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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.

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

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

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

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

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

26 **I. The available science indicates that same-sex attraction is not**
27 **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.

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

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

10 A. Same-sex attraction is not genetically determined.

11 10. In the past, many authors have hypothesized that same-sex attractions
12 are biologically determined. However, no such causes have been found. A 2019
13 large-scale study by a team of authors from Harvard, MIT, and several other
14 prestigious institutions analyzed the genomes of *almost half a million individuals*,
15 along with self-reported information about heterosexual and same-sex sexual
16 behaviors from these individuals. This massive study found only “very small”
17 correlations between any genes and same-sex behavior. The authors concluded that
18 the impact of genetic factors on sexual orientation were so small that they “do not
19 allow meaningful prediction of an individual’s sexual preference.” (Ganna et al.,
20 2019. p.6).

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

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

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

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

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

1 B. Same-sex attraction frequently changes.

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

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

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

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

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

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

22 21. A study by authors from the Harvard School of Public Health and
23 other respected institutions examined “gender- and age-related changes in sexual
24 orientation identity from early adolescence through emerging adulthood” in over
25 13,000 youth from 12 to 25 years of age, examining data collected for each
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1 participant at four times over a period of seven years. (Ott et al., 2011). On this
2 sample, Diamond and Rosky note that “Of the 7.5% of men and 8.7% of women who
3 chose a nonheterosexual descriptor at ages 18 to 21, 43% of the men and 46% of the
4 women chose a different category by age 23. Among the same-sex-attracted youth
5 who changed, 57% of the men’s changes and 62% of the women’s changes involved
6 switching to completely heterosexual.” (Diamond & Rosky, 2016, p.7-8).

7 22. Diamond and Rosky gather the results of the Ott et al. study along
8 with two separate “longitudinal” studies (i.e., studying the same individuals over
9 time), done by different researchers at different times on different samples, and
10 report that, for young adult populations (starting ages from 18 to 26), of those who
11 initially reported “any same sex attractions,” every study found that between 40% to
12 60% of each sex reported a “change in attractions” when resurveyed a few years
13 later. Of those who experienced a “change,” at least half and as high as 83%
14 “changed to heterosexuality at the second assessment.” (Diamond
15 & Rosky, 2016, p.7).

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

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

11 25. Another often-cited paper by prominent researchers summarized
12 scholarship and cautioned that “there was little evidence of true bipolarity in sexual
13 orientation” and that sexual orientation is instead “a continuous construct.” These
14 authors observed that one study found that “Only 38% of exclusive same-sex
15 attracted females stayed in this group [between ages 21 and 26], with the rest
16 moving into ‘occasional’ same-sex attraction (38%) or exclusive opposite-sex
17 attraction (25%),” while another found that across a multi-year study period “Most
18 (62%) of young women changed their identity labels at least once. . . Over time,
19 lesbian and bisexual identities lost the most adherents and heterosexual and
20 unlabeled identities gained the most.” In short, this paper’s literature review found
21 that “Evidence to support sexual orientation stability among nonheterosexuals is
22 surprisingly meager.” (Savin-Williams & Ream, 2007, p.386).

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

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

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

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

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

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

24 30. In a major 2009 report based on a review of many studies, a task force
25 of the American Psychological Association concluded:
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1 “Although the recent studies do not provide valid causal
2 evidence of the efficacy of SOCE or of its harm, some recent
3 studies document that there are people who perceive that they
4 have been harmed through SOCE... just as other recent studies
5 document that there are people who perceive that they have
6 benefited from it. . . . We conclude that there is a dearth of
7 scientifically sound research on the safety of SOCE. Early and
8 recent research studies provide no clear indication of the
9 prevalence of harmful outcomes among people who have
10 undergone efforts to change their sexual orientation or the
11 frequency of occurrence of harm because no study to date of
12 adequate scientific rigor has been explicitly designed to do so.
13 Thus, we cannot conclude how likely it is that harm will occur
14 from SOCE.” (42) b) “[I]t is still unclear which techniques or
15 methods may or may not be harmful.” (91)

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

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

26 32. There have in fact been a number of recent papers attempting to link
27 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.

1 1. Sample bias

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

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

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

23 36. Thus, given the widespread recognition that most individuals who seek
24 counseling to assist in reducing same-sex attractions are motivated by goals,
25

26 _____
² For example, Ryan et al., 2018.

27 ³ Lefevor et al., 2020; Rosik et al., 2021a.

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

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

16 38. In a related but separate biasing effect, recruitment of subjects for non-
 17 longitudinal studies from among those who self-identify as LGBT also excludes
 18 those who *did* at one time identify in that way, but for whom therapy was
 19 sufficiently effective that they *no longer* identify as LGBT, or at least no longer
 20 frequent LGBT-identified networks and venues used for recruitment. One scholar
 21 has identified and criticized the sample of a recent major study as suffering from
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24 ⁴ The APA's 2009 task force report noted "most SOCE currently seem directed to those holding
 25 conservative religious and political beliefs, and recent research on SOCE includes almost exclusively
 26 individuals who have strong religious beliefs." The report further reported that those who seek
 27 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.

