex attraction

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and/or develop or increase opposite-sex attractions, or to change sexual behaviors of any sort;

(C) A declaration that, because it is so vague that it does not provide fixed legal standards as to what is prohibited and what is not, the Counseling Censorship Law facially violates the Due Process rights of Mr. Tingley protected by the Fourteenth Amendment.

(D) That this Court enter a preliminary injunction and permanent injunction barring all enforcement of the Counseling Censorship Law;

(E) That this Court award Plaintiff costs and expenses of this action, including reasonable attorneys' fees, in accordance with 42 U.S.C. § 1988;

(F) That this Court issue the requested injunctive relief without a condition of bond or other security being required of Plaintiff;

(G) That this Court grant any other relief that it deems equitable and just in the circumstances; and

(H) That this Court retain jurisdiction over this matter for the purpose of enforcing its orders.

Respectfully submitted this 13th day of May, 2021.

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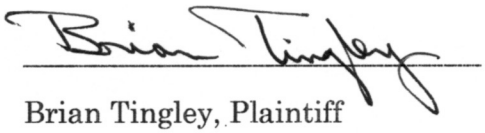
Attorneys for Plaintiff

VERIFICATION OF COMPLAINT

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that I have read the foregoing Verified Complaint, and the factual allegations thereof, and that to the best of my knowledge the facts alleged therein are true and correct.

Executed this 12th day of May, 2021.



Brian Tingley, Plaintiff

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,

Defendants.

Case No. 3:21-cv-5359

PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION AND MEMORANDUM IN SUPPORT

NOTE ON MOTION CALENDAR:
Friday, June 4, 2021

ORAL ARGUMENT REQUESTED

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Plaintiff Brian Tingley moves under Fed. R. Civ. P. 65 to preliminarily enjoin Defendants' enforcement of Senate Bill 5722, codified at Wash. Rev. Code §§ 18.130.020 and 18.130.180 (the "Counseling Censorship Law"), both facially and as applied to Plaintiff, because the Counseling Censorship Law censors private conversations between a counselor and his clients in violation of the rights of both Brian Tingley and his clients secured under the First and Fourteenth Amendments of the U.S. Constitution.

Preliminary Statement

"Speech is not unprotected merely because it is uttered by 'professionals.'" *Nat'l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2371-72 (2018). Brian Tingley, a licensed marriage and family counselor, moves this Court to enjoin the enforcement, both on its face and as applied, of Washington State's Senate Bill 5722, codified at Wash. Rev. Code §§ 18.130.020 and 18.130.180 ("the Counseling Censorship Law" or "the Law")—a law that censors private conversations between individuals and their chosen counselors in violation of the First and Fourteenth Amendment rights of both Mr. Tingley and his clients.

The client-counselor relationship requires trust and openness between client and counselor as they explore together the client's most intimate concerns and personal goals. It is the last place where government agents should intrude to declare disfavored topics and ideas off limits. Yet the Counseling Censorship Law does just that. More, many people believe that matters of sexuality and gender identity implicate not merely neutral feelings and desires, but morality and indeed obedience to God. Yet if a client is experiencing same-sex attractions, or a sense of gender identity that is discordant with his or her biological sex, the Counseling Censorship Law flatly prohibits the counselor from offering any thoughts to assist the client in pursuing even a personally chosen goal of reducing same-sex attraction, or achieving comfort in a gender identity congruent with the client's physical body and reproductive nature.

The Washington State legislature may find such beliefs or counsel archaic, objectionable, or even dangerous. But "[i]f there is a bedrock principle underlying the First Amendment, it is that the government may not prohibit the expression of an idea simply because society finds the

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idea itself offensive or disagreeable." *Otto v. City of Boca Raton*, 981 F.3d 854, 872 (11th Cir. 2020), quoting *Texas v. Johnson*, 491 U.S. 397, 414 (1989).

Because even the prospect of enforcement chills free and open discussion between Mr. Tingley and his clients, and because as detailed below Mr. Tingley has a strong probability of prevailing on the merits, enforcement of the Counseling Censorship Law should be preliminarily enjoined pending resolution of this case on the merits.

Statement of Facts

A. Plaintiff Tingley and his clients

Plaintiff Brian Tingley is a licensed Marriage and Family Therapist who has 20 years' experience counseling clients on a wide range of complex and sensitive topics. (Cmpl. ¶ 70; Tingley Decl. ¶ 3.) Mr. Tingley works with his clients to provide support, challenge, and feedback to help achieve the life and personal goals that they choose for themselves. (Cmpl. ¶ 79; Tingley Decl. ¶ 14.) Mr. Tingley counsels both adults and minors. In all cases, his counseling consists of nothing but conversation: asking his clients questions, listening empathetically, and offering suggestions as to how they can better understand themselves and their relationships and emotions, so that they can make changes that they desire, become the people they want to be, and live the lives that they want to live. (Cmpl. ¶ 76; Tingley Decl. ¶ 13-14, 66.)

Mr. Tingley is a Christian. He does not seek to impose his faith or priorities on his clients, but his faith inevitably informs his understanding of human nature. (Cmpl. ¶ 27; Tingley Decl. ¶ 9.) Mr. Tingley's website states that his practice group consists of Christian counselors, who share a goal of helping clients achieve "personal and relational growth as well as healing for the wounded spirit, soul, and body through the healthy integration of relational, psychological, and spiritual principles with clinical excellence." (Cmpl. ¶ 70; Tingley Decl. ¶ 8.)

Most of Mr. Tingley's clients share his Christian faith, and many select him and trust his counsel precisely because he shares their faith-based convictions and worldview. (Cmpl. ¶ 71-74; Tingley Decl. ¶ 10-12.) Mr. Tingley only works with clients who attend voluntarily, and in pursuit of the goals or objectives that they have set for themselves. (Cmpl. ¶ 79-80; Tingley

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Decl. ¶ 14-15.) No client has ever filed any complaint against Mr. Tingley. (Cmpl. ¶ 174; Tingley Decl. ¶ 16.)

B. Religious beliefs concerning sexuality, identity, and the possibility of change

Many Christians, including Mr. Tingley and many of his clients, believe that their identity is primarily defined by who God has created them to be, and what God has said about them, as revealed through biblical teaching, as opposed to being founded on their own feelings, determinations or wishes. (Cmpl. ¶ 127-128; Tingley Decl. ¶ 26-30, 32.) Thus, many Christians believe that living consistently with their faith is more fundamental to achieving their own happiness, stability, and satisfaction than pursuing subjective desires or feelings that would conflict with biblical teaching. (Cmpl. ¶ 67-68, 129-130, 155-158; Tingley Decl. ¶ 21-22, 40.) This central tenet of the Christian faith has many applications, including leading Christians to prioritize the teachings of their faith over their romantic and sexual desires both because they believe this to be a divine command, and in the belief that doing so will lead to their own flourishing and well-being. (Cmpl. ¶ 126-127, 129, 147; Tingley Decl. ¶ 23-24, 60.)

Moreover, Christians believe that they are to obey God's laws and instruction regardless of whether they experience conflicting desires or feelings. They accept biblical teachings that pursuing a life of faith necessarily requires Christians to "deny themselves" in many aspects of life (Matthew 16:24), and to give up behaviors that might otherwise appear desirable. (Cmpl. ¶ 126-128, 130, 146-147; Tingley Decl. ¶ 30, 72.)

Also central to Christian faith is the belief that change–even radical change–is possible: that God transforms the hearts and minds of faithful Christians so that they can live more consistently with the teachings of their faith. Christians believe that they are not captive to their own desires, but rather that with God's help, they can change to live a life that is faithful to God's commandments. (Cmpl. ¶ 127-129, 147; Tingley Decl. ¶ 31-32.)

Biblical teaching specifically addresses sex and sexuality. Consistent with that teaching, Mr. Tingley and many of his Christian clients believe that the sex that each of us receives at the

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moment of conception is not an accident, an insignificant detail, or a personal choice, but rather is a gift of God. (Tingley Decl. ¶ 27.) Thus obedience, well-being, and happiness for each individual will include acceptance of and gratitude for the particular sex that God has given to him or her. (Cmpl. ¶ 111; Tingley Decl. ¶ 26-27, 40, 51.)

Likewise, many Christians believe that sexual relationships are right and healthy only in a very specific context—namely between a man and a woman, committed to each other for life in marriage. (Cmpl. ¶ 126; Tingley Decl. ¶ 29.) The joining of male and female in marriage to conceive children and raise up each next generation is believed to be a great blessing, a great calling, and a sacred thing. (Cmpl. ¶ 125; Tingley Decl. ¶ 28.) For many believers, any sexual relationship outside of this context–regardless of how much it might be desired–is believed to be contrary to the teachings of the Christian faith. (Cmpl. ¶ 126-127; Tingley Decl. ¶ 30.)

C. Scientific knowledge and lack of knowledge concerning changes in sexual attractions and gender identity

Contrary to what is commonly asserted, the possibility of change in sexual orientation and gender identity is not an area in which science and faith are in conflict.

As Dr. Rosik details in his declaration, in recent years leading researchers in the field have acknowledged–indeed proclaimed–that it is no longer possible to maintain that change in sexual orientation is impossible or even rare. (Rosik Decl. ¶¶ 7-9, 15-28.)

Notably, internationally respected authors Professors Lisa Diamond and Clifford Rosky, who count themselves advocates for LGBTQ issues, reviewed the scientific literature in 2016 and concluded that "arguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attractions remain fixed over the life course." Instead, Diamond and Rosky reported that "Studies unequivocally demonstrate that same-sex and other-sex attractions do change over time in some individuals," and that the evidence for this is now even "indisputable." (Rosik Decl. ¶¶ 17.) Indeed, Diamond and Rosky cite multiple longitudinal studies which found that many teens and young adults who initially

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experience some degree of same-sex attractions identified as exclusively heterosexual within a few years. (Rosik Decl. ¶¶ 22.)

Similarly, as Dr. Levine details in his declaration, many young people who experience gender dysphoria or feelings of cross-gender identification ultimately resolve to identifying with their biological sex—as many as 80-98%, in the case of young children. (Levine Decl. ¶¶ 60.) Thus, even apart from faith considerations, an individual who experiences some same-sex attractions but hopes to ultimately stabilize with predominately heterosexual attractions, or who experiences gender dysphoria but hopes to ultimately achieve comfort with an identity aligned with his or her biological sex and reproductive potential, is not hoping for an impossible thing. And such individuals may well and reasonably desire to have a trained and trusted counselor assist them as they pursue that personal goal.

D. Tingley's counseling relating to sexual attractions and gender identity

Among the wide range of problems and goals that clients bring into his office, some clients—including clients younger than 18—have asked Mr. Tingley to assist them to reduce same-sex attractions, to achieve comfort with their biological sex, or to desist from sexual behaviors such as addiction to pornography, or ongoing sexual activity, which the clients believe are wrong. (Cmpl. ¶ 108-122, 158-165, 167-172; Tingley Decl. ¶¶ 37-51, 53-64, 67-72.) As Dr. Rosik explains in his accompanying expert declaration, such goals frequently derive from the client's wishes to live consistently with his or her religious beliefs. (Rosik Decl. ¶¶ 36, 48.) Mr. Tingley currently has and expects to continue to receive clients with similar wishes, objectives, and motivations. (Cmpl. ¶ 123, 164-166, 173; Tingley Decl. ¶ 52, 57, 66, 73.) Mr. Tingley wishes to continue supporting these clients for professional, religious, and human reasons. (Cmpl. ¶ 175; Tingley Decl. ¶ 74.)

Mr. Tingley never promises clients that he can solve the issues they bring to him, but he has often seen his clients make progress toward their goals on these issues. (Cmpl. ¶ 116, 163, 165, 169, 172-173; Tingley Decl. ¶ 45, 62-64, 69, 72.)

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E. The Counseling Censorship Law

The Counseling Censorship Law restricts "performing conversion therapy on a patient under age eighteen" to the list of conduct, acts, or conditions that would constitute "unprofessional conduct" for a "license holder." Wash. Rev. Code ("RCW") § 18.130.180.

While the Law defines "Conversion therapy" as "a regime that seeks to change an individual's sexual orientation or gender identity"—which specifically includes "efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex," RCW § 18.130.020—it excepts "counseling. . . that provide[s] acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development that do[es] not seek to change sexual orientation or gender identity." *Id*. Yet the Law does not define a boundary between "change" and "exploration and development."

The Law threatens severe penalties, including fines up to $5,000 for each violation, suspension from practice, and even the loss of license and livelihood. RCW § 18.130.160.

Thus, the Counseling Censorship Law expressly prevents counselors from speaking, and minor clients from hearing, proscribed ideas and messages even if the counselor (and client) believes them to be true. It further prevents clients who desire a prohibited goal from obtaining help from trained and trusted counselors as they pursue their goals.

Washington State seeks to deprive minor clients of these rights even as it authorizes these same minors (from age 16 upwards) to engage in sexual activity with a person of any older age–entailing the potentially lifechanging implications of becoming a parent (RCW § 9A.44); to obtain an abortion without parental consent (at any age) (RCW § 9.02.100); to change their gender on their birth certificate (at any age) (Wash. Admin. Code § 246.490.075); and even to marry (from age 17) (RCW § 26.04.010). Moreover, there is no bar in Washington State on minors at any age undergoing irreversible and life-altering hormonal or surgical measures that would purport to "affirm" a transgender identity.

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Argument

The Counseling Censorship Law infringes rights of Mr. Tingley, and of his clients, that are protected by the First and Fourteenth Amendments. At a minimum a preliminary injunction should be entered categorically enjoining enforcement of the law due to its violation of Due Process, and enjoining enforcement of the Law against Mr. Tingley due to its violations of the First Amendment.

Governing Legal Standard

To obtain a preliminary injunction, the plaintiff must show that (1) he is "likely to succeed on the merits," (2) he is "likely to suffer irreparable harm," (3) "the balance of equities tips in his favor," and (4) the requested injunction "is in the public interest." *Am. Beverage Ass'n v. City and County of San Francisco*, 916 F.3d 749, 754 (9th Cir. 2019) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). But when First Amendment rights are at risk, the analysis essentially reduces to a single question—whether the plaintiff is likely to succeed on the merits. This is because even the brief loss of First Amendment rights causes "irreparable injury" and tilts "the balance of hardships … sharply in [the plaintiff's] favor," and "it is *always* in the public interest to prevent the violation of a party's constitutional rights." *Id.* at 758 (emphasis added) (cleaned up); *see also Sammartano v. First Judicial Dist. Ct.*, 303 F.3d 959, 974 (9th Cir. 2002) ("Courts considering requests for preliminary injunctions have consistently recognized the significant public interest in upholding First Amendment principles.").

Because Plaintiff has a high likelihood of success on the merits, enforcement of the Counseling Censorship law should be preliminarily enjoined.

I. The Counseling Censorship Law Violates the Free Speech Rights of Plaintiff Tingley Because it Bans Protected Speech Based on Content and Viewpoint.

A. The Law regulates speech, not conduct.

In *Pickup v. Brown*, 728 F.3d 1042, 1055-1056 (9th Cir. 2013), a panel of the Ninth Circuit held that prohibited counseling was conduct, not speech. But as the Eleventh Circuit observed when confronted with an attempt to restrict what doctors might say to their patients,

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"characterizing speech as conduct is a dubious constitutional enterprise," *see Wollschlaeger v. Governor, Fla.*, 848 F.3d 1293, 1308-1309 (11th Cir. 2017), and the logic of *Pickup* has since been rejected by the Supreme Court. *NIFLA*, 138 S. Ct. at 2373-74; *see also NAACP v. Button*, 371 U.S. 415, 439 (1963) ("[A] State may not, under the guise of prohibiting professional misconduct, ignore constitutional rights.").

The Counseling Censorship Law regulates speech facially and as applied here. *All* that Mr. Tingley does with his clients is speak with them. Yet these conversations are prohibited by the Counseling Censorship Law. Putting it bluntly, "[i]f speaking to clients is not speech, the world is truly upside down." *Otto*, 981 F.3d at 866.

B. The Law is subject to strict scrutiny because it censors speech based on content and viewpoint.

1. The Law censors speech based on content.

A law that restricts speech based on its content is presumptively unconstitutional and must overcome strict scrutiny. *Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015); *see also IMDb.com v. Becerra*, 962 F.3d 1111, 1120 (9th Cir. 2020).

A restriction is content-based if it facially draws distinctions based on a speaker's message; it cannot be justified without reference to speech's content; or it was adopted because of disagreement with the message conveyed. *Reed*, 576 U.S. at 163-164. *See also IMDb.com*, 962 F.3d at 1120 (A statute is content-based "if it, by its very terms, singles out particular content for differential treatment.") (cleaned up); *Victory Processing, LLC v. Fox*, 937 F.3d 1218, 1226 (9th Cir. 2019) ("[A] law is content-based because it explicitly draws distinctions based on the message a speaker conveys."). A reliable way of determining whether a restriction is content-based is if enforcement authorities must necessarily "examine the content of the message that is conveyed" to know whether the Law has been violated. *McCullen v. Coakley*, 573 U.S. 464, 479 (2014) (citation omitted).

The Counseling Censorship Law discriminates based on content under any of these articulations. The first step in any enforcement investigation under the Law must be to inquire

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into the *content* of what was discussed in confidence behind the closed door of the counseling room. *See Otto*, 981 F.3d at 861 ("[B]ecause the ordinances depend on what is said, they are content-based restrictions that must receive strict scrutiny.").

2. The Law discriminates based on viewpoint.

A law discriminates based on viewpoint when it regulates speech "based on 'the specific motivating ideology or the opinion or perspective of the speaker.'" *Reed*, 576 U.S. at 168-69 (quoting *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 829 (1995)). Such an application is a particularly "egregious form of content discrimination." *Id*. The Supreme Court has condemned viewpoint discrimination in the strongest possible terms; warning that "Those who begin coercive elimination of dissent soon find themselves exterminating dissenters." *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 641 (1943).

The Counseling Censorship Law discriminates based on viewpoint. The Law does not ban *all* counseling concerning sexual orientation, gender identity, or sexual "behaviors." Quite the contrary, it explicitly excepts "counseling or psychotherapies that provide acceptance, support, and understanding . . . of clients' . . . identity exploration" so long as they "do not seek to change sexual orientation or gender identity." Wash. Rev. Code. § 18.130.020(4)(b).

