No. 13-15023

IN THE

United States Court of Appeals

FOR THE NINTH CIRCUIT

DONALD WELCH, ANTHONY DUK, and AARON BITZER,

Plaintiffs-Appellees,

v.

EDMOND G. BROWN, JR., Governor of the State of California, *et al*.,

Defendants-Appellants.

On Appeal from a Decision of the United States District Court for the Eastern District of California
No. 12-CV-02484-WBS-KJN, THE HONORABLE WILLIAM B. SHUBB

AMICUS CURIAE BRIEF OF AMERICAN COLLEGE OF PEDIATRICIANS IN SUPPORT OF PLAINTIFFS AND APPELLEES AND IN SUPPORT OF AFFIRMING THE DECISION OF THE U.S. DISTRICT COURT

(Pursuant to FRAP 29(a), all parties have consented to the filing of Amici Curiae Briefs.)

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PURSUANT TO F.R.A.P. 29(a), ALL PARTIES HAVE CONSENTED TO THE FILING OF *AMICUS CURIAE* BRIEFS

Pursuant to Federal Rules of Appellate Procedure 29(a), prior to the filing of this *amicus curiae* brief, the parties filed consent to file *amici curiae* briefs in this matter.

CORPORATE DISCLOSURE PURSUANT TO F.R.A.P. 26.1

As *Amicus Curiae* American College of Pediatricians is an independent, non-profit organization, there is no corporation or other entity that has any ownership interest in or controlling interest over American College of Pediatricians.

INTEREST OF *AMICUS CURIAE* AMERICAN COLLEGE OF PEDIATRICIANS

Amicus Curiae American College of Pediatricians is a national organization of pediatricians and other healthcare professionals dedicated to the health and well-being of children. Formed in 2002, the College is committed to fulfilling its mission by producing sound policy, based upon the best available research, to assist parents and influence society in the endeavor of childrearing. Membership is open to qualifying healthcare professionals who share the College's Mission, Vision and Values. The College currently has members in 44 states, and in several countries outside the United States. The College is a not-for-profit corporation organized for scientific and educational purposes, exempt from taxation under

Section 501(c)(3) of the U.S. Internal Revenue Code. The home office is located in Gainesville, Florida.

The Mission of the American College of Pediatricians is to enable all children to reach their optimal physical and emotional health and well-being. To this end, the College recognizes the basic father-mother family unit, within the context of marriage, to be the optimal setting for childhood development, but also pledges its support to all children, regardless of their circumstances.

The American College of Pediatricians promotes a society where all children, from the moment of their conception, are valued unselfishly. The College encourages mothers, fathers and families to advance the needs of their children above their own. The College expects societal forces to support the two-parent, father-mother family unit and provide role models of ethical character and responsible behavior for children.

As it relates to this case, SB 1172 prohibits "sexual orientation change efforts" ("SOCE") by mental health providers on patients less than 18 years of age under all circumstances. CAL. STATS. 2012, CH. 835, § 1(a)-(m) ("SB 1172"); ER 253. Consequently, *Amicus Curiae* American College of Pediatricians contends that this poses a grave threat to the health, safety, and welfare of children and encroaches upon and interferes with the physician-patient relationship and the physician-patient privilege.

Finally, and as set forth above, this *amicus* brief is filed upon the written consent of all the parties. *Amicus Curiae* American College of Pediatricians and its counsel of record, Peter D. Lepiscopo, hereby affirm that no counsel for any party authorized this brief in whole or in part and that no person other than counsel of record drafted the brief. No person or entity, other than *amicus*, made any monetary contribution to the preparation or submission of this brief.

ARGUMENT

I. SUMMARY OF ARGUMENT

This brief argues that as it relates to patients less than 18 years of age, SB 1172 dissolves the physician-patient relationship, waives the physician-patient privilege, and threatens the health, safety, and welfare of patients.