But it threatens severe punishment and even loss of license and livelihood if a counselor dares to provide counsel—desired and requested by his client—that "seek[s] to change [an individual's] sexual orientation or gender identity." *Id.* The law very expressly seeks to silence one viewpoint in the counseling room: the viewpoint that feelings and behaviors relating to sexual orientation and gender identity can change; that individuals are not necessarily prisoners of undesired feelings; and that individuals are not irrevocably predestined to violate their own religious convictions. "The [Law] thus codif[ies] a particular viewpoint . . . and prohibit[s] the therapist[] from advancing any other perspective when counseling clients." *Otto*, 981 F.3d at 864.

But this the Washington legislature may not do. "The First Amendment exists precisely so that speakers with unpopular ideas do not have to lobby the government for permission before

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they speak." *Otto*, 981 F.3d at 864. Instead, "[t]he test of truth is the power of an idea to get itself accepted in a competitive marketplace of ideas and the people lose when the government is the one deciding which ideas should prevail." *NIFLA*, 138 S. Ct. at 2375 (cleaned up).

3. The speech targeted by the Law is not less protected because it is speech by professionals or it is directed at minors.

The strict scrutiny which such a content- and viewpoint-based law must survive can neither be excused nor lessened based on an argument that the law censors only a less protected category of "professional speech," as was suggested in *Pickup*. The Supreme Court in *NIFLA* expressly rejected the idea that professional speech is less protected, emphasizing that it has "long protected the First Amendment rights of professionals," "stressed the danger of content-based regulations in the fields of medicine and public health" where "[d]octors help patients make deeply personal decisions and . . . candor is crucial," and noted that attempts to censor the content of "doctor-patient discourse" have historically been characteristic of totalitarian regimes such as those of Nazi Germany, China under the Cultural Revolution, and Romania's Nicolae Ceausescu. 138 S. Ct. at 2374 (cleaned up). "States cannot choose the protection that speech receives under the First Amendment [by electing to regulate a profession], as that would give them a powerful tool to impose invidious discrimination of disfavored subjects." *Id.* at 2375 (cleaned up); *see also IMDb.com*, 962 F.3d at 1121 ("[S]tate legislatures do not have freewheeling authority to declare new categories of speech outside the scope of the First Amendment.") (cleaned up).

Following *NIFLA*, the Eleventh Circuit recently held that an ordinance nearly identical to the Counseling Censorship Law was "presumptively unconstitutional," *Otto*, 981 F.3d at 868, *quoting Reed*, 576 U.S. at 163, and in fact could not stand. "[T]he First Amendment does not allow communities to determine how their neighbors may be counseled about matters of sexual orientation or gender." *Otto*, 981 F.3d at 871.

Similarly, with *Pickup*'s rationale now rejected, this Court's strong teaching in *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002), stands and is directly on point. There, striking a law that

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sought to censor what advice physicians could give to patients about the medical use of marijuana, the Ninth Circuit emphasized "the core First Amendment values of the doctor-patient relationship," and that "professional speech may be entitled to the strongest protection our Constitution has to offer." *Conant*, 309 F.3d at 637 (cleaned up). It found the restriction on the speech between doctor and patient there to be both content- and viewpoint-based, applied strict scrutiny, and invalidated the law. *Id*. at 637-639.

Nor is the Law excused from strict scrutiny because it limits its censorship to conversations with minors. Minors themselves "are entitled to a significant measure of First Amendment protection," and a legislature does not possess "a free-floating power to restrict the ideas to which children may be exposed." *Brown v. Ent. Merchs. Ass'n*, 564 U.S. 786, 794 (2011) (cleaned up). Speech cannot be suppressed "solely to protect the young from ideas or images that a legislative body thinks unsuitable for them." *Id*. at 795 (cleaned up).

C. The Counseling Censorship Law cannot survive strict scrutiny.

To survive strict scrutiny, Defendants must prove that the Counseling Censorship Law "furthers a compelling interest and is narrowly tailored." *Reed*, 576 U.S. at 171 (cleaned up). Defendants bear the burden of establishing this both on the merits and for purposes of defeating a request for preliminary injunction. *Ashcroft v. ACLU*, 542 U.S. 656, 660-61, 666 (2004). The State must "specifically identify an 'actual problem'" and show that restricting "speech [is] actually necessary to the solution." *Brown*, 564 U.S. at 799 (cleaned up).

"A narrowly tailored regulation … actually advances the state's interest (is necessary), does not sweep too broadly (is not overinclusive), does not leave significant influences bearing on the interest unregulated (is not underinclusive), and" cannot "be replaced" by a regulation "that could advance the interest as well with less infringement of speech (is the least-restrictive alternative)." *Republican Party of Minn. v. White*, 416 F.3d 738, 751 (8th Cir. 2005); *see Victory Processing*, 937 F.3d at 1227-1228 (same).

In an as-applied challenge to a restriction of First Amendment rights, government must also prove that the compelling interest would be injured if an exception were granted to the

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challenger. *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 430-32 (2006) (applying the compelling interest test in the context of RFRA). Otherwise, application of the law in that particular setting cannot further the interest.

The Counseling Censorship Law fails these requirements at every point.

1. The Counseling Censorship Law cannot survive strict scrutiny because, as enforced against pure speech, it does not further any cognizable governmental interest.

The Counseling Censorship Law fails strict scrutiny at the threshold because it serves *no* cognizable interest at all as applied against counseling speech. There is no statistically valid evidence that counseling of the type that Mr. Tingley provides is either harmful or ineffective. (*See* Rosik Decl. ¶¶ 29-53; Levine Decl. ¶¶ 38-44, 83-85.) But more fundamentally, arguments about harm and efficacy are irrelevant as a matter of law. It is a lodestar of First Amendment jurisprudence that censorship cannot be justified on the plea that bad ideas cause harm. No doubt "ideas have consequences,"[1] but under our laws this provides no footing for censorship unless and until that risk of harm rises to the high and immediate urgency defined by the "clear and present danger" test. *See Brandenburg v. Ohio*, 395 U.S. 444, 447-49 (1969) (per curiam) (general advocacy of armed resistance not sufficient to justify punishment for speech); *see also Herceg v. Hustler Magazine, Inc.*, 814 F.2d 1017, 1024 (5th Cir. 1987) (rejecting the suggestion that "a less stringent standard than the *Brandenburg* test be applied in cases involving non-political speech that has actually produced harm")

It is equally clear that the State of Washington does not have a cognizable interest in preventing the dissemination of ideas concerning personal, philosophical, scientific, and religious topics on the grounds that such ideas are (or it believes them to be) false or offensive. *McCullen*, 573 U.S. at 476 (citing *FCC v. League of Women Voters of Cal.*, 468 U.S. 364, 377 (1984)) ("[T]he First Amendment's purpose" is "to preserve an uninhibited marketplace of ideas in which truth will ultimately prevail."); *United States v. Alvarez*, 567 U.S. 709, 729 (2012)

[1] *See* Richard M. Weaver, *Ideas Have Consequences* (Univ. Chi. Press, 1948).

("Truth needs neither handcuffs nor a badge for its vindication."); *United States v. Swisher*, 811 F.3d 299, 317-18 (9th Cir. 2016) (adopting the *Alvarez* finding that "lies do not fall into a category of speech that is excepted from First Amendment protection"); *Texas v. Johnson*, 491 U.S. 397, 414 (1989) (The "bedrock principle underlying the First Amendment . . . is that the government may not prohibit the expression of an idea simply because society finds the idea itself offensive or disagreeable."); *Snyder v. Phelps*, 562 U.S. 443, 458, (2011) ("[S]peech cannot be restricted simply because it is upsetting or arouses contempt."); *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos.*, 515 U.S. 557, 574 (1995) ("[T]he point of all speech protection . . . is to shield just those choices of content that in someone's eyes are misguided, or even hurtful.").

However much the State of Washington may dislike the ethics, goals, and even religious beliefs of clients seeking counsel for unwanted sexual attractions and identity, "the [client's] freedom to learn about them, fully to comprehend their scope and portent, and to weigh them against the tenets of the 'conventional wisdom,' may not be abridged." *Eisenstadt v. Baird*, 405 U.S. 438, 457 (1972) (Douglas, J., concurring). The Ninth Circuit has made the same point, denying that the state has power to paternalistically regulate speech between doctor and patient to prevent individuals from making "bad decisions." *Conant*, 309 F.3d at 637.

2. The Counseling Censorship Law cannot survive strict scrutiny because it is not narrowly tailored.

The Counseling Censorship Law in its present form must also fail because it is not narrowly tailored. "Precision must be the touchstone when it comes to regulations of speech, which so closely touch our most precious freedoms." *NIFLA*, 138 S. Ct. at 2376 (cleaned up).

The Senate Bill Report behind SB 5722 expressed concern about supposed practices that "induce nausea, vomiting, and other responses from youth, while showing them erotic images." No specific instances are documented in the Report. (Cmpl. ¶ 56.) The House Report further asserted that problematic practices include "physical abuse of children." (Cmpl. ¶ 56.) Perhaps Washington State has the power to regulate such conduct and procedures. But the scope of the

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State's power to regulate such conduct by health professionals is not before this Court. Instead, the Counseling Censorship Law prohibits even simple, voluntary conversation if that conversation is directed toward a goal and viewpoint of which the legislature disapproves. The Counseling Censorship Law is sweepingly overbroad with respect to any legitimate governmental interest. *United States v. Stevens*, 559 U.S. 460, 473 (2010) (a law is overbroad if "a substantial number of its applications are unconstitutional, judged in relation to the statute's plainly legitimate sweep") (citation omitted); *Simon & Schuster, Inc. v. Members of N.Y. State Crime Victims Bd.*, 502 U.S. 105, 121 (1991) (law requiring a criminal to pay income derived from describing crime into an escrow account was overbroad because it applied to any reference to crimes).

The Law is also *under*inclusive with respect to its claimed goals. If a statute is underinclusive, this negates the legitimacy of the law in at least three distinct ways. First, it contradicts the claim that the law is "narrowly tailored" to the harm it purports to address. *Brown*, 564 U.S. at 799-804. Second, the poor fit between the law and the alleged harm "raises serious doubts about whether [the government] is, in fact, serving, with this statute, the significant interests which [it] invokes" to justify the law. *Florida Star v. B.J.F.*, 491 U.S. 524, 540 (1989). Third, underinclusiveness may justify an inference that the law was in fact targeted against religiously motivated practices, rather than being genuinely "of general applicability." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 542-43, 545 (1993). Such is the case here.

The Counseling Censorship Law is severely underinclusive as a means toward the goal it purports to serve, triggering each of these concerns. Based on the recitations of the legislative record, the harm that the law purportedly seeks to avoid is the psychic distress to individuals caused by what the State deems to be misguided counsel. (Compl. ¶ 56-61.) Even if this were a legitimate basis for governmental censorship (it is not), our world–and Washington State–is filled with sexual and relational advice pointing in every conceivable direction, much of which may cause distress to those who follow it. No doubt misguided counseling on other topics (*e.g.*,

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recommendations to use hallucinogenic drugs, websites or YouTube videos that encourage minors to adopt transgender identities, or promotion of extreme diets) could equally lead to adverse impacts and distress for some clients. Yet the Washington legislature has not launched a general inquiry into such risks, nor banned "counseling that may lead to psychological distress." Instead, it has exclusively named, targeted, and censored from counseling conversations only a narrow category and a specific viewpoint, defined by current political fashion rather than by any demonstration of unique harm.

3. The Counseling Censorship Law cannot survive strict scrutiny because it is not the least-restrictive alternative.

A law subject to strict scrutiny is also not "narrowly tailored" if the purported interests could have been served by a less restrictive alternative. The government bears the burden to prove that available alternatives would have been ineffective. *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 817 (2000). Where speech which the government considers harmful is at issue, the "least restrictive alternative" is unlikely to involve censorship. "The remedy for speech that is false is speech that is true. This is the ordinary course in a free society. The response to the unreasoned is the rational; to the uninformed, the enlightened; to the straightout lie, the simple truth." *Alvarez*, 576 U.S. at 727. "[M]ore speech, not enforced silence" is the best response to perceived falsehoods or misguided ideas. *Whitney v. California*, 274 U.S. 357, 377 (1927); *see also Video Software Dealers Ass'n v. Schwarzenegger*, 556 F.3d 950, 965 (9th Cir. 2009) (California failed to show that an education campaign could not equally serve its asserted interest).

Alternatives in addition to "more speech" were also evident. Washington State could have crafted a voluntary certification program for professionals who agree not to offer counseling of the type the legislature dislikes. *See Linmark Assocs., Inc. v. Willingboro Twp.*, 431 U.S. 85, 97 (1977) (government could have used financial incentives, rather than speech restrictions, to advance its interests).

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There is no sign that the Washington legislature considered these alternatives. Given the existence of these plausible, less restrictive alternatives to Washington's content-based restriction on speech, the Law is not narrowly tailored. *Playboy Ent. Grp.*, 529 U.S. at 816; *McCullen*, 573 U.S. at 479.

II. The Counseling Censorship Law Violates the Free Speech Rights of Clients of Plaintiff Tingley.

A. Plaintiff has standing to assert the First Amendment rights of his clients.

Mr. Tingley has standing to assert the rights of his clients that are violated by the Counseling Censorship Law. Such standing should be recognized where the party "has a 'close' relationship with the person who possesses the right," and where there is also some "'hindrance' to the possessor's ability to protect his own interests." *Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004). These considerations exist strongly here.

First, as a counselor Mr. Tingley has an extremely close relationship with clients who seek his assistance with goals relating to relationships and sexual attractions. (Tingley Decl. ¶ 84.) Counseling conversations relating to such topics are intensely sensitive, intimate, and important for clients, and "candor is crucial." *NIFLA*, 138 S. Ct. at 2374; *see also Maryland v. Joseph H. Munson Co.*, 467 U.S. 947, 958 (1984) (fund-raising company may assert free speech rights of client charities, where the protected interest was "at the heart of the . . . relationship between Munson and its clients").

Second, there are multiple obstacles here to counseling clients "protect[ing] [their] own interests." As was true in *Eisenstadt*, the Counseling Censorship Law does not prohibit *receiving* counsel, so even while Mr. Tingley's clients are denied access to ideas that they desire to hear, they "are not themselves subject to prosecution and, to that extent, are denied a forum in which to assert their own rights." 405 U.S. at 446.

Third, it is extremely difficult or even impossible for these clients to step forward to vindicate their own rights to engage in therapeutic conversations with Mr. Tingley. (Tingley Decl. ¶ 85.) These clients already experience emotional turmoil, and it is hardly speculative to

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predict that putting their personal difficulties into the spotlight of litigation would cause additional anguish and harm. (Tingley Decl. ¶ 86.)

Finally, where First Amendment rights are threatened, the rules for representative standing are relaxed. *Joseph H. Munson Co.*, 467 U.S. at 956. Courts find standing "when enforcement of the challenged restriction against the litigant would … indirectly [violate] third parties' rights." *Warth v. Seldin*, 422 U.S. 490, 510 (1975); *see also Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 757 (1976) (advertisers may assert readers' right to receive information). This concern is present here.

B. The Counseling Censorship Law violates the First Amendment right of clients of Tingley to receive desired information and counsel.

"The right of freedom of speech and press includes not only the right to utter or to print, but . . . the right to receive, the right to read" *Griswold v. Connecticut*, 381 U.S. 479, 482 (1965); *see also Va. State Bd. of Pharmacy*, 425 U.S. at 756 ("[T]he protection afforded is to the communication, to its source and to its recipients both."). Thus, for all the reasons that the Law violates Mr. Tingley's free speech rights, "enforcement of the challenged restriction against [Mr. Tingley] would . . . indirectly [violate] third parties' rights." *Warth*, 422 U.S. at 510.

III. The Counseling Censorship Law Violates the Due Process Rights of Plaintiff Because It Grants Unbridled Discretion in Enforcement.

The government is prohibited from imposing or threatening punishment based on a law that is "so standardless that it authorizes or encourages seriously discriminatory enforcement." *United States v. Williams*, 553 U.S. 285, 304 (2008); *see also Kolender v. Lawson*, 461 U.S. 352, 357-358 (1983) (striking statute that required persons "loitering" on the street to "account for their presence" upon request by an officer). And where an ordinance "interferes with the right of free speech or of association, a more stringent vagueness test should apply." *Holder v. Humanitarian Law Project*, 561 US 1, 19 (2010) (citation omitted).

The Counseling Censorship Law is unconstitutionally vague on its face in critical respects. First, it provides no standards or guidance to define the line between speech that

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permissibly seeks to "facilitat[e]" a client's "identity exploration and development," and speech that unlawfully seeks to "change" that person's gender identity or sexual orientation. The boundary between "exploration" and "change" is unknowable. (Cmpl. ¶ 46, 220-221.) Second, critical terms in the Counseling Censorship Law, including "gender identity", "gender expressions", "identity exploration", and "identity development" are undefined in the Law itself, and also undefined in science, and indeed have more in common with slogans than with a fixed standard identifying what counseling speech is prohibited and subject to punishment under the Law, and what is not. (Cmpl. ¶ 45, 222-232.) Third, there is no indication whether the prohibition on any "regime that *seeks* to change . . ." sexual orientation or gender identity refers to the subjective intent of the client, or that of the counselor. (Cmpl. ¶ 47, 233-234.)

These factors combine to afford effectively unbounded discretion to those authorized to bring enforcement actions under the Law. Essentially any exploratory discussion on matters of gender, gender expression, sexual orientation, sexual behaviors, or sexual or romantic attractions could be accused after the fact as a violation of the Law. (Cmpl. ¶ 181; Tingley Decl. ⁋ 81.) And just as the Law itself targets a disfavored viewpoint, counselors who share that disfavored viewpoint must fear that they themselves will be targeted, and that the unbounded discretion afforded by the vague statutory language will be used to bring discriminatory and harassing enforcement actions against themselves. (Cmpl. ¶ 177-178; Tingley Decl. ⁋ 78.)

This fear is necessarily multiplied by the extraordinary provision of this law which authorizes "*any . . . person*" to bring enforcement actions–potentially including ideological opponents or activists with no connection whatsoever to either the counselor or his client. (Cmpl. ¶ 55). Enforcement power in such hands, "defined" only by undefined terms at the very center of the Law's prohibitions, cannot satisfy the demands of Due Process.