II. SB 1172 THREATENS THE PHYSICIAN-PATIENT RELATIONSHIP AND THE PHYSICIAN-PATIENT PRIVILEGE

SB 1172, § 865.1 prohibits physicians from engaging in any SOCE related speech and/or treatment of patients who are less than 18 years of age. ER 253. In so doing, SB 1172 encroaches upon and interferes with the physician-patient relationship and the physician-patient privilege. For example, California Evidence Code ("EC"), §§ 900 *et seq*., create the physician-patient privilege, which clearly identifies the relationship between the physician and the patient. In particular, the Legislature saw fit to protect the relationship by creating a barrier to the discovery of any communications between the physician and patient.

Similarly, and relevant to the analysis of SB 1172, the confidentiality of these and the related psychotherapist—patient relationships are deemed so inviolable that the U.S. Supreme Court has strongly protected them even where they have not been as expressly protected as they are in California. Specifically, the Court has recognized the value to society of protecting the psychotherapist-patient relationship, as well as the attendant privilege:

> "The psychotherapist privilege serves the public interest by **facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem**. The mental health of our citizenry, no less than its physical health, is a public good of **transcendent importance**."

Jaffee v. Redmond, 518 U.S. 1, 11 (1996) ("*Jaffee*") (emphasis added). The communications between the psychotherapist and patient is in furtherance of this relationship, which is specifically created (and protected) for the sole and express purpose of facilitating treatment of patients' mental and/or emotional problems. *Id*. In direct contravention of this express purpose, SB 1172 interferes with that relationship thereby preventing proper treatment of patients by psychotherapists.

As set forth in EC § 993, the holder of this privilege is the patient and SB 1172 did not repeal or amend § 993or any of the other provisions of the privilege. Moreover, privileges can only be waived **voluntarily**, and any waiver of a privilege must be made **knowingly** and **intelligently**. *See*, *generally*, *Townsend v. Sain*, 372 U.S. 293 (1963)(regarding the privilege against self-incrimination; citing

Blackburn v. Alabama, 361 U.S. 199 (1960)). SB 1172 provides no element of a voluntary waiver by the patient or the patient's parents. To the contrary, SB 1172 compels the dissolution of the physician-patient relationship and waiver of the physician-patient privilege.

In short, SB 1172 imposes mandatory medical advice and treatment upon patients less than 18 years of age, regardless of whether medical professionals would prescribe a different manner of medical treatment—neither the physician nor the patient has any choice in the matter. [1] Applied in a different context, the logic and scope of SB 1172 would, for example, serve as a legal basis to prohibit physicians from discussing or performing abortions.

Based on the foregoing, SB 1172 compels the dissolution of the physician-patient relationship and imposes a waiver of the physician-patient privilege without due process of law. *See*, CAL.CONST. ART. I, SEC. 7; U.S. CONST., AMEND. XIV, SEC. I.

III. SB 1172 POSES A GRAVE THREAT TO THE HEALTH, SAFETY, AND WELFARE OF PATIENTS LESS THAN 18 YEARS OF AGE

This section is intended to respond to the Statement of Facts section in Appellants' Opening Brief (pp. 8-17).

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1 This, of course, results in state and federal equal protection claims based on age discrimination, to wit: while patients who are 18 years of age or older can receive SOCE related treatment, those patients less than 18 years of age are deprived of such treatment. *See*, CAL.CONST. ART. I, SEC. 7; U.S. CONST., AMEND. XIV, SEC. I.

A. INTRODUCTION

Does the sexual orientation change therapy that SB1172 seeks to ban, include reparative therapy and other forms of sexual orientation change therapy that merely aims to repair the guilt and shame from troubled parental relationships, trauma from sexual abuse, or child/adolescent school age peer related abuse? If it does, it will outlaw beneficial therapy for no good reason. For example, same sex attraction and homosexuality can decrease via various forms of sexual orientation change therapy which seek to decrease the shame and guilt that have led to the same-sex attraction in the first place. Accordingly, SB 1172's interference with the physician-patient relationship poses a grave threat to the health, safety, and welfare of patients less than 18 years of age.

1. Homosexuality Is Not A Genetically Determined Trait

Dr. Francis Collins, Director of the Genome Project, has stated that while homosexuality may be genetically influenced, it is "… not hardwired by DNA, and (that) whatever genes are involved represent predispositions, not predetermination[s]." He also states that "…the prominent role of individual free will choices have a profound effect on us."[2] One of those free will choices is the choice to pursue sexual orientation change therapy.

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2 Collins F. *The Language of God: A Scientist Presents Evidence for Belief*. New York. Free Press. 2007.p.260 and p.263.

2. Homosexual Attraction Is Determined By A Combination Of Familial, Environmental, Social And Biological Influences

Sexual orientation is not fixed at birth but rather is environmentally shaped and unfolds slowly across childhood, adolescence and even into adulthood for some individuals. Inheritance of predisposing personality traits may play a role for some. Accordingly, homosexual attraction is potentially changeable.[3]

3. For Many Youth, Homosexual Attraction Develops Due To Negative Or Traumatic Experiences, Such As Sexual Abuse

These children need therapy for the trauma, not affirmation of a "gay identity." Trauma (as an objective, measurable external event) lends itself to quantitative research and has been studied relative to homosexuality. One example of this is the disproportionate extent of sexual abuse during the childhoods of adult

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3 *My Genes Made Me Do It!*, Dr. Neil Whitehead. This online book presents a scientific and detailed look at the nature/nurture debate; Langstrom, N, Rahman Q, Carlstrom, E, Lichtenstein, P. (2008), *Genetic and environmental effects on same-sexual behavior: A population study of twins in Sweden*, Archives of Sexual Behavior, DOI 10.1007/s10508-008-9386-1; Santilla P, Sandnabba NK, Harlaar N, Varjonen M, Alanko K, von der Pahlen B. (2008). *Potential for homosexual response is prevalent and genetic*. Biological Psychology, 77, 102-105; Bailey, J.M., Dunne, M.P., & Martin, N.G. (2000), *Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample*; *Journal of Personality and Social Psychology*, 78 (3), 524-536; Bearman, P.S., & Bruckner, H. (2002), *Opposite-sex twins and adolescent same-sex attraction*, American Journal of Sociology, 107 (5), 1179-1205; Frisch, M. & Hviid, A. (2006), *Childhood family correlates of heterosexual and homosexual marriages: A national cohort study to two million Danes*; *Archives of Sexual Behavior*, 35, 533-547.

homosexuals.[4] Another example is the increased association of homosexuality and gender identity disorder with parental separation at critical developmental stages.[5]

There are also two forms of psychological trauma commonly associated with homosexuality. The first is the trauma caused by the child's subjective experience of the same-sex parent's lack of availability, rejection, or even harsh verbal, physical, or sexual attack. This may lead to an intense longing for love from the same-sex parent that is eventually sexualized by the child. Similarly, psychological trauma may also be caused by the child's subjective experience of the opposite-sex parent's lack of availability, rejection, or even harsh verbal, physical, or sexual attack. This may lead to an intense fear of and aversion toward opposite-sex

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4 Satinover, J. (1996) *Homosexuality and the Politics of Truth*, Grand Rapids, MI: Hamewith Books, p.106; Beitchman, J., Zucker, K., Hood, J., DaCosta, G., Akman, D. (1991), *A review of the short-term effects of child sexual abuse*, Child Abuse & Neglect, 15: 537-556; Steed, J.J. and Templer, D (2010) "*Gay Men and Lesbian Women with Molestation History: Impact on Sexual Orientation and Experience of Pleasure*," The Open Psychology Journal, Vol. 3, 36-41; Templer, D et.al., (2001) "*Comparative Data of Childhood and Adolescence Molestation in Heterosexual and Homosexual Persons*," Archives of Sexual Behavior, Vol. 30, No. 5, 535 – 541.