IV. The Counseling Censorship Law Violates the Free Exercise Rights of Mr. Tingley and His Clients.

For the reasons explained above, the Counseling Censorship Law is unconstitutional as applied to anyone. And it is unconstitutional as applied to Mr. Tingley for the additional reason

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that it restricts the religious exercise of Mr. Tingley and his clients. The right to "free exercise" includes not merely the right to believe, but to live one's faith. This includes the right to "the performance of (or abstention from) physical acts," as well as the right to "profess whatever religious doctrine one desires," *Employment Div., Dept. of Human Resources of Ore. v. Smith*, 494 U.S. 872, 877 (1990), along with "communicating" these teachings to others so that they may live according to that faith. *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC*, 565 U.S. 171, 199 (2012) (Alito, J., concurring). Professionals such as counselors do not surrender this "first freedom" by accepting a professional license.

A. The Counseling Censorship Law violates free exercise rights because it is not neutral.

A law that burdens religious conduct is subject to strict scrutiny unless it is "neutral." *Smith*, 494 U.S. at 879. To assess neutrality, courts start with the law's text and its effect "in its real operation." *Lukumi*, 508 U.S. at 532-36. Here, the targeting is in plain view. As detailed in the Complaint, it is well known that counseling of the type the legislature has tarred as "conversion therapy" is principally sought by religiously motivated clients, provided by counselors who share similar religious convictions, and is both sought and provided for the purpose of bringing feelings and/or behaviors into line with faith-based views of human nature, morals, and a life well lived. (Cmpl. ¶¶ 62-68.)

For example, the 2009 task force of the American Psychological Association reported that "most [sexual orientation change efforts or "SOCE"] currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs." (Emphasis added) (Cmpl. ¶ 67.) A 2013 statement issued by the American Counseling Association asserted that "conversion therapy . . . is a religious . . . practice." (Cmpl. ¶ 63.) And in the important 2016 paper quoted above, Prof. Lisa Diamond and Prof. Clifford Rosky cited multiple peer-reviewed papers to conclude that "the majority of individuals seeking to change their sexual orientation report doing so for religious reasons rather than to escape discrimination." (Cmpl. ¶ 68.)

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Thus, as has been known for more than a decade, it is people of faith who are standing where the legislature has chosen to target. This is not neutrality; this is hostility. Under *Smith* and *Lukumi*, strict scrutiny must be applied. For all the reasons reviewed above, the Counseling Censorship Law cannot survive that rigorous test. *See supra* at p. 11-16.

B. The Counseling Censorship Law violates free exercise rights regardless of whether it is "neutral and of general applicability."

While satisfying the *Smith* test is necessary to justify a law that restricts free exercise, it is not always sufficient. The Supreme Court has expressly rejected the idea "that any application of a valid and neutral law of general applicability is necessarily constitutional under the Free Exercise Clause," *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012, 2021 n.2 (2017). In *Hosanna-Tabor*, 565 U.S. at 182-187, for example, the Court unanimously barred application of a neutral and generally applicable employment discrimination law against a religious school, on free exercise grounds, without applying the *Smith* test. Notably, the Court has *never* applied the *Smith* test to permit censorship of faith-motivated speech because the government dislikes the purpose or message of that speech.

Questions about the nature of men, women, sexuality, sexual relations, and marriage—what will lead toward a whole life and what will not—have been a central concern of religions including at least Judaism, Christianity, and Islam since ancient times. Teaching and counsel directed to a right ordering of one's relationship to one's body and gender, and to sex, marriage, and family, are central to the content and propagation of religious faith. For this reason, notwithstanding *Smith*, the First Amendment flatly denies Washington State the power to tell a Christian that he cannot seek the help of a trusted counselor to pursue a path of conduct in his life consistent with his faith. Nor can it tell Mr. Tingley that he cannot provide counsel that is informed by and consistent with his own faith and that of his client concerning sexuality and personal identity.

Perhaps coming at the same point by a different route, the hybrid rights exception expressly carved out by the Supreme Court in *Smith* likewise dictates that the Counseling

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Censorship Law—as applied to Mr. Tingley and his faith-motivated clients—must undergo strict scrutiny regardless of whether it is "neutral and generally applicable," because it implicates *both* free exercise and free speech rights. *See Miller v. Reed*, 176 F.3d 1202, 1207 (9th Cir. 1999) (noting that *Smith* "excepts a hybrid-rights claim from its rational basis test"). In order to invoke that exception, the plaintiff must demonstrate only a "fair probability" or "likelihood" but not "certitude" of success on the companion claim. *Miller*, 176 F.3d at 1207 (cleaned up). The Plaintiff here has surpassed this marginal threshold, *see supra* at p. 7-11, so strict scrutiny applies—and is fatal. *See supra* at p. 11-16.

V. The Remaining Factors Favor Granting a Preliminary Injunction.

For all the reasons reviewed above, Plaintiff Tingley has demonstrated likelihood of success on the merits. Once a likelihood of success in establishing a First Amendment violation has been established, no separate "balance of equities" analysis is necessary to conclude that a preliminary injunction should issue. (*See supra* at p. 7.) The violation of First Amendment rights of Mr. Tingley and his clients constitutes irreparable harm, and the State of Washington has no cognizable interest in preventing the "harms from ideas" to citizens that the Counseling Censorship Law purports to avert. (*See supra* at p. 12-13).

Conclusion

For the reasons set forth above, Plaintiff Brian Tingley respectfully requests that this Court issue a preliminary injunction prohibiting any enforcement action both facially and as-applied against Plaintiff under the Counseling Censorship Law pending entry of a final order in this case.

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Respectfully submitted this 13th day of May, 2021.

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**Pro Hac Vice* applications filed concurrently

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CERTIFICATE OF SERVICE

I hereby certify that on May 13, 2021, I electronically filed the foregoing document with the Clerk of Court using the CM/ECF system. The foregoing document will be served via private process server with the Summons and Complaint to all Defendants.

DATED: May 13, 2021

s/ Kristen K. Waggoner

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,

Defendants.

Civil No. 3:21-cv-5359

EXPERT DECLARATION OF DR. STEPHEN B. LEVINE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

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I, Dr. Stephen B. Levine, declare as follows:

I. CREDENTIALS & SUMMARY

1. I am Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine and maintain an active private clinical practice. I received my MD from Case Western Reserve University in 1967 and completed a psychiatric residency at the University Hospitals of Cleveland in 1973. I became an Assistant Professor of Psychiatry at Case Western in 1973 and became a Full Professor in 1985.

2. Since July 1973, my specialties have included psychological problems and conditions relating to individuals' sexuality and sexual relations, therapies for sexual problems, and the relationship between love, intimate relationships, and wider mental health. In 2005, I received the Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research which "recognizes extraordinary contributions to clinical sexuality and/or sexual research over the course of a lifetime and achievement of excellence in clinical and/or research areas of sexual disorders."[1] I am a Distinguished Life Fellow of the American Psychiatric Association.

3. I have served as a book and manuscript reviewer for numerous professional publications. I have been the Senior Editor of the first (2003), second (2010), and third (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In addition to five previously solo-authored books for

[1] Society for Sex Therapy & Research Awards, https://sstarnet.org/awards/.

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professionals, I have recently published *Psychotherapeutic Approaches to Sexual Problems* (2020). The book has a chapter titled "The Gender Revolution."

4. I first encountered a patient suffering what we would now call gender dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender Identity Clinic and have served as Co-Director of that clinic since that time. Across the years, our Clinic treated hundreds of patients who were experiencing a transgender identity. An occasional child was seen during this era. I was the primary psychiatric care-giver for several dozen of our patients and supervisor of the work of other therapists. As the incidence of gender dysphoria has increased among children and youth in recent years, larger numbers of minors presenting with actual or potential gender dysphoria have presented to our clinic. I currently am providing psychotherapy for several minors in this area. I also counsel distressed parents of these teens.

5. I was an early member of the Harry Benjamin International Gender Dysphoria Association (now known as the World Professional Association for Transgender Health or WPATH) and served as the Chairman of the committee that developed the 5th version of its Standards of Care. The vast majority of the 6th version contains the exact prose that my committee wrote for the 5th version. In 1993 our Gender Identity Clinic was renamed, moved to a new location, and became independent of Case Western Reserve University. I continue to serve as Co-Director.

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6. In 2006, Judge Mark Wolf of the Eastern District of Massachusetts asked me to serve as an independent, court-appointed expert in litigation involving the treatment of a transgender inmate within the Massachusetts prison system. I have been retained by the Massachusetts Department of Corrections as a consultant on the treatment of transgender inmates since 2007.

7. In 2019, I was qualified as an expert and testified concerning the diagnosis, understanding, developmental paths and outcomes, and therapeutic treatment of transgenderism and gender dysphoria, particularly as it relates to children, in the matter of *In the Interest of J.A.D.Y. and J.U.D.Y.*, Case No. DF-15-09887-S, 255th Judicial District, Dallas County, TX.

8. A fuller review of my professional experience, publications, and awards is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

9. My many years of experience in working with adults or older young adults who are living in a transgender identity or who suffer from gender dysphoria provide a wide lifecycle view which, along with my familiarity with the literature concerning them, provides an important cautionary perspective. The psychiatrist or psychologist treating a trans child or adolescent of course seeks to make the young patient happy, but the overriding consideration is the creation of a happy, highly functional, mentally healthy person for the next 50 to 70 years of life. I refer to treatment that keeps this goal in view as the "life course" perspective.

10. A summary of the key points that I explain in this statement is as follows:

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a. Sex as defined by biology and reproductive function cannot be changed. While hormonal and surgical procedures may enable a female-identifying male to "pass" as being female (or vice versa) during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex. (Section II.A.)

b. The diagnosis of "gender dysphoria" encompasses a diverse array of conditions, with widely differing pathways and characteristics depending on age of onset, biological sex, mental health, intelligence, motivations for gender transition, socioeconomic status, country of origin, etc. Data from one population (e.g., adults) cannot be assumed to be applicable to others (e.g., children). (Section II.B.) Generalizations about the treatment children in one country (e.g., Holland) do not necessarily apply to another (e.g., United States).

c. Among psychiatrists and psychotherapists who practice in the area, there are currently widely varying views concerning both the causes of and appropriate therapeutic response to gender dysphoria in children. Existing studies do not provide a basis for a scientific conclusion as to which therapeutic response results in the best long-term outcomes for affected individuals. (Sections II.E, II.F.)

d. A majority of children (in several studies, a large majority) who are diagnosed with gender dysphoria "desist"—that is, their gender dysphoria

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does not persist—by puberty or adulthood unless transgender-affirming therapeutic or medical interventions modify the normal course of maturation. It is not currently known how to distinguish children who will persist from those who will not. (Section III.)

e. Some recent studies suggest that active affirmation of transgender identity in young children will substantially reduce the number of children who would desist from transgender identity through the course of puberty. This raises the ethical concern that this will increase the number of individuals who suffer the multiple long-term physical, mental, and social harms and limitations that are strongly associated with living life as a transgender person. (Sections III, V.)

f. Typically, social transition is a first step in gender affirmation. It is itself an important intervention with profound implications for the long-term mental and physical health of the child. When a mental health professional (MHP) evaluates a child or adolescent and then recommends social transition, that professional should be available to help with interpersonal, familial, and psychological problems that may already exist and will likely arise after transition. However, today many children are started on puberty blockers, and adolescents are medically transitioned, without a thorough, long-lasting mental health assessment and psychological ongoing care, leaving themselves and their families on their own to deal with ongoing and subsequent problems. (Sections III, V.)

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g. The knowledge base concerning the cause and treatment of gender dysphoria available today has low scientific quality. (Section IV.)

h. There are no studies that show with any methodological and statistical validity that affirmation of transgender identity in young children reduces suicide or suicidal ideation, or improves long-term outcomes as compared to other therapeutic approaches. Meanwhile, multiple studies show that adult individuals living transgender lives suffer much higher rates of suicidal ideation, completed suicide, and negative physical and mental health conditions than does the general population before and after transition, hormones, and surgery. There are no randomized studies that compare outcomes among older teens and adults with gender dysphoria who have affirmation treatment with those who do not. (Section IV.)

i. In light of what is known and not known about the impact of affirmation on the incidence of suicide, suicidal ideation, and other indicators of mental and physical health, it is scientifically baseless, and therefore unethical, to assert that a child or adolescent who expresses an interest in a transgender identity will kill him- or herself unless adults and peers affirm that child in a transgender identity. (Section IV.)

j. Putting a child or adolescent on a pathway towards life as a transgender person puts that individual at risk of a wide range of long-term or even life-long harms, including: sterilization (first chemical, then surgical) and associated regret and sense of loss; inability to experience orgasm (for

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trans women); physical health risks associated with exposure to elevated levels of cross-sex hormones; surgical complications and life-long after-care; alienation of family relationships; inability to form lasting romantic relationships and attract a desirable mate; and elevated mental health risks of depression, anxiety, and substance abuse. (Section V.)

II. BACKGROUND ON THE FIELD

A. The biological baseline of sex

11. Gender identity advocates commonly refer to the sex of an individual as "assigned at birth." This phrase is misleading. The sex of a human individual at its core structures the individual's biological reproductive capabilities—to produce ova and bear children as a mother, or to produce semen and beget children as a father. As physicians know, sex determination occurs at the instant of conception, depending on whether a sperm's X or Y chromosome fertilizes the egg. Medical technology can now determine a fetus's sex before birth almost as easily as after birth. It is thus not correct to assert that doctors "assign" the sex of a child at birth. Instead, they simply recognize the existing fact of that child's sex. Barring rare disorders of sexual development, anyone can identify the sex of an infant by genital inspection. What the general public may not understand, however, is that every nucleated cell of an individual's body is chromosomally identifiably male or female—XY or XX.

12. The self-perceived gender of a child, in contrast, arises in part from how others label the infant: "I love you, son (daughter)." This designation occurs thousands of times in the first two years of life when a child begins to show

awareness of the two possibilities. As acceptance of the designated gender corresponding to the child's sex is the outcome in >99% of children everywhere, anomalous gender identity formation begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the product of how the child was privately regarded and treated? Does it stem from trauma-based rejection of maleness or femaleness, and if so, flowing from what trauma? Does it derive from a tense, chaotic interpersonal parental relationship without physical or sexual abuse? Is it a symptom of another, as of yet unrevealed, emotional disturbance or neuropsychiatric condition such as autism? The answers to these relevant questions are not scientifically known.

13. Under the influence of hormones secreted by the testes or ovaries, numerous additional sex-specific differences between male and female bodies continuously develop postnatally, culminating in the dramatic maturation of the primary and secondary sex characteristics with puberty. These include differences in hormone levels, height, weight, bone mass, shape and development, musculature, body fat levels and distribution, and hair patterns, as well as physiological differences such as menstruation. These are genetically programmed biological consequences of sex, which also serve to influence the consolidation of gender identity during and after puberty.

14. Despite the increasing use of cross-sex hormones and various surgical procedures to reconfigure some male bodies to visually pass as female, or vice versa, the biology of the person remains as defined by his (XY) or her (XX) chromosomes,

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including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally-defined sex. For instance, the XX (genetically female) individual who takes testosterone to stimulate certain male secondary sex characteristics will nevertheless remain unable to produce sperm and father children. Thus in critical respects, gender affirmation changes can only be anatomically "skin deep." Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become "a complete man" or "a complete woman," this is not biologically attainable.[2] It is possible for some adolescents and adults to pass unnoticed in daily life as the opposite sex that they aspire to be—but with limitations, costs, and risks, as I detail later. These risks include a continuing sense of inauthenticity as a member of the opposite sex.

B. Definition and diagnosis of gender dysphoria

15. Specialists have used a variety of terms over time, with somewhat shifting definitions, to identify and speak about a distressing incongruence between an individual's sex as determined by their chromosomes and their thousands of genes, and the gender with which they eventually subjectively identify or to which they aspire. Today's American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5") employs the term Gender Dysphoria and

[2] S. Levine (2018), *Informed Consent for Transgendered Patients*, J. OF SEX & MARITAL THERAPY at 6 ("*Informed Consent*"); S. Levine (2016), *Reflections on the Legal Battles Over Prisoners with Gender Dysphoria*, J. AM. ACAD. PSYCHIATRY LAW 44, 236 at 238 ("*Reflections*").

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defines it with separate sets of criteria for adolescents and adults on the one hand, and children on the other.

16. There are at least five distinct pathways to gender dysphoria: early childhood onset; onset near or after puberty with no prior cross gender patterns; onset after defining oneself as gay or lesbian for several or more years and participating in a homosexual life style; adult onset after years of heterosexual transvestism; and onset in later adulthood with few or no prior indications of cross-gender tendencies or identity.

17. Gender dysphoria has very different characteristics depending on age and sex at onset. Young children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients.[3] The developmental and mental health patterns for each of these groups are sufficiently different that data developed in connection with one of these populations cannot be assumed to be applicable to another.

18. The criteria used in DSM-5 to identify Gender Dysphoria include a number of signs of discomfort with one's natal sex and vary somewhat depending on the age of the patient, but in all cases require "clinically significant distress or impairment in . . . important areas of functioning" such as social, school, or occupational settings.

[3] K. Zucker (2018), *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies & 'Desistance' Theories about Transgender & Gender Non-Conforming Children"* by Temple Newhook et al., INT'L J. OF TRANSGENDERISM at 10 ("*Myth of Persistence*").

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19. When these criteria in children (or adolescents, or adults) are not met, two other diagnoses may be given. These are: Other Specified Gender Dysphoria and Unspecified Gender Dysphoria. Specialists sometimes refer to children who do not meet criteria as being "subthreshold."

20. Children who conclude that they are transgender are often unaware of a vast array of adaptive possibilities for how to live life as a man or a woman—possibilities that become increasingly apparent over time to both males and females. A boy or a girl who claims or expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that reflect constrictive notions of what men and women can be.[4] A young child's—or even an adolescent's—understanding of this topic is quite limited. Nor can they grasp what it may mean for their future to be sterile. These children and adolescents consider themselves to be relatively unique; they do not realize that discomfort with the body and perceived social role is neither rare nor new to civilization. What is new is that such discomfort is thought to indicate that they must be a trans person.

21. "Gender identity," as that term is commonly used in public discourse as well as academic publication, is distinct from sex. Unfortunately, "gender identity" has no distinct objective definition by which a subject's gender identity may be confirmed. The Department of Health and Human Services has defined

[4] S. Levine (2017), *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, J. OF SEX & MARITAL THERAPY at 7 ("*Ethical Concerns*") (available at http://dx.doi.org/10.1080/0092623X.2017.1309482.)

"gender identity" as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth.[5] A publication sponsored by the ACLU, National Center for Lesbian Rights, Human Rights Campaign, and National Education Association asserts that gender identity encompasses any "deeply-felt sense of being male, female, both or neither," and can include a "gender spectrum" "encompassing a wide range of identities and expressions." That source goes on to say that an individual may have an "internal sense of self as male, female, both or neither," and that "each person is in the best position to define their own place on the gender spectrum."[6] The medical text *Principles of Transgender Medicine and Surgery*, states that "Gender identity can be conceptualized as a continuum, a Mobius, or patchwork."[7]

22. In sum, gender identity is said to refer to an individual's subjective perceptions of where that person falls on a continuum of genders ranging from very masculine gender to very feminine, but is also said to include genders which are some of either or something else entirely, or no gender at all (e.g., agender). There are no objective indicia that define or establish one's gender within this paradigm.

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[5] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) at 31,384.

[6] Asaf Orr et al., NATIONAL CENTER FOR LESBIAN RIGHTS, *Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools*, at 5-7 (2015), https://www.nclrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015-Online.pdf.

[7] R. Ettner, et al. (2016), *Principles of Transgender Medicine and Surgery* (Routledge 2nd ed.) at 43.

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23. In clinical experience, I observe patients experiencing gender identity as an often-evolving mixture of male and female identification, which may be influenced by the patient's reactions to cultural stereotypes, and/or by the patient's past and present family dynamics. The gender identity composite, however, is just one-third of the self-labels that constitute sexual identity. The other two components are the dimensions of sexual orientation—heterosexual, homosexual, and bisexual--and the generally avoided dimension of sexual intention—what one wants to do with a partner's body and what one wants done to his or her body. In my view gender identity is merely a part of sexual identity, and an even smaller part of the individual's total self-identification.

C. Impact of gender dysphoria on minority and vulnerable groups

24. In considering the appropriate response to gender dysphoria, it is important to know that certain groups of children and adolescents have an increased prevalence and incidence of trans identities. These include: children of color,[8] children with mental developmental disabilities,[9] including children on the autistic spectrum (at a rate more than 7x the general population),[10] children residing in foster care homes, adopted children (at a rate more than 3x the general

[8] G. Rider et al. (2018), *Health and Care Utilization of Transgender/Gender Non-Conforming Youth: A Population Based Study*, PEDIATRICS 141:3 at 4 (In a large sample, non-white youth made up 41% of the set who claimed a transgender or gender-nonconforming identity, but only 29% of the set who had a gender identity consistent with their sex.).

[9] D. Shumer & A. Tishelman (2015), *The Role of Assent in the Treatment of Transgender Adolescents*, INT. J. TRANSGENDERISM at 1 (available at doi: 10.1080/15532739.2015.1075929).

[10] D. Shumer et al. (2016), *Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic*, LGBT HEALTH, 3(5) 387 at 387.

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population),[11] children with a prior history of psychiatric illness,[12] and more recently adolescent girls (in a large recent study, at a rate more than 2x that of boys) (Rider, 2018 at 4).

25. The social transitioning, hormonal, and surgical paths often recommended and facilitated by gender clinics may lead to sterilization by the time the patient reaches young adulthood. They may add a future source of despair in an already vulnerable person. Caution and time to reflect as the patient matures are prudent when dealing with a teen's sense of urgency about transition.

D. Three competing conceptual models of gender dysphoria and transgender identity

26. Discussions about appropriate responses by MHPs to actual or sub-threshold gender dysphoria are complicated by the fact that various speakers and advocates (or a single speaker at different times) view transgenderism through at least three very different paradigms, often without being aware of, or at least without acknowledging, the distinctions.

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[11] D. Shumer et al. (2017), *Overrepresentation of Adopted Adolescents at a Hospital-Based Gender Dysphoria Clinic*, TRANSGENDER HEALTH Vol. 2(1) 76 at 77.

[12] L. Edwards-Leeper et al. (2017), *Psychological Profile of the First Sample of Transgender Youth Presenting for Medical Intervention in a U.S. Pediatric Gender Center*, PSYCHOLOGY OF SEXUAL ORIENTATION AND GENDER DIVERSITY, 4(3) 374 at 375; R. Kaltiala-Heino et al. (2015), *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 9(9) 1 at 5. (In 2015 Finland gender identity service statistics, 75% of adolescents assessed "had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria."); L. Littman (2018), *Parent Reports of Adolescents & Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, PLoS ONE 13(8): e0202330 at 13 (Parental survey concerning adolescents exhibiting Rapid Onset Gender Dysphoria reported that 62.5% of gender dysphoric adolescents had "a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria.").

27. Gender dysphoria is **conceptualized and described by some professionals and laypersons as though it were a serious, physical medical illness that causes suffering**, comparable, for example, to prostate cancer, a disease that is curable before it spreads. Within this paradigm, whatever is causing distress associated with gender dysphoria—whether secondary sex characteristics such as facial hair, nose and jaw shape, presence or absence of breasts, or the primary anatomical sex organs of testes, ovaries, penis, or vagina—should be removed to alleviate the illness. The promise of these interventions is the cure of the gender dysphoria.

28. It should be noted, however, that gender dysphoria is a psychiatric, not a medical, diagnosis even though that is how it is often introduced into court settings. Since its inception in DSM-III in 1983, it has always been specified in the psychiatric DSM manuals and is not specified in medical diagnostic manuals. Notably, gender dysphoria is the only psychiatric condition to be treated by surgery, even though no endocrine or surgical intervention package corrects any identified biological abnormality. (Levine, *Reflections,* at 240.) This medicalization of gender dysphoria is at some level at odds with psychologists' longstanding concerns about or even opposition to "practice guidelines that recommend the use of medications over psychological interventions in the absence of data supporting such recommendations.[13]

[13] AM. PSYCH. ASS'N (2005) *Report of the 2005 Presidential Task Force on Evidence-Based Practice* at 2 (available at https://www.apa.org/practice/resources/evidence/evidence-based-report.pdf.)

29. Gender dysphoria is alternatively **conceptualized in developmental terms**, as an adaptation to a psychological problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood or confusion about the self that intensifies with puberty. This paradigm starts from the premise that all human lives are influenced by past processes and events. Trans lives are not exceptions to this axiom. (Levine, *Reflections* at 238.) MHPs who think of gender dysphoria through this paradigm may work both to identify and address the apparent causes of the basic problem of the deeply uncomfortable self, and also to ameliorate suffering when the underlying problem cannot be solved. They work with the patient and (ideally) the patient's family to inquire what forces may have led to the trans person repudiating the gender associated with his sex. The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influences, and the fact that young children work out their psychological issues through fantasy and play. The developmental paradigm does not preclude a biological temperamental contribution to some patients' lives; it merely objects to assuming these problems are biological in origin. All sexual behaviors and experiences involve the brain and the body.

30. In addition, the developmental paradigm recognizes that, with the important exception of genetic sex, essentially all aspects of an individual's identity evolve—often markedly—across the individual's lifetime. This includes gender.

31. Some advocates assert that a transgender identity is biologically caused, fixed from early life, and invariably persists through life in an unchanging manner. This assertion, however, is not supported by science.[14] Although numerous studies have been undertaken to attempt to demonstrate a distinctive physical brain structure associated with transgender identity, as of yet there is no evidence that these patients have any defining abnormality in brain structure that precedes the onset of gender dysphoria. The belief that gender dysphoria is the consequence of brain structure is challenged by the sudden increase in incidence of child and adolescent gender dysphoria over the last twenty years in North America and Europe. Meanwhile, multiple studies have documented rapid shifts in gender ratios of patients presenting for care with gender-related issues, pointing to cultural influences,[15] while a recent study documented "clustering" of new presentations in specific schools and among specific friend groups, pointing to social influences.[16] Both of these findings strongly suggest cultural factors. From the beginning of epidemiological research into this arena, there have always been some countries (Poland and Australia, for example) where the sex ratios were reversed as compared to North America and Europe, again demonstrating a powerful effect of cultural influences.

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[14] Even the advocacy organization The Human Rights Campaign asserts that a person can have "a fluid or unfixed gender identity." https://www.hrc.org/resources/glossary-of-terms.

[15] Levine, *Ethical Concerns*, at 8 (citing M. Aitken et al. (2015), *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, J. OF SEXUAL MED.12(3) 756 at 756-63.)

[16] Lisa Littman (2018), *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of dysphoria*, PLoS ONE 13(8): e0202330.

32. Further, as I detail later below, many studies and clinical observations confirm that gender identity can and does change or evolve over time for many individuals. And recent studies and anecdotal reports provide strong if preliminary evidence that therapeutic choices can have a powerful effect on whether and how gender identity does change, or gender dysphoria desists.

33. In recent years, for adolescent patients, intense involvement with online transgender communities or "friends" is the rule rather than the exception, and the MHP will also be alert to this as a potentially significant influence on the identity development of the patient. Finally, the large accumulating reports of late adolescent and young adult individuals who return to their natally assigned gender identity highlight the error of assuming a trans identity is a permanent feature[17].

34. The third paradigm through which gender dysphoria is alternatively conceptualized is from **a sexual minority rights perspective**. Under this paradigm, any response other than medical and societal affirmation and implementation of a patient's claim to "be" the opposite gender is a violation of the individual's civil right to self-expression. Any effort to ask "why" questions about the patient's condition, or to address underlying causes, is viewed as a violation of autonomy and civil rights. Any attempt to slowly review the risks of affirmative and alternative interventions in detail is viewed as irrelevant. In the last few years, this paradigm has been successful in influencing public policy and the education of

[17] P. Expósito-Campos (2021). *A Typology of Gender Detransition and Its Implications for Healthcare Providers*. J. OF SEX & MARITAL THERAPY, 47(3), 270–280.

pediatricians, endocrinologists, and many mental health professionals. Obviously, however, this is not a medical, psychiatric, or scientific perspective.

E. Four competing models of therapy

35. Because of the complexity of the human psyche and the difficulty of running controlled experiments in this area, substantial disagreements among professionals about the causes of psychological disorders, and about the appropriate therapeutic responses, are not unusual. When we add to this the very different paradigms for understanding transgender phenomena discussed above, it is not surprising that such disagreements also exist with regard to appropriate therapies for patients experiencing gender-related distress. I summarize below the leading approaches, and offer certain observations and opinions concerning them.

(1) The "watchful waiting" therapy model

36. I review below the uniform finding of follow-up studies that the large majority of children who present with gender dysphoria will desist from desiring a transgender identity by adulthood if left untreated. (Section III.A)

37. When a pre-adolescent child presents with gender dysphoria, a "watchful waiting" approach seeks to allow for the fluid nature of gender identity in children to naturally evolve—that is, take its course from forces within and surrounding the child. Watchful waiting has two versions:

a. Treating any other psychological co-morbidities—that is, other mental illnesses as defined by DSM-5—that the child may exhibit (e.g., separation anxiety, bedwetting, attention deficit disorder, obsessive-compulsive disorder) without a focus on gender (model #1); and

b. No treatment at all for anything but a regular follow-up appointment. This might be labeled a "hands off" approach (model #2).

(2) The psychotherapy model: Alleviate distress by identifying and addressing causes (model #3)

38. One of the foundational principles of psychotherapy has long been to work with a patient to identify the causes of observed psychological distress and then to address those causes as a means of alleviating the distress. The National Institute of Mental Health has promulgated the idea that 75% of adult psychopathology has its origins in childhood experience.

39. Many experienced practitioners in the field of gender dysphoria, including myself, have believed that it makes sense to employ these long-standing tools of psychotherapy for patients suffering gender dysphoria, asking the question as to what factors in the patient's life are the determinants of the patient's repudiation of his or her natal sex. (Levine, *Ethical Concerns*, at 8.) I and others have reported success in alleviating distress in this way for at least some patients, whether or not the patient's sense of discomfort or incongruence with his or her natal sex entirely disappeared. Relieving accompanying psychological co-morbidities leaves the patient freer to consider the pros and cons of transition as he or she matures.

40. Among other things, the psychotherapist who is applying traditional methods of psychotherapy may help—for example—the male patient appreciate the wide range of masculine emotional and behavioral patterns as he grows older. He may discuss with his patient, for example, that one does not have to become a

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"woman" in order to be kind, compassionate, caring, noncompetitive, and devoted to others' feelings and needs.[18] Many biologically male trans individuals, from childhood to older ages, speak of their perceptions of femaleness as enabling them to discuss their feelings openly, whereas they perceive boys and men to be constrained from emotional expression within the family and larger culture. Men, of course, can be emotionally expressive, just as they can wear pink. Converse examples can be given for girls and women. These types of ideas regularly arise during psychotherapies.

41. As I note above, many gender-nonconforming children and adolescents in recent years derive from minority and vulnerable groups who have reasons to feel isolated and have an uncomfortable sense of self. A trans identity may be the individual's hopeful attempt to redefine the self in a manner that increases their comfort and decreases their anxiety. The clinician who uses traditional methods of psychotherapy may not focus on their gender identity, but instead work to help them to address the actual sources of their discomfort. Success in this effort may remove or reduce the desire for a redefined identity. This often involves a focus on disruptions in their attachment to parents in vulnerable children, for instance, those in the foster care system.

42. Because "watchful waiting" can include treatment of accompanying psychological co-morbidities, and the psychotherapist who hopes to relieve gender

[18] S. Levine (2017), *Transitioning Back to Maleness*, ARCH. OF SEXUAL BEHAVIOR 47(4) at 7 ("*Transitioning*") (available at https://link.springer.com/article/10.1007/s10508-017-1136-9.)

dysphoria may focus on potentially causal sources of psychological distress rather than on the gender dysphoria itself, there is no sharp line between "watchful waiting" and the psychotherapy model in the case of prepubescent children.

43. To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can predictably enable a return to male identification for gender dysphoric genetically male boys, adolescents, and men, or return to female identification for gender dysphoric genetically female girls, adolescents, and women. On the other hand, anecdotal evidence of such outcomes does exist. I and other clinicians have witnessed reinvestment in the patient's biological sex in some individual patients who are undergoing psychotherapy. And from the earliest days of my career, traditional psychotherapy showed both promise and beneficial outcomes in reducing the distress of gender dysphoria. It did so without presuming gender affirmation as a preferred or mandated approach. When distress is significantly lessened, the person may find some comfortable adaptation short of bodily change.

44. More recently, I myself have published a paper on a patient who sought my therapeutic assistance to reclaim his male gender identity after 30 years living as a woman and is in fact living as a man today, (Levine, *Transitioning*), I have seen children desist even before puberty in response to thoughtful parental interactions and a few meetings of the child with a therapist. I have seen patients desist when their intimate relationships change.

(3) The affirmation therapy model (model #4)

45. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with the transgender identity to which the child expresses an attraction. These advocates treat any question about the causes of the child's transgender identification as inappropriate and assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition and need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

46. Some advocates, indeed, assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. I address claims about suicide and health outcomes in Sections IV and V below.

47. The idea that social transition is the only accepted treatment for prepubertal children is not correct. On the contrary, one respected academic in the field has recently written that "almost all clinics and professional associations in the world" do not use "gender affirmation" for prepubescent children and instead "delay any transitions after the onset of puberty."[19] This approach is widely

[19] J. Cantor (2020), *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY VOL. 46, NO. 4, 307-313.

practiced because when the intrapsychic, biological, and social developmental processes of puberty are allowed to act unimpaired (but accompanied by supporting therapy), resolution of the gender dysphoria is by far the most common outcome.[20] Natural desistance offers a reasonable likelihood of sparing the individual the life-long physical, mental, and social stresses associated with living in a transgender identity, which I discuss in Section V.

48. It is notable that even the Standards of Care published by WPATH, an organization which in general leans strongly towards affirmation in the case of adults, do not specify affirmation of transgender identity as the indicated therapeutic response for young children. Instead, the WPATH Standards of Care recognize that social transition in early childhood "is a controversial issue, and divergent views are held by health professionals"; state that "[t]he current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood"; and acknowledge that "previously described relatively low persistence rates of childhood gender dysphoria" are "relevant" to the wisdom of social transition in childhood.[21]

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[20] D. Singh et al. (2021), *A Follow-Up Study of Boys With Gender Identity Disorder*, FRONTIERS IN PSYCHIATRY Vol. 12:632784 at 12 (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8039393/.)

[21] WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH (2011), *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th Version) at 17. I note that I regretfully resigned from the precursor organization of WPATH in 2002 after concluding that many of its positions of enthusiastic and unqualified support of transition for individuals suffering from gender dysphoria were dictated by politics and ideology, rather than by any scientific basis. WPATH is composed of a mix of practitioners and transgender activists with little or no scientific training, and its most recent self-designated "Standards of Care" are not reflective of the practices of a large number of psychiatrists and Ph.D. psychologists who practice in this area. For this reason, WPATH's cautious position with regard to transition of children who suffer from gender dysphoria is all the more notable.

49. In contrast to WPATH's cautious position with respect to children, in 2018 the American Academy of Pediatrics issued a statement asserting that "gender transition" "is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria."[22] But in a peer-reviewed paper, based on a careful review of the sources cited in the AAP statement, prominent researcher James Cantor concluded that "In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all," and described Rafferty 2018 as "a systematic exclusion and misrepresentation of entire literatures." (Cantor at 312.) Based on my professional expertise and my review of the literature, I agree with Dr. Cantor's evaluation of Rafferty 2018.

50. In fact, the DSM-5 added—for both children and adolescents—a requirement that a sense of incongruence between biological and felt gender must last at least six months as a precondition for a diagnosis of gender dysphoria, precisely because of the risk of "transitory" symptoms and "hasty" diagnosis that might lead to "inappropriate" treatments.[23]

51. I do not know what proportion of practitioners are using which model. However, in my opinion, in the case of young children, prompt and thorough

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[22] J. Rafferty (2018), *Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness*, PEDIATRICS 142(4): 2018-2162.

[23] K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al. (eds.), MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH (Springer-Verlag Italia).

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affirmation of a transgender identity disregards the principles of child development and family dynamics and is not supported by science. Rather, the MHP must focus attention on the child's underlying internal and familial issues. Ongoing relationships between the MHP and the parents, and the MHP and the child, are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with over time by each of them.