5 Rekers, G and Swihart J (1989) "*The Association of Gender Identity Disorder with Parental Separation*," *Psychological Reports* 65, No. 3, Vol. 2: 1272-74; Satinover, J. (1996), *Homosexuality and the Politics of Truth*, Grand Rapids, MI: Hamewith Books, p.107.

relationships. In both situations, by objective standards, the parent may or may not be described in these terms.[6]

While these traumas are unusually common in the childhoods of same-sex attracted persons, they are not universal, and in many cases, other, less typical traumas may be present. This reflects the inherent complexity of the interaction between one's biologically influenced temperament, various environmental factors and the free-will choices individuals make.[7]

4. Forcing Health Professionals To Affirm Same-Sex Attractions And A Gay Identity During The Adolescent Years Is Premature And Harmful

When professionals label some teenagers as "gay," or encourage them to label themselves this way by being "affirmed," there is a serious risk of erroneously labeling students who were only experimenting or experiencing

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6 Satinover, J. (1996) *Homosexuality and the Politics of Truth*, Grand Rapids, MI: Hamewith Books, p.107; Bailey, J., Miller, J., Willerman, L. (1993), *Maternally rated childhood gender nonconformity in homosexuals and heterosexuals*, Archives of Sexual Behavior. 22, 5: 461-469; Rekers, G et.al. (1983), *Family Correlates of Male Childhood Gender Disturbance*, Journal of Genetics and Psychology 142, No. 1: 31-42; Ross, M.W. (Ed), (1983), *Parental and interpersonal relationships of transsexual and masculine and feminine homosexual men*, Journal of Homosexuality, Special Issue, Homosexuality & Social Sex Roles, volume 9, No. 1: 75-85; Wolfe, C. (Ed), (1999) *Homosexuality and American Public Life*. Washington DC: Spence Publishing Co., pp. 85-97.

7 Satinover, J. (1996) *Homosexuality and the Politics of Truth*, Grand Rapids, MI: Hamewith Books, p.107.

temporary sexual confusion. Such premature labeling will lead some adolescents into homosexual behaviors that increase the risk for serious health consequences.

Among adolescents who claim a "gay" identity, the health risks include higher rates of sexually transmitted infections, alcoholism, substance abuse, anxiety, depression and suicide.[8] Delaying such labeling significantly reduces these medical and psychiatric health risks. For example, researchers find that adolescents who defer "coming out as gay" decrease the risk of suicide at a rate of 20 percent for each year that they delay self-labeling as homosexual or bisexual.[9]

5. Sexual Orientation Change Therapy Has Proven Effective For Those With Unwanted Homosexual Attractions

The National Association for Research and Therapy of Homosexuality (NARTH) recently released a landmark survey and analysis of 125 years of scientific studies and clinical experience dealing with homosexuality. This report, *What Research Shows*, draws three major conclusions: (1) individuals with unwanted same sex attraction often can be successfully treated; (2) there is no undue risk to patients from embarking on such therapy and (3), as a group,

8 *Facts About Youth. Health Risks of the Homosexual Lifestyle*. 2010, Accessed at the Facts website: http://factsaboutyouth.com/posts/health-risks-of-the-homosexual-lifestyle/.

9 Remafedi G, Farrow JA, Deisher RW, (1991), *Risk factors for attempted suicide in gay and bisexual youth*, Pediatrics 87:869-875.

homosexuals experience significantly higher levels of mental and physical health problems compared to heterosexuals.[10]

B. REMOVAL OF HOMOSEXUALITY FROM THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

As presented by Appellants, the scientific and professional consensus that homosexuality is a normal expression of human sexuality and is not a disease, condition or disorder in need of a 'cure' is a politically motivated conclusion. It is not based on philosophical, ethical, scientific or consensus opinion.

The decisions by the American Psychiatric Association ("APsyA") in 1972/3 and American Psychological Association ("APA") in 1974 to declare that "homosexuality" itself was no longer a diagnosable and treatable disorder were political–not scientific. Several books and exposés have been done on the manipulation and misrepresentation involved by LGBT activist groups in these actions. For example, in 1973, members of the APsyA decided to declassify homosexuality itself as a psychiatric disorder through a non-representative vote of its membership, despite the presence of its historical and reasonably successful treatment for fifty years and in the absence of any new or compelling research to the contrary. In effect, this was a political decision. Various authors–including those who favored and those who opposed this decision–identified this as the case

10 *Facts About Youth. Health Risks of the Homosexual Lifestyle*. 2010. Accessed at the Facts website: http://factsaboutyouth.com/posts/health-risks-of-the-homosexual-lifestyle/.

both then and now. *See, e.g.*, Ronald Bayer, MD: *Homosexuality and American Psychiatry: The Politics of Diagnosis* (1987); Jeffery Satinover, MD: *Homosexuality and the Politics of Truth* (1996); Rogers Wright and Nicholas Cummings: *Destructive Trends in Mental Health* (2005).