52. Likewise, since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics.

F. Patients differ widely and must be considered individually.

53. In my opinion, it is not possible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-related issues. There is no single pathway of development and outcomes governing transgender identity, nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

54. As to causes in children and adolescents, details about the onset of gender dysphoria may be found in an understanding of family relationship dynamics. In particular, the relationship between the parents and each of the parents and the child, and each of the siblings and the child, should be well known by the MHP. Further, a disturbingly large proportion of children and adolescents who seek professional care in connection with gender issues have a wider history of

psychiatric co-morbidities. (*See supra* n. 12.) A 2017 study from the Boston Children's Hospital Gender Management Service program reported that: "Consistent with the data reported from other sites, this investigation documented that 43.3% of patients presenting for services had significant psychiatric history, with 37.1% having been prescribed psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3% with a history of suicide attempts." (Edwards-Leeper at 375.) It seems likely that an even higher proportion will have had prior undiagnosed psychiatric conditions.

55. In the case of adolescents, as I have noted above, there is evidence that peer social influences through "friend groups" (Littman) or through the internet can increase the incidence of gender dysphoria or claims of transgender identity, so the responsible MHP will want to probe these potential influences to better understand what is truly deeply tied to the psychology of this particular individual, and what may instead be "tried on" by the youth as part of the adolescent process of self-exploration and self-definition.

III. GENDER IDENTITY, GENDER DYSPHORIA, AND THERAPIES FOR GENDER DYSPHORIA IN YOUNGER CHILDREN

A. Natural desistance is by far the most frequent resolution of gender dysphoria in young children absent social transition.

56. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, the dysphoria does *not* persist through puberty. A recent article reviewed all existing follow-up studies that the author

could identify of children diagnosed with gender dysphoria (11 studies) and reported that "every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." (Cantor at 307.) Another author reviewed the existing studies and reported that in "prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance."[24] A third summarized the existing data as showing that "Symptoms of GID at prepubertal ages decrease or disappear in a considerable percentage of children (estimates range from 80-95%)."[25] As cited above, a 2021 extended follow-up of originally evaluated prepubertal boys found a persistence rate of only 12 percent. (Singh 2021.)

57. It is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist. (Levine, *Ethical Concerns*, at 9.)

58. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described "rapid onset gender disorder." I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male gender identity at some

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[24] S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at 963 ("*Practice Parameter*").

[25] P. T. Cohen-Kettenis et al. (2008), *The Treatment of Adolescent Transsexuals: Changing Insights*, J. SEXUAL MED. 5(8) 1892 at 1895.

point during their teen years. However, data on outcomes for this age group with and without therapeutic interventions is not yet available to my knowledge.

B. Social transition of young children is a powerful psychotherapeutic intervention that changes outcomes.

59. In contrast, there is now data that suggests that a therapy that encourages social transition before or during puberty dramatically changes outcomes. A prominent group of authors has written that "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood," and "Youth with persistent TNG [transgender, nonbinary, or gender-nonconforming] identity into adulthood . . . are more likely to have experienced social transition, such as using a different name . . . which is stereotypically associated with another gender at some point during childhood."[26] Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at 7).[27]

60. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as

[26] C. Guss et al. (2015), *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. CURR. OPIN. PEDIATR. 27(4):421 ("*TGN Adolescent Care*").

[27] One study found that social transition by the child was found to be strongly correlated with persistence for natal boys, but not for girls. (Zucker, *Myth of Persistence,* at 5 (citing T. D. Steensma, et al. (2013), *Factors Associated with Desistance & Persistence of Childhood Gender Dysphoria: A Qualitative Follow-up Study*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 52, 582.))

the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I review above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete social transition before puberty had desisted when surveyed at age 15 or older. (Zucker, *Myth of Persistence*, at 7; Steensma (2013).)[28] Some vocal practitioners of prompt affirmation and social transition even claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex. As one internationally prominent practitioner stated, "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."[29] Given the consensus that no method exists to reliably predict which children suffering from gender dysphoria will desist and which persist, and given the absence of any study demonstrating the validity of any such method, this is a disconcerting statement. Certainly, it reflects a very large change as compared to the desistance rates documented apart from social transition.

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[28] Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013) at 584.

[29] D. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children,* THE PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34.

61. Accordingly, I agree with noted researcher in the field Ken Zucker, who has written that social transition in children must be considered "a form of psychosocial treatment." (Zucker, *Debate,* at 1.)

62. I also agree with Dr. Zucker's further observation that "…we cannot rule out the possibility that early successful treatment of childhood GID [Gender Identity Disorder] will diminish the role of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications."[30]

63. By the same token, a therapeutic methodology for children that *increases* the likelihood that the child will continue to identify as the opposite gender into adulthood will *increase* the need for the long and potentially problematic processes of hormonal and genital and cosmetic surgical procedures.

64. Given these facts, it is the cross-gender affirming methods endorsed by gender identity advocates that are changing the identity outcomes that would otherwise naturally result for the large majority of prepubertal children who suffer from gender dysphoria. It is thus these methods that could most properly be described as "conversion therapy." By contrast, the watchful waiting approach which monitors the child's mental health while working to resolve co-morbidities and reduce life stress, and while allowing time for the natural psychosocial

[30] Zucker, *Myth of Persistence*, at 8 (citing H. Meyer-Bahlburg (2002), *Gender Identity Disorder in Young Boys: A Parent- & Peer-Based Treatment Protocol*, CLINICAL CHILD PSYCHOLOGY & PSYCHIATRY 7, 360 at 362.)

developmental processes of adolescence to shape the child's identity, is properly seen as the far less invasive therapeutic approach.

65. Not surprisingly, given these facts, encouraging social transition in children remains controversial. Supporters of such transition acknowledge that "Controversies among providers in the mental health and medical fields are abundant. . . . These include differing assumptions regarding . . . the age at which children . . . should be encouraged or permitted to socially transition . . . . These are complex and providers in the field continue to be at odds in their efforts to work in the best interests of the youth they serve."[31]

66. In sum, therapy for young children that encourages transition (including use of names, pronouns, clothing, and restrooms associated with the opposite sex) cannot be considered to be neutral, but instead is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine, *Reflections,* at 241.) Ethically, then, it should be undertaken only subject to standards, protocols, and reviews appropriate to such experimentation. In my judgment, many gender clinics today are encouraging and assisting children to transition without following these ethically required procedures.

[31] A. Tishelman et al. (2015), *Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples*, PROF. PSYCHOL. RES. PR. at 11 ("*Serving TG Youth*") (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4719579/pdf/nihms706503.pdf).

67. Moreover, it is not clear how these clinics could create a legal, ethical, and practical informed consent process. Parents would need to understand the risks and benefits of the recommended therapy and of alternative approaches, and to grapple with the scientific deficiencies in this arena, including: the absence of randomized controlled studies, the absence of long follow-up studies of previous children who have undergone these interventions, and the rates of success and failure of the intervention. And it is a difficult question when either minors or parents can ethically (and perhaps legally) grant consent to a medical or therapeutic pathway that carries a high probability of leading to prescription of potentially sterilizing drugs while the child is still a minor. In every case, the professional has an ethical obligation to ensure that meaningful and legal informed consent is obtained.

C. The administration of puberty blockers to children as a treatment for gender dysphoria is experimental, presents obvious medical risks, and appears to affect identity outcomes.

68. Gender clinics are increasingly prescribing puberty blockers for children as young as ten, as a component of a regime that commonly includes social transition. Puberty blockers are often described as merely providing a completely reversible "pause," which supposedly gives the child additional time to determine his or her gender identity while avoiding distress which would be caused by pubertal development of the body consistent with the child's biological sex. The language used about puberty blockers often states or implies that this major hormonal disruption of some of the most basic aspects of ordinary human development is a small thing, and entirely benign.

69. In fact, it is important to recognize that the available (limited) evidence suggests that clinically, puberty blockers administered to children at these ages, for this purpose, and in conjunction with social transition, do not operate as a "pause." After reviewing the evidence provided by experts from different perspectives, including an expert declaration that I submitted, the U.K. High Court recently concluded that "the vast majority of children who take [puberty blockers] move on to take cross-sex hormones," and thus that puberty blockers in practice act as a "stepping stone to cross-sex hormones."[32] In my opinion, this finding accurately summarizes the available data.

70. It is equally important to recognize that administration of puberty blockers as a treatment for gender dysphoria is an off-label use of these powerful drugs which is entirely experimental. This application can by no means be considered equivalent to the only application for which puberty blockers have been tested for efficacy and safety and approved—which is for the delay of precocious puberty until the normal time for pubertal development. The U. K. High Court panel accurately summarized the science when they described the use of puberty blockers as "experimental" and as putting children on a "clinical pathway" which is a "lifelong and life changing treatment . . . with very limited knowledge of the degree to which it will or will not benefit them." (*Tavistock*, ¶¶136, 143.)

[32] Opinion of the United Kingdom High Court of Justice Administrative Court, Divisional Court (December 1, 2020), in *Bell and A. v. Tavistock and Portman NHS Trust and Others*, Case No: CO/60/2020, at ¶¶136-137 (available at https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf.)

71. This is a very profound experiment being conducted on children. It is well known that the hormonal changes associated with ordinary puberty drive not only the obvious physical and sexual changes in the adolescent, but also drive important steps in cognitive development—that is, in brain functioning—as well as increases in bone density. As the bodies and interests of peers change, the trans adolescent who—as a result of puberty blockade hormones— maintains a puerile appearance and development, risks isolation and social anxiety. This risk is not given adequate weight when the treatment is justified as creating merely a useful pause.

72. We simply do not have meaningful data concerning the long-term effects on brain, bone, and other organs of interrupting or preventing this natural developmental process between the ages of 10 and 16. Psychology likewise does not know the long-term effects on coping skills, interpersonal comfort, and intimate relationships of pubertal blockade and, as it were, standing on the sideline in the years when one's peers are undergoing their maturational gains in these vital arenas of future mental health.

73. A number of recent papers have claimed to report beneficent or at least neutral short-term effects of use of puberty blockers. None of these even purports to address long-term effects as the subjects mature into adulthood, and even as to short-term effects these studies suffer from methodological deficiencies that prevent them from supporting such conclusions. Recently, the British National Health Service commissioned the respected National Institute for Health and Care

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Excellence (NICE) to conduct a thorough evidence review of all available studies that touch on the efficacy and safety of use of puberty blockers for children with gender dysphoria. The exhaustive, 130-page results of this review were published in October 2020. While of course this report provides extensive detail, its overall summary was that, according to widely accepted criteria for measuring the reliability of clinical evidence, "The quality of evidence for [all claims concerning safety and efficacy of this use of puberty blockers] was assessed as very low certainty."[33] They found that "the studies all lack appropriate controls" and "were not reliable," that "the studies that reported safety outcomes provided very low certainty evidence," and that studies that claimed marginally positive outcomes "could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding bias or chance." (NICE at 13.)

74. So far as I am aware, no study yet reveals whether the life-course mental and physical health outcomes for the relatively new class of "persisters" (that is, those who would have desisted absent a transgender-affirming social and/or pharmaceutical intervention, but instead persisted as a result of such interventions) are more similar to those of the general non-transgender population, or to the notably worse outcomes exhibited by the transgender population generally.

[33] NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (2020), Evidence review: Gonadotrophin releasing hormone analogues for children and adolescence with gender dysphoria (available at https://arms.nice.org.uk/resources/hub/1070905/attachment.)

75. Taking into account the risks, the lack of any reliable evidence concerning long-term outcomes from the use of puberty blockers, and the inability of pre-adolescents and even adolescents to comprehend the physical, relational, and emotional significance of life as a sexually mature adult, I also agree with the conclusion of the U. K. High Court that "it is highly unlikely that a child age 13 or under would ever be . . . competent to give consent to being treated with [puberty blockers]," and that it is "very doubtful" that a child of 14 or 15 "could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent." (*Tavistock*, ¶ 145.)

IV. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT "AFFIRMATION" OF TRANSGENDER IDENTITY IN CHILDREN AND ADOLESCENTS REDUCES SUICIDE OR RESULTS IN BETTER PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY.

76. I am aware that organizations including The Academy of Pediatrics and Parents and Friends of Lesbians and Gays (PFLAG) have published statements that suggest that all children who express a desire for a transgender identity should be promptly supported in that claimed identity. Recently, the governing counsel of the American Psychological Association adopted the *APA Resolution on Gender Identity Change Efforts*, which broadly (and wrongly) categorizes any approach to gender dysphoria other than gender affirming methods as unethical and dangerous. These positions appear to rest on the belief—which is widely promulgated by certain advocacy organizations—that science has already established that prompt "affirmance" is best for all patients, including all children and adolescents, who

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present indicia of transgender identity.[34] As I have discussed above and further discuss later below, this belief is scientifically incorrect, and ignores both what is known and what is unknown.

77. The knowledge base concerning the causes and treatment of gender dysphoria has low scientific quality.

78. In evaluating claims of scientific or medical knowledge, it is important to understand that it is axiomatic in science that no knowledge is absolute, and to recognize the widely-accepted hierarchy of reliability when it comes to "knowledge" about medical or psychiatric phenomena and treatments. Unfortunately, in this field opinion is too often confused with knowledge, rather than clearly locating what exactly is scientifically known. In order of increasing confidence, such "knowledge" may be based upon data comprising:

a. Expert opinion—it is perhaps surprising to educated laypersons that expert opinion standing alone is the lowest form of knowledge, the least likely to be proven correct in the future, and therefore does not garner as much respect from professionals as what follows;

b. A single case or series of cases (what could be called anecdotal evidence) (Levine, *Reflections*, at 239.);

c. A series of cases with a control group;

d. A cohort study;

[34] The APA Resolution on Gender Identity Change Efforts (APA GICE Resolution) is available at https://www.apa.org/about/policy/ resolution-gender-identity-change-efforts.pdf.

e. A randomized double-blind clinical trial;

f. A review of multiple trials;

g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

79. The strongest forms of scientific knowledge emerge from the latter three types of research—randomized, blind trials; reviews of multiple randomized, blind trials, and meta-analyses. When the APA Task Force on Promotion and Dissemination of Psychological Procedures considered what criteria would empirically validate a treatment, the task force relied heavily on whether a procedure had been "tested in randomized controlled trials (RCT) with a specific population and implemented using a treatment manual."[35] Social affirmation of children, use of puberty blockers as a treatment for gender dysphoria, and administration of cross-sex hormones to adolescents, have never been clinically tested and validated in this way.

80. Critically, "there are no randomized control trials with regard to treatment of children with gender dysphoria." (Zucker, *Myth of Persistence,* at 8.) On numerous critical questions relating to cause, developmental path if untreated, and the effect of alternative treatments, the knowledge base remains primarily at the level of the practitioner's exposure to individual cases, or multiple individual

[35] Am. Psych. Assoc'n (2006), *Evidence-Based Practice in Psychology*, AM. PSYCHOLOGIST, Vol. 61, No. 4, 271 at 272.

cases. As a result, claims to certainty are not justifiable. (Levine, *Reflections*, at 239.)

81. Unfortunately, advocates of unquestioning affirmation further complicate efforts to understand the available science by speaking indistinctly, ignoring differences between approaches that are likely to be clinically important. For example, the recent APA resolution speaks of "individuals who have experienced pressure or coercion to conform to their sex assigned at birth." (APA GICE at 1.) "Pressure or coercion" does not describe either the "watchful waiting" or psychotherapy models I have described above, nor therapy structured around a patient's own desire to become comfortable with his or her natal sex. Nor is it possible to extrapolate from outcomes experienced by those who have been subjected to "coercive" techniques to predict outcomes for patients who receive responsible "watchful waiting" or psychotherapeutic care as I have described and as many experienced practitioners practice.

82. Unsurprisingly, prominent voices in the field have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has recognized that "Different clinical approaches have been advocated for childhood gender discordance. . . . There have been no randomized controlled trials of any treatment. . . . [T]he proposed benefits of treatment to eliminate gender discordance … must be carefully weighed against … possible deleterious effects." (Adelson et al., *Practice Parameter,* at 968–69.) Similarly, the APA has stated, "because no approach to working with [transgender and gender

nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children."[36]

83. Contrary to the impression that statements in the recent APA GICE Resolution might leave, recent published research has not changed this situation. It remains the case that no randomized controlled trials of any treatment for gender dysphoria have been conducted, and recently published studies suffer from other serious methodological defects as well.

84. For example, the APA GICE Resolution cites Turban et al. (2020), *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*,[37] ("*Association*"), and this article has been cited to support claims that failing to affirm a transgender identity in children presenting with gender dysphoria results in a higher risk of their attempting suicide.

85. But the sample and methodology of Turban, *Association* (2020) are profoundly flawed and cannot support such a conclusion. A group of researchers has published a detailed critique of these defects,[38] which I will not attempt to replicate here. To highlight the most obvious defects, however, *Association* (2020) relied entirely on data drawn from an online convenience sampling of transgender-identified and genderqueer adults recruited from trans-affirming websites. It is well

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[36] Am. Psych. Assoc'n (2015), *Guidelines for Psychological Practice with Transgender & Gender Nonconforming People*, AM. PSYCHOLOGIST 70(9) 832 at 842.

[37] 77 JAMA PSYCHIATRY 77(1) 68-76.

[38] R. D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria* (2021), ARCH. SEX BEHAV. 50, 7-16.

known that one "cannot make statistical generalizations from research that relies on convenience sampling."[39] Nor did the authors of *Association* (2020) control for the subjects' mental health status prior to the reported exposure to what the study deemed a "gender identity change effort." I agree with D'Angelo et al. (2021) that "failure to control for the subjects' baseline mental health makes it impossible to determine whether the mental health or the suicidality of subjects worsened, stayed the same, or potentially even improved after the non-affirming encounter." (D'Angelo (2021) at 10.)

86. Looking at the literature in this area more broadly, a review of 28 studies of outcomes from hormonal therapy in connection with sex reassignment reported that these studies provided only "very low quality evidence" for a variety of reasons.[40] Large gaps exist in the medical community's knowledge regarding the long-term effects of sex-reassignment surgery (SRS) and other gender identity disorder treatments in relation to their positive or negative correlation to suicidal ideation, attempts, and completion.

87. What is known is not encouraging. With respect to suicide, individuals with gender dysphoria are well known to commit suicide or otherwise suffer increased mortality before and after not only social transition, but also before and

[39] *Handbook of Survey Methodology for the Social Sciences* (2021) (Lior Gideon, ed. Springer).

[40] H. Murad et al. (2010), *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes.* CLINICAL ENDOCRINOLOGY; 72(2): 214-231. See also R. D'Angelo (2018), *Psychiatry's ethical involvement in gender-affirming care*, AUSTRALASIAN PSYCHIATRY Vol 26(5) 460-463, noting the large number of non-responders in follow-up outcome studies, and observing that "it is generally not known whether they are alive or dead," and that "it is . . . pure speculation to assume that none committed suicide."

after SRS. (Levine, *Reflections,* at 242.) For example, in the United States, the death rates of trans veterans are comparable to those with schizophrenia and bipolar diagnoses—20 years earlier than expected. These crude death rates include significantly elevated suicide rates. (Levine, *Ethical Concerns,* at 10.) Similarly, researchers in Sweden and Denmark have reported on almost all individuals who underwent sex-reassignment surgery over a 30-year period.[41] The Swedish follow-up study found a suicide rate in the post-SRS population 19.1 times greater than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions. (Levine, *Ethical Concerns,* at 10.)

88. Advocates of immediate and unquestioning affirmation of social transition in children who indicate a desire for a transgender identity sometimes assert that any other course will result in a high risk of suicide in the affected children and young people. Contrary to these assertions, no studies show that affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either a "watchful waiting" or a psychotherapeutic model of response, as I have described above.[42]

89. In considering "suicide," mental health professionals distinguish between suicidal thoughts (ideation), suicide gestures, suicide attempts with a

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[41] C. Dhejne et al. (2011), *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS ONE 6(2) e16885 ("*Long Term*"); R. K. Simonsen et al. (2016), *Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality*, NORDIC J. OF PSYCHIATRY 70(4):241-7

[42] A recent article, J. Turban et al. (2020), *Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS 145(2), has been described in press reports as demonstrating that administration of puberty-suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

lethal potential, and completed suicide. Numerous studies have found suicidal ideation to have been present at some time in life in ~40-50% of trans-identifying persons. This figure is approximately twice that reported in gay and lesbian communities. In the heteronormative communities, ideation is approximately 4%. Mental health professionals distinguish clearly between gestures and potentially lethal attempts, which often result in hospitalization.

90. I will also note that any discussion of suicide when considering younger children involves very long-range and very uncertain prediction. Suicide in pre-pubescent children is rare and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide. The estimated suicide rate of trans adolescents is the same as teenagers who are in treatment for serious mental illness. What trans teenagers do demonstrate is more suicidal ideation and attempts (however serious) than other teenagers.[43] Their completed suicide rates are not known.

91. In sum, claims that affirmation will reduce the risk of suicide for children are not based on science. Such claims overlook the lack of even short-term supporting data as well as the lack of studies of long-term outcomes resulting from the affirmation or lack of affirmation of transgender identity in children. They also overlook the other tools that the profession does have for addressing depression and

[43] A. Perez-Brumer, et al. (2017), *Prevalence & Correlates of Suicidal Ideation Among Transgender Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9) at 739.

suicidal thoughts in a patient once that risk is identified. (Levine, *Reflections*, at 242.)

92. A number of data sets have also indicated significant concerns about wider indicators of physical and mental health, including ongoing functional limitations;[44] substance abuse, depression, and psychiatric hospitalizations;[45] and increased cardiovascular disease, cancer, asthma, and COPD.[46] Worldwide estimates of HIV infection among transgendered individuals are up to 17-fold higher than the cisgender population. (Levine, *Informed Consent,* at 6.)

93. Meanwhile, no studies show that affirmation of pre-pubescent children or adolescents leads to more positive outcomes (mental, physical, social, or romantic) by, e.g., age 25 or older than does "watchful waiting" or ordinary therapy. Because affirmation and social transition for children and adolescents, and the use of puberty blockers for transgender children, are a recent phenomenon, it could hardly be otherwise.

94. Given what is known and what is not known about the incidence and causes of suicide attempts and suicide in children and adolescents who suffer from gender dysphoria, and what is known about the incidence of suicide attempts and suicide in individuals who have transitioned to live in a transgender identity, it is in

[44] G. Zeluf, et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A Web-Based Survey*, BMC PUBLIC HEALTH 16, 903.

[45] C. Dhejne, et al. (2016), *Mental Health & Gender Dysphoria: A Review of the Literature*, INT'L REV. OF PSYCHIATRY 28(1) 44.

[46] C. Dragon, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-for-Service Claims Data*, LGBT HEALTH 4(6) 404.

my view unethical for a mental health professional to tell a young patient, or the parents of a young patient, that social transition, puberty blockers, or use of cross-sex hormones will reduce the likelihood that the young person will commit suicide.

95. Instead, transition of any sort must be justified, if at all, as a life-enhancing measure, not a lifesaving measure. (Levine, *Reflections,* at 242.) In my opinion, this is an important fact that patients, parents, and even many MHPs fail to understand.

V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON MOVING QUICKLY TO "AFFIRM" TRANSGENDER IDENTITY IN CHILDREN AND ADOLESCENTS.

96. As I have detailed above, enabling and affirming social transition in a prepubescent child appears to be highly likely to increase the odds that the child will in time pursue pubertal suppression and persist in a transgender identity into adulthood. This means that the MHP, patient, and in the case of minors, parents must consider long-term as well as short-term implications of life as a transgender individual when deciding whether to permit or encourage a child to socially transition.

97. Indeed, given the very high rates of children who desist from desiring a trans identity through the course of uninterrupted puberty, it is efforts to "affirm" a sex-discordant gender identity in prepubescent children that should be understood as the therapeutic path that is most likely to "change" or "convert" the child's adult gender identification, diverting the child from his or her probable maturation away from trans-identification.

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98. The APA and other gender identity advocates argue that gender affirmation practices are safe and effective. (APA GICE Resolution at 3.) But if we consider the long term—a life course perspective— a great deal of data point in the opposite direction. The multiple studies from different nations (including societies which pride themselves on being actively inclusive of sexual minorities, such as Sweden and Denmark) that have documented the increased vulnerability of the adult transgender population to substance abuse, mood and anxiety disorders, suicidal ideation, and other health problems warn us that assisting the child or adolescent down the road to becoming a transgender adult is a very serious decision, and stand as a reminder that a casual assumption that transition will improve the young person's life is not justified based on numerous scientific snapshots of cohorts of trans adults and teenagers. American public health professionals repeatedly have published descriptions of trans populations as marginalized and vulnerable to many adversities.[47]

99. The possibility that steps along this pathway, while lessening the pain of gender dysphoria, could lead to additional sources of crippling emotional and psychological pain, are too often not considered by advocates of social transition and not considered at all by the trans child. (Levine, *Reflections,* at 243.)

100. I detail below several classes of predictable, likely, or possible harms to the patient associated with transitioning to live as a transgender individual.

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[47] K. L. Ard, & A. S. Keuroghlian (2018), *Training in Sexual and Gender Minority Health - Expanding Education to Reach All Clinicians*. NEW ENGLAND J. OF MED, 379(25), 2388–2391; W. Liszewski et al. (2018), *Persons of Nonbinary Gender - Awareness, Visibility, and Health Disparities*. NEW ENGLAND J. OF MED., 379(25), 2391–2393.

A. Physical risks associated with transition

101. Sterilization. It is not uncommon for patients who begin down the path defined by puberty blockers and social transition to end up feeling the need to undergo surgical treatment to alleviate gender dysphoria. As I have noted above, there is not good scientific evidence that SRS results in better long-term mental health outcomes. What is certain, however, is that SRS that removes testes, ovaries, or the uterus is inevitably sterilizing, and irreversible. While some patients who have experienced regret after undergoing SRS have then undergone reconstructive surgery, such surgery cannot restore fertility. And while by no means all transgender adults elect SRS, many patients do ultimately feel compelled to take this serious step in their effort to live fully as the opposite sex.

102. More immediately, practitioners recognize that the administration of cross-sex hormones, which is often viewed as a less "radical" measure, and is now increasingly done to minors, creates at least a risk of irreversible sterility. The U.K. High Court in the Tavistock litigation, after reviewing the evidence, concluded that cross-sex hormones "may well lead to a loss of fertility," and in my opinion that finding accurately summarizes the present medical understanding.[48] As a result, even when treating a child, the MHP, patient, and parents must consider loss of reproductive capacity—sterilization—to be one of the major risks of starting down the road. The risk that supporting social transition may put the child on a pathway

[48] *Bell v. Tavistock* Opinion (December 1, 2020), ¶138. *See also* C. Guss et al., *TGN Adolescent Care* at 4 ("a side effect [of cross-sex hormones] may be infertility") and 5 ("cross-sex hormones . . . may have irreversible effects"); Tishelman et al., *Serving TG Youth* at 8 (Cross-sex hormones are "irreversible interventions" with "significant ramifications for fertility").

that leads to intentional or unintentional permanent sterilization is particularly concerning given the disproportionate representation of minority and other vulnerable groups among children reporting a transgender or gender-nonconforming identity. (*See supra* ¶ 24.)

103. Loss of sexual response. Puberty blockers prevent maturation of the sexual organs and response. Some, and perhaps many, transgender individuals who transitioned as children and thus did not go through puberty consistent with their sex face significantly diminished sexual response as they enter adulthood and are unable ever to experience orgasm. In the case of males, the cross-sex administration of estrogen limits penile genital function. Much has been written about the negative psychological and relational consequences of anorgasmia among non-transgender individuals that is ultimately applicable to the transgendered. (Levine, *Informed Consent,* at 6.)

104. Other effects of hormone administration. I have discussed the risks and unknowns associated with puberty blockers above, noting that most children who are started on puberty blockers continue on the pathway to cross-sex hormones. It is well known that many effects of cross-sex hormones cannot be reversed should the patient later regret his transition. After puberty, the individual who wishes to live as the opposite sex will in most cases have to take cross-sex hormones for most of their life, even after undergoing sex reassignment surgery.

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105. The long-term health risks of this major alteration of hormonal levels have not yet been quantified in terms of exact risk.[49] However, a recent study found greatly elevated levels of strokes and other acute cardiovascular events among male-to-female transgender individuals taking estrogen. Those authors concluded, "it is critical to keep in mind that the risk for these cardiovascular events in this population must be weighed against the benefits of hormone treatment."[50] Another group of authors similarly noted that administration of cross-sex hormones creates "an additional risk of thromboembolic events"—which is to say blood clots (Guss et al., *TGN Adolescent Care* at 5), which are associated with strokes, heart attacks, and lung and liver failure. Clinicians must distinguish the apparent short-term safety of hormones from likely or possible long-term consequences, and help the patient or parents understand these implications as well. The young patient may feel, "I don't care if I die young, just as long I get to live as a woman." The mature adult may take a different view.

106. Health risks inherent in complex surgery. Complications of surgery exist for each procedure,[51] and complications in surgery affecting the reproductive organs and urinary tract can have significant anatomical and functional complications for the patient's quality of life.

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[49] *See* Tishelman et al., *Serving TG Youth* at 6-7 (Long-term effect of cross-sex hormones "is an area where we currently have little research to guide us.").

[50] D. Getahun et al. (2018), *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, ANN. OF INTERN. MED. 169(4) 205 at 8.

[51] Levine, *Informed Consent*, at 5 (citing T. van de Grift, G. Pigot et al. (2017), *A Longitudinal Study of Motivations Before & Psychosexual Outcomes After Genital Gender-Confirming Surgery in Transmen*, J. SEXUAL MED.14(12) 1621).

107. Disease and mortality generally. The MHP, the patient, and in the case of a child, the parent must also be aware of the wide sweep of strongly negative health outcomes among transgender individuals, as I have detailed above.

B. Social risks associated with transition

108. Family and friendship relationships. Gender transition routinely leads to isolation from at least a significant portion of one's family in adulthood. In the case of a juvenile transition, this will be less dramatic while the child is young, but commonly increases over time as the child and his siblings mature into adulthood. By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often "virtual" friends known only online) and the generally limited set of others who are comfortable interacting with transgender individuals. (Levine, *Ethical Concerns,* at 5.)

109. Long term psychological and social impact of sterility. The life-long negative emotional impact of infertility on both men and women has been well studied. While this impact has not been studied specifically within the transgender population, the opportunity to be a parent is likely a human, emotional need, and so should be considered an important risk factor when considering gender transition for any patient. However, it is particularly difficult for parents of a young child to seriously contemplate that child's potential as a future parent and grandparent. This makes it all the more critical that the MHP spend substantial and repeated time with parents to help them see the implications of what they are considering.

110. Sexual-romantic risks associated with transition. After adolescence, transgender individuals find the pool of individuals willing to develop a romantic

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and intimate relationship with them to be greatly diminished. When a trans person who passes well reveals his or her natal sex, many potential cisgender mates lose interest. When a trans person does not pass well, he discovers that the pool of those interested consists largely of individuals looking for exotic sexual experiences rather than genuinely loving relationships. (Levine, *Ethical Concerns*, at 5, 13.) Nor is the problem all on the other side; transgender individuals commonly become strongly narcissistic, unable to give the level of attention to the needs of another that is necessary to sustain a loving relationship.[52]

111. Social risks associated with delayed puberty. The social and psychological impacts of remaining puerile for, e.g., three to five years while one's peers are undergoing pubertal transformations, and of undergoing puberty at a substantially older age, have not been systematically studied, although clinical mental health professionals often hear of distress and social awkwardness in those who naturally have a delayed onset of puberty. In my opinion, individuals in whom puberty is delayed multiple years are likely to suffer at least subtle negative psychosocial and self-confidence effects as they stand on the sidelines while their peers are developing the social relationships (and attendant painful social learning experiences) that come with adolescence. (Levine, *Informed Consent,* at 9.)

C. Mental health costs or risks

112. One would expect the negative physical and social impacts reviewed above to adversely affect the mental health of individuals who have transitioned. In

[52] S. Levine, *Barriers to Loving: A Clinician's Perspective* (Routledge, New York 2013) at 40.

addition, adult transitioned individuals find that living as the other (or, in a manner that is consistent with the stereotypes of the other as the individual perceives them) is a continual challenge and stressor, and many find that they continue to struggle with a sense of inauthenticity in their transgender identity. (Levine, *Informed Consent,* at 9.)

113. In addition, individuals often pin excessive hope in transition, believing that transition will solve what are in fact ordinary social stresses associated with maturation, or mental health co-morbidities. Thus, transition can result in deflection from mastering personal challenges at the appropriate time or addressing conditions that require treatment.

114. Whatever the reason, transgender individuals including transgender youth certainly experience greatly increased rates of mental health problems. I have detailed this above with respect to adults living under a transgender identity. Indeed, Swedish researchers in a long-term study (up to 30 years since SRS, with a median time since SRS of > 10 years) concluded that individuals who have SRS should have postoperative lifelong psychiatric care. (Dhejne, *Long Term*, at 6-7.) With respect to youths a cohort study found that transgender youth had an elevated risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal intent (16.7% vs. 4.4%) relative to the matched controls; and a significantly greater proportion of transgender youth accessed inpatient mental

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health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services.[53]

115. The responsible MHP cannot focus narrowly on the short-term happiness of the patient, but must instead consider the happiness and health of the patient from a "life course" perspective. The many studies that I have cited here warn us that as we look ahead to the patient's life as a young adult and adult, the prognosis for the physical health, mental health, and social well-being of the child or adolescent who transitions to live in a transgender identity is not good.

116. A study published in 2019 by the American Journal of Psychiatry reported the high mental health utilization patterns of adults for ten years after surgery for approximately 35% of patients.[54] That is a very high level of mental health distress, compared to the general population.

117. This same 2019 study received considerable attention for its claim to discern "a statistically significant relationship between time since surgery and mental health status" based upon the researchers observing "that as of 2015, patients who had surgeries further in the past had better mental health than patients whose surgeries were more recent."[55] But this claim is another example of the grave methodological defects that are too common in recent publications in this

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[53] S. Reisner et al. (2015), *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, J. OF ADOLESCENT HEALTH 56(3) at 6; see also supra ¶ 24.

[54] Bränström & Pachankis, (2019), *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries*, AM. J. OF PSYCHIATRY 177(8) 727-734.

[55] *Correction of a Key Study: No Evidence of "Gender-Affirming" Surgeries Improving Mental Health,* Society for Evidence Based Gender Medicine (Aug. 30, 2020), https://www.segm.org /ajp_correction_2020 (citing and summarizing professional critiques of the *Reduction* article).

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field. Shortly after publication, the study's analysis and conclusion were trenchantly criticized, among other reasons because of the study's failure to compare subjects' post-surgery mental health with those subjects' mental health *before* undergoing SRS.

118. As a result of two post-publication reviews by independent statisticians that rejected the interpretation of the data and additional critical letters to the editor, the authors corrected the article to retract the claim of a statistically significant relationship between gender affirmation surgery and later-improved mental health (while leaving intact a finding of "no evidence of benefits of hormonal treatments"). Specifically, the American Journal of Psychiatry stated that "the results [of the reanalysis] demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts."[56]

119. The *Reduction* article is notable for another, and positive, reason, as its authors acknowledged valid critiques and corrected the claims in their published work.[57] This is the way science should work—contending views testing the data and conclusions—something that is increasingly difficult to do in the gender identity field when its advocates insist that only gender affirmation treatments are to be contemplated.

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[56] *Correction to Bränström and Pachankis* (2020), AM. J. OF PSYCHIATRY 177:8 at 734.

[57] R. Bränström and J. E. Pachankis (2020), *Toward Rigorous Methodologies for Strengthening Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals' Mental Health: Response to Letters*, 177 AM. J. OF PSYCHIATRY 769-772.

D. The risk of regret following transition

120. The large numbers of children and young adults who have desisted as documented in both group and case studies each represent "regret" over the initial choice in some sense.

121. The phenomenon of desistance or regret experienced *later* than adolescence or young adulthood, or among older transgender individuals, has to my knowledge not been quantified or well-studied. However, it is a real phenomenon. I myself have worked with multiple individuals who have abandoned trans female identity after living in that identity for years, and who would describe their experiences as "regret."

122. I have seen several Massachusetts inmates and trans individuals in the community abandon their [trans] female identity after several years. (Levine, *Reflections,* at 239.) In the gender clinic which I founded in 1974 and to this day, in a different location, continue to co-direct, we have seen many instances of individuals who claimed a transgender identity for a time, but ultimately changed their minds and reclaimed the gender identity congruent with their sex.

123. More dramatically, a surgical group prominently active in the SRS field has published a report on a series of seven male-to-female patients requesting surgery to transform their surgically constructed female genitalia back to a male form.[58]

[58] Djordjevic et al. (2016), *Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery*, J. SEX MED. 13(6) 1000.