Finally, even the supporters of SB 1172 acknowledged that the major DSM decision was prompted by activism and a perception of changing attitudes—not any hard science:

> "3. History of Homosexuality and the American Psychiatric Association (APA) A number of research studies on homosexuality conducted in the 1940's and 1950's, **combined with protests** during the civil rights movement of the 1960's and 1970's **led to the reformation of how** homosexuality was classified by mental health and medical associations such as the APA and the APA removed homosexuality from its official Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973. **Prior to the civil rights movement**, the medical view of homosexuality was that it was a mental disorder and disease. There were a series of resulting **encounters between activists and psychiatrists** at the annual meeting of the APA between 1970 and 1972 **where gay activists challenged the APA**. **As a result the diagnosis of homosexuality was deleted from the DSM-II**."

See, 2 Supplemental Excerpts of Record (SER) 260 (Senate committee analysis noting the role of activism and protests in the APA decision) (emphasis added). Clearly, the change of position by the APA was not the product of carefully collected empirical data or scientific research but rather political and coercive pressure by gay activists: a standard that this Court should not employ to dissolve

the psychotherapist—patient relationship or abridge the psychotherapist—patient privilege.

C. THERE IS NO EVIDENCE THAT SOCE IS HARMFUL TO PATIENTS LESS THAN 18 YEARS OF AGE

SB1172 claims that SOCE is harmful or dangerous, but both APA and APsyA are severely negligent when they warn potential clients about the *potential for harm* in receiving SOCE. In reality, this is a potential which the APA fails to acknowledge exists for any and all forms of "psychological help" for any and all forms of "presenting problems or concerns." No approach to mental–let alone medical–healthcare is without some risk. For APA to give a partially true warning that SOCE may potentially cause harm–and not do so in the context that every other approach to psychological or professional care also does–is not just negligent, but less than truthful. These are better documented in Volume 1, Section 2 of the *Journal of Human Sexuality* ("JHS")[11] and Guideline 6 of *NARTH Practice Guidelines*.[12]

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[11] *See*, Phelan, J, Whitehead, N, Sutton, P. (2009), *What Research Shows: Narth's Response to the APA Claims on Homosexuality*, Journal of Human Sexuality, Vol 1. Retrieved from http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1.

[12] *See*, *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior*, Journal of Human Sexuality, 5-65, retrieved on 2/26/13: http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines.

SB 1172 claims that SOCE causes harm, which is based on the APA's Task Force Report. The credibility for the alleged harms is nonexistent. Specifically, there is no objective evidence that any harm even or ever occurred.

First, there is no evidence–besides the interviewees' claims–that those who claimed to be harmed after participating in SOCE actually participated in any SOCE.

Second, there is no evidence–besides the interviewees' claims–that they actually experienced the harms they claimed.

Third, there is no evidence–besides the interviewees' claims–that if they did experience SOCE and the harms they claimed, that the harms occurred as a result of, during, or after the sessions of SOCE.

Fourth, there is no evidence–besides the interviewees' claims–that all or even some of them did not experience any of the problems they report either before they began SOCE or during or after the SOCE for reasons unrelated to the SOCE.

Finally, in effect, the information that APA offers is nothing more than self-serving "hearsay."

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D. IN ITS ZEAL TO SUPPORT AND PROMOTE SB 1172, THE APA HAS ACTED NEGLIGENTLY, UNETHICALLY, UNSCIENTIFICALLY, AND UNPROFESSIONALLY

The APA is in violation of the first point in its *Ethical Practices and Code of Conduct.* [13] Specifically, the APA has permitted SB 1172 to remain uncorrected as to the misleading conclusion that the APA "task force concluded that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people." Contrary to this misrepresentation in SB 1172, the APA actually concluded that:

> "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom."

See, Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, p. 83; cf. p. 67, 120.[14]

In its 2009 Task Force Report, the APA arbitrarily dismisses 50 years of clinical and scientific reports, including therapist and patient claims of decreased same-sex sexual behavior, but accepts recent reports of claims of harm related to SOCE, all without explaining and providing details for such positions. The APA

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[13] *See, Ethical Principles of Psychologists and Code of Conduct* (2010), American Psychological Association, Retrieved on 2/26/13: http://www.apa.org/ethics/code/principles.pdf.

[14] *See, Appropriate Therapeutic Responses to Sexual Orientation* (2009), American Psychological Association, Retrieved on 2/26/13: *http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf*.

also cites research studies which support its own ideological biases (*i.e*, SOCE are harmful, "gay-affirmative therapies" are helpful) but they do not meet the standards used to reject studies that do not support the APA ideological bias. For example, see Jones, Rosik, Williams, and Byrd (2010).[15] Similarly, Dean Byrd, PhD, has demonstrated that in matters related to homosexuality, too often the APA's actions and pronouncements are only "activism masquerading as science." *See, When Activism Masquerades as Science: Potential Consequences of Recent APA Resolutions*.[16]

While the various mental health disciplines have all warned potential consumers about the "potential harm of participating in SOCE," none of them have seen fit to actually ban the practice of SOCE. State law already authorizes the mental health professions to respond to and deal with alleged professional malfeasance. SB 1172 essentially treats all licensed mental health professionals ("LMHP") who would engage in SOCE as malfeasant. While every mental health professional has the "potential" to harm a minor under their care, most–including those who offer SOCE–do not. SB 1172 infringes on all LMHP's 1st Amendment

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[15] *See*, The General Psychologist, Division 1 (2010), San Diego. American Psychological Association Convention, Retrieved on 2/26/13: http://www.apadivisions.org/division-1/publications/newsletters/general/2010/10-issue.pdf.

[16] *See*, Byrd, A.D., *When Activism Masquerades as Science: Potential Consequences of Recent APA Resolutions*, Retrieved on 2/26/13: http://narth.com/docs/masquerades.html.

rights–by treating all as if they were abusive, negligent, or malfeasant. It is the job of the existing state mental health boards that govern the practice of LMHP to assess whether violations have occurred. SB 1172 usurps the statutory right and responsibility of the mental health boards to regulate the practice of the members of their own professions.

E. "SEXUAL ORIENTATION" CAN CHANGE

The major premise of SB1172's argument against SOCE is the notion that sexual orientation cannot change. The APA Task Force Report attempted to identify an objective phenomenon (*i.e.*, orientation) vs. a subjective phenomenon (*i.e.*, identity). "Sexual orientation" is defined as an unchangeable characteristic, while "sexual identity" is changeable. Yet, the Report also admits as a "psychological fact" that for some people, *sexual orientation identity*–but not orientation itself–is "fluid." This is pseudo-science (at best, conjecture, with no objective way of clarifying one's orientation–*i.e.*, real self) from their self-reported identity (*i.e.*, "individual or group membership or affiliation, self labeling.") The following quotes are from the APA's 2009 Task Report asserting the "fluidity" of various aspects of "sexual orientation," in general, for women and for adolescents:

1. Same-sex sexual attractions and behavior occur in the context of a variety of sexual orientations and sexual orientation identities, and for some, sexual

orientation identity (i.e., individual or group membership and affiliation, self-labeling) is fluid or has an indefinite outcome. (*See*, p. 2.)

2. Recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid. (*See*, p. 14.)

3. Some women find current categories for conceptualizing their sexual orientation and sexual orientation identity limiting, as concepts in popular culture and professional literature do not mirror their experiences of fluidity and variation in sexuality and relationships. (*See*, p. 63.)

4. Some adolescents are more comfortable with fluid or flexible identities due to gender differences and generational or developmental concerns, and their sexual orientation identities may not be exclusive or dichotomous. (*See*, p. 76.)