124. I noted above an increasingly visible online community of young women who have desisted after claiming a male gender identity at some point during their teen years. (*See supra* ¶ 58.) Given the rapid increase in the number of girls presenting to gender clinics within the last few years, the phenomena of regret and desistance by young women deserves careful attention and study by MHPs. (See Expósito-Campos, 2021.)

125. Thus, one cannot assert with any degree of certainty that once a transgendered person, always a transgendered person, whether referring to a child, adolescent, or adult, male or female.

I, Dr. Stephen B. Levine, hereby declare under penalty of perjury that the statements in this affidavit are true and accurate to the best of my knowledge, and represent my professional opinions.

By: Stephen B Levine MD
Dr. Stephen B. Levine

Subscribed and sworn to before me
this 10th day of May, 2021.

Mary J Mizner
Notary Public, State of Ohio
My Commission expires 3/9/25

EXHIBIT A

Brief Introduction

Dr. Levine is a Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine. He is the author or coauthor of numerous books on topics relating to human sexuality and related relationship and mental health issues. Dr. Levine has been teaching, providing clinical care, and writing since 1973, and has generated original research, invited papers, commentaries, chapters, and book reviews. He has served as a journal manuscript and book prospectus reviewer for many years. Dr. Levine has been co-director of the Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. in Beachwood, Ohio from 1992 to the present. He received a lifetime achievement Masters and Johnson's Award from the Society for Sex Therapy and Research in March 2005.

Personal Information

Date of birth 1/14/42

Medical license no. Ohio 35-03-0234-L

Board Certification 6/76 American Board of Neurology and Psychiatry

Education

1963 BA Washington and Jefferson College

1967 MD Case Western Reserve University School of Medicine

1967-68 Internship in Internal Medicine University Hospitals of Cleveland

1968-70 Research associate, National Institute of Arthritis and Metabolic Diseases, Epidemiology Field Studies Unit, Phoenix, Arizona, United States Public Health Service

1970-73 Psychiatric Residency, University Hospitals of Cleveland

1974-77 Robert Wood Johnson Foundation Clinical Scholar

Appointments at Case Western Reserve University School of Medicine

1973- Assistant Professor of Psychiatry

1979-Associate Professor

1982-Awarded tenure

1985-Full Professor

1993-Clinical Professor

Honors

Summa Cum Laude, Washington & Jefferson

Teaching Excellence Award-1990 and 2010 (residency program)

Visiting Professorships

- Stanford University-Pfizer Professorship program (3 days)–1995
- St. Elizabeth's Hospital, Washington, DC –1998
- St. Elizabeth's Hospital, Washington, DC--2002

Named to America's Top Doctors consecutively since 2001

Invitations to present various Grand Rounds at Departments of Psychiatry and Continuing Education Lectures and Workshops

Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research, April 2005 along with Candace Risen and Stanley Althof

2006 SSTAR Book Award for The Handbook of Clinical Sexuality for Mental Health Professionals: Exceptional Merit

2018—Albert Marquis Lifetime Achievement Award from Marquis Who's Who. (exceling in one's field for at least twenty years)

Professional Societies

1971- American Psychiatric Association; fellow; #19909

2005-American Psychiatric Association- **Distinguished Life Fellow**

1973- Cleveland Psychiatric Society

1973-Cleveland Medical Library Association

1985-Life Fellow

2003 Distinguished Life Fellow

1974-Society for Sex Therapy and Research

1987-89-President

1983- International Academy of Sex Research

1983- Harry Benjamin International Gender Dysphoria Association

1997-8 Chairman, Standards of Care Committee

1994- 1999 Society for Scientific Study of Sex

Community Boards

1999-2002 Case Western Reserve University Medical Alumni Association

1996-2001 Bellefaire Jewish Children's Bureau

1999-2001 Physicians' Advisory Committee, The Gathering Place (cancer rehabilitation)

Editorial Boards

1978-80 Book Review Editor Journal Sex and Marital Therapy

Manuscript Reviewer for:

a. Archives of Sexual Behavior
b. Annals of Internal Medicine
c. British Journal of Obstetrics and Gynecology
d. JAMA
e. Diabetes Care
f. American Journal of Psychiatry
g. Maturitas
h. Psychosomatic Medicine
i. Sexuality and Disability
j. Journal of Nervous and Mental Diseases
k. Journal of Neuropsychiatry and Clinical Neurosciences
l. Neurology
m. Journal Sex and Marital Therapy
n. Journal Sex Education and Therapy
o. Social Behavior and Personality: an international journal (New Zealand)
p. International Journal of Psychoanalysis
q. International Journal of Transgenderism
r. Journal of Urology
s. Journal of Sexual Medicine
t. Current Psychiatry
u. International Journal of Impotence Research
v. Postgraduate medical journal
w. Academic Psychiatry

Prospectus Reviewer

a. Guilford
b. Oxford University Press
c. Brunner/Routledge

d. Routledge

Administrative Responsibilities

Principal Investigator of approximately 70 separate studies involving pharmacological interventions for sexual dysfunction since 1989.

Co-leader of case conferences at DELRLLC.com

Recent Expert Witness Appearances

Served as court-appointed expert for US District Court, Judge Mark L.Wolf in *Michelle Kosilek vs. Massachusetts Dept of Corrections et al.* (transsexual issue) in Boston 2007.

Testified by deposition in *Battista vs. Massachusetts Dept of Corrections* (transsexual issue) in Cleveland October 2009.

Witness for Massachusetts Dept. of Corrections in their defense of a lawsuit brought by prisoner Katheena Soneeya. March 22, 2011 Deposition in Boston and October 2018 in Cleveland.

Witness for State of Florida in *Florida vs. Reyne Keohane* July 2017.

Expert testimony by deposition and at trial in *In the Interests of the Younger Children*, Dallas, TX, 2019.

Consultancies

Massachusetts Department of Corrections—evaluation of 12 transsexual prisoners and the development of a Gender Identity Disorders Program for the state prison system. Monthly consultation with the GID treatment team since February 2009 and the GID policy committee since February 2010

California Department of Corrections and Rehabilitation; 2012-2015; education, inmate evaluation, commentary on inmate circumstances, suggestions on future policies

Virginia Department of Corrections –evaluation of an inmate

New Jersey Department of Corrections—evaluation of an inmate

Idaho Department of Corrections—workshop 2016

Grant Support/Research Studies

TAP–studies of Apomorphine sublingual in treatment of erectile dysfunction

Pfizer–Sertraline for premature ejaculation

Pfizer–Viagra and depression; Viagra and female sexual dysfunction; Viagra as a treatment for SSRI-induced erectile dysfunction

NIH- Systemic lupus erythematosis and sexuality in women

Sihler Mental Health Foundation

a. Program for Professionals
b. Setting up of Center for Marital and Sexual Health
c. Clomipramine and Premature ejaculation
d. Follow-up study of clergy accused of sexual impropriety
e. Establishment of services for women with breast cancer

Alza–controlled study of a novel SSRI for rapid ejaculation

Pfizer–Viagra and self-esteem

Pfizer- double-blind placebo control studies of a compound for premature ejaculation

Johnson & Johnson – controlled studies of Dapoxetine for rapid ejaculation

Proctor and Gamble: multiple studies to test testosterone patch for post menopausal sexual dysfunction for women on and off estrogen replacement

Lilly-Icos—study of Cialis for erectile dysfunction

VIVUS – study for premenopausal women with FSAD

Palatin Technologies- studies of bremelanotide in female sexual dysfunction—first intranasal then subcutaneous administration

Medtap – interview validation questionnaire studies

HRA- quantitative debriefing study for Female partners of men with premature ejaculation, Validation of a New Distress Measure for FSD,

Boehringer-Ingelheim- double blind and open label studies of a prosexual agent for hypoactive female sexual desire disorder

Biosante- studies of testosterone gel administration for post menopausal women with HSDD

J&J a single-blind, multi-center, in home use study to evaluate sexual enhancement effects of a product in females.

UBC-Content validity study of an electronic FSEP-R and FSDS-DAO and usability of study PRO measures in premenopausal women with FSAD, HSDD or Mixed FSAD/HSDD

National registry trial for women with HSDD

Endoceutics—two studies of DHEA for vaginal atrophy and dryness in post menopausal women

Palatin—study of SQ Bremelanotide for HSDD and FSAD

Trimel- a double-blind, placebo controlled study for women with acquired female orgasmic disorder.

S1 Biopharma- a phase 1-B non-blinded study of safety, tolerability and efficacy of Lorexys in premenopausal women with HSDD

HRA – qualitative and cognitive interview study for men experiencing PE

Publications

A) Books

1) Pariser SR, Levine SB, McDowell M (eds.), Clinical Sexuality, Marcel Dekker, New York, 1985

2) Sex Is Not Simple, Ohio Psychological Publishing Company, 1988; Reissued in paperback as: Solving Common Sexual Problems: Toward a Problem Free Sexual Life, Jason Aronson, Livingston, NJ. 1997

3) Sexual Life: A Clinician's Guide. Plenum Publishing Corporation. New York, 1992

4) Sexuality in Midlife. Plenum Publishing Corporation. New York, 1998

5) Editor, Clinical Sexuality. Psychiatric Clinics of North America, March, 1995.

6) Editor, (Candace Risen and Stanley Althof, associate editors) Handbook of Clinical Sexuality for Mental Health Professionals. Routledge, New York, 2003

1. 2006 SSTAR Book Award: Exceptional Merit

7) Demystifying Love: Plain Talk For The Mental Health Professional. Routledge, New York, 2006

8) Senior editor, (Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals, 2nd edition. Routledge, New York, 2010.

9) Barriers to Loving: A Clinician's Perspective. Routledge, New York, 2014.

10) Senior editor Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 3rd edition Routledge, New York, 2016

B) Research and Invited Papers

When his name is not listed in a citation, Dr. Levine is either the solo or the senior author.

1) Sampliner R. Parotid enlargement in Pima Indians. Annals of Internal Medicine 1970; 73:571-73

2) Confrontation and residency activism: A technique for assisting residency change: World Journal of Psychosynthesis 1974; 6: 23-26

3) Activism and confrontation: A technique to spur reform. Resident and Intern Consultant 173; 2

4) Medicine and Sexuality. Case Western Reserve Medical Alumni Bulletin

1974:37:9-11.

5) Some thoughts on the pathogenesis of premature ejaculation. J. Sex & Marital Therapy 1975; 1:326-334

6) Marital Sexual Dysfunction: Introductory Concepts. Annals of Internal Medicine 1976;84:448-453

7) Marital Sexual Dysfunction: Ejaculation Disturbances 1976; 84:575-579

8) Yost MA: Frequency of female sexual dysfunction in a gynecology clinic: An epidemiological approach. Archives of Sexual Behavior 1976;5:229-238

9) Engel IM, Resnick PJ, Levine SB: Use of programmed patients and videotape in teaching medical students to take a sexual history. Journal of Medical Education 1976;51:425-427

10) Marital Sexual Dysfunction: Erectile dysfunction. Annals of Internal Medicine 1976;85:342-350

11) Male Sexual Problems. Resident and Staff Physician 1981:2:90-5

12) Female Sexual Problems. Resident and Staff Physician 1981:3:79-92

13) How can I determine whether a recent depression in a 40 year old married man is due to organic loss of erectile function or whether the depression is the source of the dysfunction? Sexual Medicine Today 1977;1:13

14) Corradi RB, Resnick PJ Levine SB, Gold F. For chronic psychologic impotence: sex therapy or psychotherapy? I & II Roche Reports; 1977

15) Marital Sexual Dysfunction: Female dysfunctions 1977; 86:588-597

16) Current problems in the diagnosis and treatment of psychogenic impotence. Journal of Sex & Marital Therapy 1977;3:177-186

17) Resnick PJ, Engel IM. Sexuality curriculum for gynecology residents. Journal of Medical Education 1978; 53:510-15

18) Agle DP. Effectiveness of sex therapy for chronic secondary psychological impotence Journal of Sex & Marital Therapy 1978;4:235-258

19) DePalma RG, Levine SB, Feldman S. Preservation of erectile function after aortoiliac reconstruction. Archives of Surgery 1978;113-958-962

20) Conceptual suggestions for outcome research in sex therapy Journal of Sex & Marital Therapy 1981;6:102-108

21) Lothstein LM. Transsexualism or the gender dysphoria syndrome. Journal of Sex & Marital Therapy 1982; 7:85-113

22) Lothstein LM, Levine SB. Expressive psychotherapy with gender dysphoria patients Archives General Psychiatry 1981; 38:924-929

23) Stern RG Sexual function in cystic fibrosis. Chest 1982; 81:422-8

24) Shumaker R. Increasingly Ruth: Towards understanding sex reassignment surgery Archives of Sexual Behavior 1983;12:247-61

25) Psychiatric diagnosis of patients requesting sex reassignment surgery. Journal of Sex & Marital Therapy 1980; 6:164-173

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,

Defendants.

Case No. 3:21-cv-5359

EXPERT DECLARATION OF CHRISTOPHER ROSIK, PH.D. IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Christopher Rosik, hereby declare as follows:

1. I hold a Ph.D. in clinical psychology from an APA-approved program at Fuller Graduate School of Psychology in Pasadena, California.

2. I have been a licensed clinical psychologist for over thirty years, and I currently practice at the Link Care Center in Fresno, California, where I am the Director of Research.

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3. I am a clinical faculty member of Fresno Pacific University, as well as a member of the American Psychological Association, International Society for the Study of Trauma and Dissociation, and the National Association of Social Workers.

4. A fuller review of my professional experience and publications is provided in my curriculum vitae, a copy of which is attached hereto as **Exhibit A**.

5. I have further identified the academic, scientific, and other materials referenced in this declaration in the references attached hereto as **Exhibit B**.

6. In this declaration, I provide my expert views, with reference to recent scientific publications, on three questions:

- Whether current science supports the belief that same-sex attraction is genetically determined? As I explain in Section I below, it does not, but rather contradicts that belief.
- Whether current science supports the belief that individuals who experience some same-sex attraction rarely experience any change in those attractions. As I explain in Section I below, it does not. Instead, many studies document that these individuals very often experience significant changes in their experienced sexual attractions.
- Whether current science supports the assertion that voluntary, conversational counseling to assist individuals who wish to achieve a reduction in same-sex attractions or an increase in opposite-sex attractions is harmful to most or even many participants. As I explain in Section II below, no methodologically sound study supports that conclusion, and some more careful recent studies find that such counseling is beneficial to mental health on average.

I. The available science indicates that same-sex attraction is not genetically determined and often changes.

7. It is often asserted that sexual attractions or orientation are fixed and not subject to change. In my opinion, this is incorrect, and indeed is unsustainable in the face of modern science.

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8. In fact, a much-cited recent review of the relevant scientific literature by prominent LGBTQ-advocate authors concluded that "[A]rguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attractions remain fixed over the life course." (Diamond & Rosky, 2016, p.2). I agree with these authors.

9. Diamond and Rosky conclude that rather than resting on science, assertions that sexual orientation cannot change "rely on unspoken legal and moral premises whose validity must be questioned." (Diamond & Rosky, 2016, p.11).

A. Same-sex attraction is not genetically determined.

10. In the past, many authors have hypothesized that same-sex attractions are biologically determined. However, no such causes have been found. A 2019 large-scale study by a team of authors from Harvard, MIT, and several other prestigious institutions analyzed the genomes of *almost half a million individuals*, along with self-reported information about heterosexual and same-sex sexual behaviors from these individuals. This massive study found only "very small" correlations between any genes and same-sex behavior. The authors concluded that the impact of genetic factors on sexual orientation were so small that they "do not allow meaningful prediction of an individual's sexual preference." (Ganna et al., 2019. p.6).

11. Before the extensive genomic work of Ganna et al. published in 2019, some studies had attributed a somewhat higher influence of genetics on the formation of sexual orientation. But even these studies attributed only minority influence to genetics, leaving sexual orientation no more genetically determined than "a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having lower back pain, and feeling body dissatisfaction." (Diamond & Rosky, 2016, p.4).

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12. Rather than being biologically predestined, many individuals who identify as other than heterosexual believe that they possessed and exercised choice in their sexual orientation. Surveying the literature again, Diamond and Rosky reject the claims of "[b]oth scientists and laypeople . . . that same-sex sexuality is rarely or never chosen," instead concluding that "individuals who perceive that they have some choice in their same-sex sexuality are more numerous than most people think." (Diamond & Rosky, 2016, p.20). In my own counseling experience, I have worked with patients who likewise perceive that they initially made choices that led to or strengthened their same-sex attractions.

13. Suggesting there is much left to learn about the complex origins of same-sex attractions and behavior, even the APA's own stance on the biological origin of sexual orientation has shifted over the years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way," asserting that "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, plays a significant role in a person's sexuality" (APA, 1998).

14. But just ten years later, in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles...." (APA, 2008; emphasis added).

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B. Same-sex attraction frequently changes.

15. It has often been assumed or asserted in the literature in the past, and is still often asserted by non-scientists or in the popular press today, that sexual orientation is fixed and unchanging.

16. In my opinion, based both on my own clinical experience and more recent scientific research, this assumption is not just unfounded, but provably false.

17. Writing in 2016, Diamond and Rosky concluded, after surveying the scientific literature, that "Studies unequivocally demonstrate that same-sex and other-sex attractions do change over time in some individuals," and that the evidence for this is now so clear as to be "indisputable." (Diamond & Rosky, 2016, p.6-7).

18. Empirically, the frequency of change in sexual orientation is particularly high among those who experience same-sex attraction.

19. Thus, after reviewing and summarizing extensive scientific literature, chapters in the American Psychological Association *Handbook of Sexuality and Psychology* conclude that "research on sexual minorities [i.e., all those who do not identify as exclusively heterosexual] has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time" (636), and that "Youth who are unsure or uncertain of their identity predominantly transition to a heterosexual identity" (562).

20. Many individual articles and studies reach the same conclusion.

21. A study by authors from the Harvard School of Public Health and other respected institutions examined "gender- and age-related changes in sexual orientation identity from early adolescence through emerging adulthood" in over 13,000 youth from 12 to 25 years of age, examining data collected for each

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participant at four times over a period of seven years. (Ott et al., 2011). On this sample, Diamond and Rosky note that "Of the 7.5% of men and 8.7% of women who chose a nonheterosexual descriptor at ages 18 to 21, 43% of the men and 46% of the women chose a different category by age 23. Among the same-sex-attracted youth who changed, 57% of the men's changes and 62% of the women's changes involved switching to completely heterosexual." (Diamond & Rosky, 2016, p.7-8).

22. Diamond and Rosky gather the results of the Ott et al. study along with two separate "longitudinal" studies (i.e., studying the same individuals over time), done by different researchers at different times on different samples, and report that, for young adult populations (starting ages from 18 to 26), of those who initially reported "any same sex attractions," every study found that between 40% to 60% of each sex reported a "change in attractions" when resurveyed a few years later. Of those who experienced a "change," at least half and as high as 83% "changed to heterosexuality at the second assessment." (Diamond & Rosky, 2016, p.7).

23. In another review of the literature, Diamond provided the following summary: "The other major conclusion that we can draw from these studies is that change in patterns of same-sex and other-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented [taken from several large datasets], between 25 and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon." (Diamond, 2016, p.253).

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24. Authors analyzing data collected for approximately 2500 individuals as part of the National Survey of Midlife Development in the United States found that, of those of any age who identified at the start of the study as bisexual, a decade later approximately 32% identified as exclusively heterosexual, while of those who identified at the start of the study as homosexual (that is, exclusively attracted to the same sex), a decade later 28% identified as attracted to the opposite sex (heterosexual or bisexual). (Mock & Eibach, 2012, Table 2). Heterosexual identity was far more stable: among those who identified as heterosexual at the start of the study, only 0.78% of men and 1.36% of women identified a different orientation a decade later. (Mock & Eibach, 2012, p.645).

25. Another often-cited paper by prominent researchers summarized scholarship and cautioned that "there was little evidence of true bipolarity in sexual orientation" and that sexual orientation is instead "a continuous construct." These authors observed that one study found that "Only 38% of exclusive same-sex attracted females stayed in this group [between ages 21 and 26], with the rest moving into 'occasional' same-sex attraction (38%) or exclusive opposite-sex attraction (25%)," while another found that across a multi-year study period "Most (62%) of young women changed their identity labels at least once. . . Over time, lesbian and bisexual identities lost the most adherents and heterosexual and unlabeled identities gained the most." In short, this paper's literature review found that "Evidence to support sexual orientation stability among nonheterosexuals is surprisingly meager." (Savin-Williams & Ream, 2007, p.386).

26. Savin-Williams' and Ream's own study of adolescents and young adults pointed to the same conclusion, "highlight[ing] the high proportion of participants with same- and both-sex attraction and behavior that migrated into opposite-sex categories between [interview periods]." (Savin-Williams & Ream, 2007, p.388).

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27. Meanwhile, other noted scholars argue that the "sexual orientation" categories of "gay" or "straight" are to some extent socially defined, such that surrounding "cultural press" may in essence coerce an adolescent boy who merely experiences "affectional bonding" with another male to categorize and thus understand himself through the rigid binary category of "gay," whereas that same type of affection would not lead the boy to think of himself that way in a different cultural setting. (Hammack, 2005).

28. My observations in my own professional experience are consistent with the findings of the many studies cited above concerning the inconstancy of same-sex attraction or identification. Over the years I have provided counseling support for several individuals who came to me experiencing unwanted same-sex attractions and behaviors, some of whom over time came to reduce same-sex attractions and behaviors, increase opposite-sex attractions, and, in general, further develop their heterosexual potential.

II. There is no statistically valid evidence that voluntary counseling is harmful.

29. It is often asserted that "conversion therapy" or other forms of "sexual orientation change efforts" (or "SOCE") are severely harmful. In fact, there is no meaningful evidence that conversational counseling with willing clients to explore possibilities of change in unwanted same-sex attractions and behaviors is harmful to most or even many participants.

A. The conclusions of the 2009 task force of the American Psychological Association.

30. In a major 2009 report based on a review of many studies, a task force of the American Psychological Association concluded:

> "Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE… just as other recent studies document that there are people who perceive that they have benefited from it. . . . . We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE." (42) b) "[I]t is still unclear which techniques or methods may or may not be harmful." (91)

31. This statement is twelve years old. However, writing in 2021 a group of proponents of "SOCE" bans affirmed that the pertinent research base remains sparse up to the present, providing an insufficient basis on which to make confident judgments about SOCE. As they wrote, "There is limited SOGIECE [sexual orientation and gender identity and expression change efforts]-related research—a critical knowledge gap . . . . Rigorous research syntheses to support or refine legislative proposals related to SOCIECE are not available at this time." (Kinitz et al., 2021, p. 3.)

B. Recent studies purporting to show harm contain fatal methodological errors.

32. There have in fact been a number of recent papers attempting to link what the authors broadly label "SOCE" to psychological harms.[1] However, abundant methodological limitations mean that these attempts are unable to establish harm from voluntary counseling relationships, or to change the conclusion reached by the APA in 2009. Two key examples are sufficient to illustrate the problem.

[1] Blosnich et al., 2020; Green et al., 2020; Meanley et al., 2020; Ryan et al., 2018; Salway et al., 2020.

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1. Sample bias

33. Firstly, multiple recent studies fall into the methodological error of improper generalization. These studies are conducted on samples exclusively made up of those who self-identify as LGBT at the time the study subjects are recruited.[2] This, however, excludes two groups whose experiences and results are extremely relevant to the claims made, and are likely to be quite different than those of individuals who self-identify as LGBT.

34. First, recruiting methods or screens that focus on those who self-identify as LGBT exclude those who have never identified themselves in this way. But research suggests a significant subpopulation of sexual minorities (including those who experience opposite-sex attractions) choose not to be defined by those attractions, and so do not identify themselves as LGBT if asked, and are unlikely to be found in the LGBT-identified networks and venues often utilized by researchers for participant recruitment.[3] These individuals tend to be more traditionally religious, more active in their religion, less engaged in same-sex behavior regardless of experienced attractions, and more interested in a child- and family-centered life.

35. This was noted a generation ago by Shidlo and Schroeder (2002), but has seemingly been ignored in the recent studies. Those authors commented ". . . on the basis of the conversion therapy literature and our own empirical research, we have found that conversion therapists and many clients of conversion therapy steadfastly reject the use of *lesbian* and *gay*. Therefore, to have used gay-affirmative words would have been inaccurate and unfaithful to their views." (249)

36. Thus, given the widespread recognition that most individuals who seek counseling to assist in reducing same-sex attractions are motivated by goals,

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[2] For example, Ryan et al., 2018.

[3] Lefevor et al., 2020; Rosik et al., 2021a.

morality, and a conception of self that are shaped by religious conviction,[4] it appears that studies that recruit subjects exclusively within the self-identifying LGBTQ community are thereby excluding from their samples a large number—perhaps a majority—of those who seek out and participate in voluntary counseling with the goal of reducing same-sex attractions or behaviors. There is no reason to believe that the experiences and reactions of the self-identifying LGBTQ subjects whom they have surveyed—even if accurately self-reported—reflect the experiences of a large number of sexual minorities. On the contrary, it would be reasonable to hypothesize that such counseling is likely to be more effective for, and appreciated by, precisely those who do not consider experienced sexual attractions to define who they are.

37. The exclusion of these sexual minorities from the study samples makes any generalization of harm reported in these recent studies to counseling of individuals who do not self-identify as LGBTQ a scientifically improper research practice.

38. In a related but separate biasing effect, recruitment of subjects for non-longitudinal studies from among those who self-identify as LGBT also excludes those who *did* at one time identify in that way, but for whom therapy was sufficiently effective that they *no longer* identify as LGBT, or at least no longer frequent LBGT-identified networks and venues used for recruitment. One scholar has identified and criticized the sample of a recent major study as suffering from

[4] The APA's 2009 task force report noted "most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs." The report further reported that those who seek counseling with a goal of moving away from same-sex attractions are "predominately . . . men who are strongly religious and participate in conservative faiths." (25) Several years later, Professors Diamond and Rosky, after surveying the literature, reached the same conclusion, writing that "majority of individuals seeking to change their sexual orientation report doing so for religious reasons . . . ." Diamond & Rosky, 2016 p. 6.

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this flaw, noting that "those who may have attained the goal of SOCE—to adopt heterosexual identity, orientation or sexual function—were systematically screened from the survey sample, which only included those currently identifying as a sexual minority." Sullins, 2020. In other words, unless this error is avoided, the sample precisely excludes those who are likely to report that therapy was satisfactory, effective, and/or not experienced as harmful.

39. These structural biases in the samples used by such studies are all the more critical given that self-reported, unverified information is itself recognized to present an important risk of distortion and bias. As the 2009 APA Task Force report noted, "People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall." (29) By utilizing samples whose participants come from diverse religious and socio-political outlooks, not just those who self-identify as LGBTQ, the impact of inaccurate reports distorted by a combination of inaccurate memory and the personal advocacy goals of participants and researchers could be significantly mitigated. Unfortunately, such diverse samples are exceedingly rare in this literature.

2. Failure to conduct before-and-after comparisons

40. Secondly, none of the recent studies that attempt to link "SOCE" to increased distress and suicidality reported and compared against participants' level of distress *prior* to their engaging in "SOCE." That is, these studies report that the study subjects suffered from mental health issues after engaging in "SOCE," but they do not report what level of mental health issues those same subjects suffered *before* engaging in "SOCE."[5] Basic research methodology dictates any study attempting to attribute a cause (e.g., "SOCE") to an effect (e.g., harm) must take

[5] Blosnich et al., 2020; Green et al., 2020; Flentje et al., 2013; Salway et al., 2020.

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into account important and potentially confounding factors. The lack of a control for pre-"SOCE" distress makes it impossible for studies that suffer from this defect to reach any valid conclusions about causation.

41. In one striking example, data that permits an answer to the "before 'SOCE'" question is available but was disregarded in a research paper published by Blosnich et al., 2020. That data negates and even inverts the hypothesis of causation advanced in the published paper. Blosnich et al., utilized a dataset (the Generations survey) available to other scholars. Oddly, Blosnich and colleagues did not take into account data concerning the subjects' pre-"SOCE" distress in their study design even though such information was available in the same dataset, yet nevertheless these authors purported to find that "SOCE" had "insidious associations with suicide risk" and "may compound or create…suicidal ideation and suicide attempts." I will note that "insidious associations" is a rhetorical rather than a scientific statement, while "may compound or create" describes a hypothesis that should be tested, not a scientific finding.

42. More recently, Professor Donald Sullins performed a re-analysis of the original study of Blosnich et al. but took into account the "SOCE" distress levels experienced by the study subjects *before* they participated in what Blosnich designates as "SOCE." (Sullins, 2020 (preprint).) Sullins' reanalysis discovered a very different reality. While the effect of controlling for pre-"SOCE" suicidality was larger for adults than for minors, Sullins reported:

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> After controlling for pre-existing conditions, there no longer remained any positive associations of SOCE with suicidality in the Generations data. Far from increasing suicidality, recourse to SOCE generally reduced it. For the most part the observed reduction in suicidality is not small, especially for those who received SOCE treatment as adults. Following SOCE, the odds of suicide ideation were reduced by two-thirds (AOR of .30) for adults and by one-third (AOR of .67) for minors. Suicide attempts were reduced by four-fifths (AOR of .20) for adults following SOCE, though they were not reduced for minors . . . (14)
>
> The reduced propensity to progress to suicide attempts following SOCE therapy after previous suicide morbidity was even greater. When followed by SOCE treatment, suicide ideation was less than a fifth as likely (AOR .18, Table 4) and suicide planning less than a seventh as likely (AOR .13, Table 4) to lead to a suicide attempt. Adults who experienced SOCE intervention following suicidal thoughts or plans were 17-25 times (AOR .06-.04, Table 4) less likely to attempt suicide. Minors undergoing SOCE were no more likely (AOR .43-.52, not significant, Table 4) to attempt suicide after initial thoughts or plans of suicide compared to their peers who did not undergo SOCE. (14-15)

43. Sullins goes on to observe that "On the question of SOCE and suicidality, in fact Blosnich et al. may have stated the case exactly backwards." (15).

44. Finally, Sullins goes on to provide an illustrative analogy:

> "Imagine a study that finds that most persons using anti-depressants also have had depressive symptoms, thereby concluding that persons "exposed" to anti-depressants were much more likely to experience depression, and recommending that anti-depressants therefore be banned. This imagined study would have used the same flawed logic as Blosnich et al.'s study, with invidious consequences for persons suffering from depression." (20)

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45. More scholarly criticism of these and other recent studies that suffer from these profound methodological flaws continues to emerge.[6]

III. Available evidence indicates that voluntary counseling to change sexual orientation can be effective in motivated individuals.

46. It is also frequently asserted—despite the extensive evidence that change in the components of sexual orientation is not only possible but frequent—that counseling to assist an individual toward desired change is never effective. Again, the available science does not support this assertion.

A. The conclusions of the 2009 task force of the American Psychological Association.

47. The 2009 APA Task Force report acknowledged that "There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation." (120) More specifically:

> "We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective." (43)

48. The Task Force report further stated:

> "Former participants in SOCE reported diverse evaluations of their experiences: Some individuals perceived that they had benefited from SOCE, . . . [These] individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom they could identify." (3)

[6] D'Angelo et al., 2021 (critique of Turban et al.'s (2020) study on the effects of gender identity conversion efforts); Kalin, 2020 (critique of Bränström & Pachankis (2019) study on the mental health impacts of 'gender-affirming treatments'); Rosik, 2021 (critique of Ryan et al., (2018) study on the effects of 'SOCE'); Rosik et al., 2021b (critique of the Blosnich et al.(2020) study attributing suicidality to "SOCE").

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B. Available evidence shows that voluntary counseling is effective for some individuals.

49. Authors from a variety of perspectives acknowledge that there is evidence that voluntary counseling is effective for at least some individuals who are highly motivated to change sexual attractions and behaviors.

50. A six-year longitudinal study considering willing participants who were motivated at least in part by religious beliefs and goals concluded that "The attempt to change sexual orientation did not appear to be harmful on average for these participants. The only statistically significant trends that emerged…indicated improving psychological symptoms." (Jones & Yarhouse, 2011, p.424).

51. This longitudinal study found that about half of participants reported progress toward their desired goal, with 23% of study participants reporting substantial reduction in homosexual attraction and substantial increase in heterosexual attraction and functioning, while an additional 30% of participants reported that same-sex attraction remained present only incidentally or in a way that did not seem to bring about distress.

52. A 2010 study surveyed 117 men who participated in some form of secular or religious counseling or support group activities designed to reduce same-sex attraction. Of these, some were single and some were in heterosexual marriages. 88% were motivated at least in part by what they perceived as conflict between their same-sex desires and conduct and the teachings of their faith. Within the whole study group, responses indicated a "large effect" in decrease of same-sex attractions and behavior, and also a "large effect" in increase of heterosexual attraction and behavior. (Karten & Wade, 2010).

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53. Looking at a very different population, well-received studies on voluntary, talk-based therapy pursued with gay and bisexual men with the treatment goal of suppressing or decreasing casual same-sex behavior to reduce HIV transmission risk reported success in decreasing same-sex behavior over an extended period of time.[7] Standard therapies, culturally adapted standard therapy, and lay peer counseling were shown in replicated, randomized, control trials to significantly decrease casual same-sex behavior and maintain gains at 6 to 12 month follow up. The goal behind these studies was to reduce HIV transmission among this population, but the success of these studies contradicts the hypothesis that counseling with a goal of reducing same-sex behavior is necessarily ineffective. In addition, none of these studies reported adverse effects from the counseling on the mental health of the subjects.

I declare under penalty of perjury that the foregoing is true and correct.

Dr. Chrstopher Rosik

4/23/21

Date

Subscribed and sworn to before me
this 23 day of April, 2021.

Notary Public, State of California
My Commission expires 11-01-2024

[7] Nyamathi et al., 2017; Shoptaw et al., 2005; Shoptaw et al., 2008; Reback & Shoptaw, 2014.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Fresno

Subscribed and sworn to (or affirmed) before me on this 23 day of April, 2021, by Dr. Christopher Rosik, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ESMERALDA GONZALEZ
Notary Public - California
Fresno County
Commission # 2336716
My Comm. Expires Nov 1, 2024

(Seal)

Signature

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Appendix A: Curriculum Vitae

Christopher Hastings Rosik

1734 W. Shaw Avenue
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I. Education.

B. A.	University of Oregon (Honors college), Eugene, Oregon, 1980 (psychology).
M.A.	Fuller Theological Seminary, Pasadena, California, 1984 (theological studies).
Ph.D.	Fuller Graduate School of Psychology, Pasadena, California, 1986 (clinical psychology - APA approved program).

II. Honors.

Phi Beta Kappa, Alpha of Oregon, 1980.
Exemplary Paper in Humility Theology Award, John Templeton Foundation, 1998.

III. Professional Experiences.

9/85 - 8/ 86	Clinical psychology intern, Camarillo State Hospital, Camarillo, California (APA approved internship).
11/86 - 5/88	Postdoctoral intern, Link Care Center, Fresno, California.
5/88 - Present	Licensed clinical psychologist, Link Care Center, Fresno, California.
11/94 - 6/96	Assistant Clinical Director, Link Care Center, Fresno, California.
7/96 - 12/99	Clinical Director, Link Care Center, Fresno, California.
1/01 – Present	Clinical Faculty, Fresno Pacific University
1/05 – Present	Director of Research, Link Care Center, Fresno, California

IV. Professional Affiliations.

1/84 - Present	Member, American Psychological Association.
1/86 - Present	Member, Christian Association for Psychological Studies (CAPS).
6/90 - 6/93	Member, board of directors, CAPS-Western region.
6/01 – 5/05	President-Elect, President, and Past-President, CAPS-Western Region
1/92 - Present	Member, International Society for the Study of Dissociation.
7/99 – Present	Member, Alliance for Therapeutic Choice and Scientific Integrity (Alliance)
1/11 – 12/17	President-Elect, President, and Past President, Alliance
1/11 - Present	Member, National Association of Social Workers.

V. Recent Litigation Engagements.

Vazzo v. City of Tampa, Florida, Expert declaration submitted May 6, 2019, rebuttal declaration submitted July 17, 2019. Expert testimony by deposition. (M.D. Fla. 2019)

VI. Selected Publications.

Rosik, C.H. (1989). The impact of religious orientation on conjugal bereavement among older adults. International Journal of Aging and Human Development, 28, 251-260.

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Rosik, C. H. (2003). Critical Issues in the Dissociative Disorders Field: Six Perspectives from Religiously-Sensitive Practitioners. Journal of Psychology and Theology, 31, 113-128.

Rosik, C. H., Richards, A., & Fannon, T. (2005). Member care experiences and needs: Findings from a study of East African missionaries. Journal of Psychology and Christianity, 24, 36-45.

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