5. The most detailed studies to date regarding change in sexual orientation in adolescents were conducted in 2007 and 2010. The first, by Savin-Williams and Ream, is a very large longitudinal study that documented changes in attraction so great even between the ages of 16 and 17 that the authors queried whether the concept of sexual orientation had any meaning for adolescents with same-sex attractions. Seventy-five percent of adolescents who had some initial same-sex attraction between the ages of 17-21 changed to experience opposite sex

attraction only. The second highly detailed study demonstrating significant change away from same-sex attractions in adolescents involved an enormous sample (13,840 youth) and was published by Ott *et. al*. in 2010. Of those initially "unsure" of their sexual orientation, 66% ended exclusively heterosexual. [17]

The APA also admits that patients **do report** satisfaction with efforts to change their "sexual orientation." How one defines "sexual orientation" affects how one measures and attempts to change this phenomenon, and whether or not one has, in fact, been helped. Furthermore, in his book *My Genes Made Me Do It! A scientific look at Sexual Orientation*[18], Dr. Neil Whitehead writes extensively about this point, including, for example:

> "Neutral academic surveys show there is substantial change. About half of the homosexual/bisexual population (in a non-therapeutic environment) moves towards heterosexuality over a lifetime. About 3% of the present heterosexual population once firmly believed themselves to be homosexual or bisexual. Sexual orientation is not set in concrete." [19]

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[17] *See*, . Ott, M. Q., Corliss, H. L., Wypij, D., Rosario, M., & Austin, S. B. (2010), *Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics*, Archives of Sexual Behavior; Savin-Williams, R. C., & Ream, G. L. (2007), *Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood*, Archives of Sexual Behavior, 36, 385-394.

[18] *See*, Whitehead, N. *My Genes Made Me Do It – Homosexuality and the Scientific Evidence*. Retrieved on 2/26/13: http://www.mygenes.co.nz/.

[19] *Ibid*. Retrieved on 2/26/13: http://www.mygenes.co.nz/myths.htm.

Finally, since youths–and adults–do change regularly, mostly without therapeutic treatment, there is no basis for SB 1172 to prevent patients from enlisting health care professional to help them if they so choose.

F. EVEN THE APA BELIEVES THAT PATIENTS HAVE THE RIGHT TO DETERMINE THEIR OWN DIRECTION OF TREATMENT

The *APA Task Force Report* provides that LMHP "should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments." (*See*, p. 76.) Clearly, SB 1172 abridges and infringes upon patients' right to choose his or her own medical treatment.

G. PRACTITIONERS OF SOCE SUPPORT THE RIGHT OF CLIENTS TO DETERMINE THEIR OWN DIRECTION OF TREATMENT

Professionals who are members of NARTH believe along with APA that:

> "LMHP are more likely to maximize their clients' self determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation [and that] clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns"

(*See*, pp. 63 and 69.).

Finally, for a clear delineation of what NARTH deems is ethical practice when serving persons with unwanted same sex attraction and behaviors, see

NARTH's *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior*.[20]

H. HEALTH CARE PRACTITIONERS RESPECT PATIENTS' RELIGIOUS BELIEFS AND NONRELIGIOUS REASONS FOR CHOOSING SOCE

It is undisputed that SB 1172 does not support patients' right to live according to their religious beliefs–or lack thereof. The APA insists that clients' religious beliefs in regards to homosexuality must be respected (*cf*. p. 5, 19-20, 51, 53, 56, 59, 64, 69, 70, 77-78, 82, 120), as well as the convictions of those who decide (apart from religious reasons) that their sexuality does not reflect their true self (*cf*. p. 18, 56, 68-69). Mainstream practitioners of SOCE are committed to respecting these client rights. *See, e.g.*, NARTH's *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior*.[21]

I. PARENTS HAVE THE PRIMARY RIGHT TO CARE FOR THEIR CHILDREN

As SB 1172 prohibits parents from seeking SOCE for their child, the State of California has usurped the rights of parents to be the primary caretakers of their children. State law already allows for timely responses to alleged and actual neglect and abuse of minor children by their parents. However, SB 1172 treats all

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[20] *See*, *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior*, Journal of Human Sexuality, Retrieved on 2/26/13: http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines.

[20] *Id*.

parents who would take their minor children for SOCE care as negligent or abusive. While every parent has the "potential" to harm a minor under their care, thankfully most do not. SB 1172 infringes on the rights of all parents by treating them, *a priori*, as if they were abusive or neglectful simply because they choose arrange for their minor child to receive SOCE. Child Protective Services already exists to handle reported and actual parental abuse and neglect.

Finally, if enforced, SB 1172 would violate a number of rights upheld by the *Convention on the Rights of the Child* ("CRD")[22] and the *Universal Declaration of Human Rights* ("UDHR").[23] These include the following rights secured for parents and children:

1. The right and responsibility that when adults make decisions that affect children, the best interests of children must be the primary concern. (CRD, Article 3.)

2. The right of families to be allowed to direct and guide their children so they can grow and reach their potential and the responsibility and of Governments to support them in doing so. (CRD, Articles 4 & 5.)

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[22] *See, Convention on the Rights of the Child*,http://www.unhcr.org/refworld/docid/3ae6b38f0.html.

23 See, *The Universal Declaration of Human Rights*, United Nations, Retrieved on 2/26/13: http://www.un.org/en/documents/udhr/index.shtml#a11.

3. The right of children to procure and share information, form and express their opinions, and otherwise be involved in decision-making appropriate to their level of maturity, especially when adults are making decisions that affect the children's welfare. (CRD, Articles 12 & 13.)

4. The right of children to think and believe what they want and to practice their religion, and of parents to provide religious and moral guidance to their children. (CRD, Article 14.)

5. The right of children to have access to information that is important to their health and well-being and the responsibility and of Governments to encourage mass media – radio, television, newspapers and Internet content sources–to provide information that children can understand and to not promote materials that could harm children. (CRD, Article 17.)

6. The right of parents to provide appropriate guidance to their children and the responsibility of governments to provide support services to parents on doing so. (CRD, Article 18.)

7. The right of children to an education that would develop their personality, talents and abilities to the fullest. (CRD, Article 18.)

8. The right to freedom for the full development of one's human personality. (UDHR, Article 26.)

9. The right to medical care and necessary social services. (UDHR, Article 25.)

10. The right to freedom of thought, conscience, and religion. (UDHR, Article 18.)

11. The right to freedom of opinion and expression, which includes the freedom to hold opinions without interference and to seek, receive, and impart information and ideas through any media. (UDHR, Article 19.)

12. The right to the protection of the law against arbitrary interference with one's privacy or family and attacks on one's honor and reputation. (UDHR, Article 12.)

IV. CONCLUSION

Based upon the foregoing, *Amicus Curiae* American College of Pediatricians respectfully requests the Court to **AFFIRM** the decision of the district court.

February 26, 2013. Respectfully submitted,

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STATEMENT OF RELATED CASES—CIRCUIT RULE 28-2.6

Pickup v. Brown, 12-17681 challenges the same law at issue in the instant case. However, in an order the District Court determined that the cases are unrelated. ER 364-65. Both *Pickup* and the instant case are calendared for oral argument on the same day and before the same panel.

Executed on this **26TH** day of **February, 2013**.

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CERTIFICATE OF COMPLIANCE PURSUANT TO FEDERAL RULES OF APPELLATE PROCEDURE 32(A)(7)(C) AND CIRCUIT RULE 32-1

I hereby certify that, pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached brief of *AMICUS CURIAE* AMERICAN COLLEGE OF PEDIATRICIANS is proportionally spaced, has a typeface of 14 points, and contains 4,186 words, exclusive of exempted portions.

Executed on this **26TH** day of **February, 2013**.

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CERTIFICATE OF SERVICE

I hereby certify that on **February 26, 2013**, I electronically filed the foregoing brief of *AMICUS CURIAE* AMERICAN COLLEGE OF PEDIATRICIANS with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system. All participants in the case are registered CM/ECF users and will be served by the appellate CM/ECF system. I certify and declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct.

Executed on this **26TH** day of **February, 2013**.

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