1 this flaw, noting that “those who may have attained the goal of SOCE—to adopt
 2 heterosexual identity, orientation or sexual function—were systematically screened
 3 from the survey sample, which only included those currently identifying as a sexual
 4 minority.” Sullins, 2020. In other words, unless this error is avoided, the sample
 5 precisely excludes those who are likely to report that therapy was satisfactory,
 6 effective, and/or not experienced as harmful.

7 39. These structural biases in the samples used by such studies are all the
 8 more critical given that self-reported, unverified information is itself recognized to
 9 present an important risk of distortion and bias. As the 2009 APA Task Force report
 10 noted, “People find it difficult to recall and report accurately on feelings, behaviors,
 11 and occurrences from long ago and, with the passage of time, will often distort the
 12 frequency, intensity, and salience of things they are asked to recall.” (29) By
 13 utilizing samples whose participants come from diverse religious and socio-political
 14 outlooks, not just those who self-identify as LGBTQ, the impact of inaccurate
 15 reports distorted by a combination of inaccurate memory and the personal advocacy
 16 goals of participants and researchers could be significantly mitigated.
 17 Unfortunately, such diverse samples are exceedingly rare in this literature.

18 2. Failure to conduct before-and-after comparisons

19 40. Secondly, none of the recent studies that attempt to link “SOCE” to
 20 increased distress and suicidality reported and compared against participants’ level
 21 of distress *prior* to their engaging in “SOCE.” That is, these studies report that the
 22 study subjects suffered from mental health issues after engaging in “SOCE,” but
 23 they do not report what level of mental health issues those same subjects suffered
 24 *before* engaging in “SOCE.”⁵ Basic research methodology dictates any study
 25 attempting to attribute a cause (e.g., “SOCE”) to an effect (e.g., harm) must take
 26

27 ⁵ Blosnich et al., 2020; Green et al., 2020; Flentje et al., 2013; Salway et al., 2020.

1 into account important and potentially confounding factors. The lack of a control for
2 pre-“SOCE” distress makes it impossible for studies that suffer from this defect to
3 reach any valid conclusions about causation.

4 41. In one striking example, data that permits an answer to the “before
5 ‘SOCE’” question is available but was disregarded in a research paper published by
6 Blosnich et al., 2020. That data negates and even inverts the hypothesis of
7 causation advanced in the published paper. Blosnich et al., utilized a dataset (the
8 Generations survey) available to other scholars. Oddly, Blosnich and colleagues did
9 not take into account data concerning the subjects’ pre-“SOCE” distress in their
10 study design even though such information was available in the same dataset, yet
11 nevertheless these authors purported to find that “SOCE” had “insidious
12 associations with suicide risk” and “may compound or create...suicidal ideation and
13 suicide attempts.” I will note that “insidious associations” is a rhetorical rather than
14 a scientific statement, while “may compound or create” describes a hypothesis that
15 should be tested, not a scientific finding.

16 42. More recently, Professor Donald Sullins performed a re-analysis of the
17 original study of Blosnich et al. but took into account the “SOCE” distress levels
18 experienced by the study subjects *before* they participated in what Blosnich
19 designates as “SOCE.” (Sullins, 2020 (preprint).) Sullins’ reanalysis discovered a
20 very different reality. While the effect of controlling for pre-“SOCE” suicidality was
21 larger for adults than for minors, Sullins reported:
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1 After controlling for pre-existing conditions, there no longer
2 remained any positive associations of SOCE with suicidality in
3 the Generations data. Far from increasing suicidality, recourse
4 to SOCE generally reduced it. For the most part the observed
5 reduction in suicidality is not small, especially for those who
6 received SOCE treatment as adults. Following SOCE, the odds
7 of suicide ideation were reduced by two-thirds (AOR of .30) for
8 adults and by one-third (AOR of .67) for minors. Suicide
9 attempts were reduced by four-fifths (AOR of .20) for adults
10 following SOCE, though they were not reduced for minors . . .
11 (14)

8 The reduced propensity to progress to suicide attempts
9 following SOCE therapy after previous suicide morbidity was
10 even greater. When followed by SOCE treatment, suicide
11 ideation was less than a fifth as likely (AOR .18, Table 4) and
12 suicide planning less than a seventh as likely (AOR .13, Table
13 4) to lead to a suicide attempt. Adults who experienced SOCE
14 intervention following suicidal thoughts or plans were 17-25
15 times (AOR .06-.04, Table 4) less likely to attempt suicide.
16 Minors undergoing SOCE were no more likely (AOR .43-.52,
17 not significant, Table 4) to attempt suicide after initial
18 thoughts or plans of suicide compared to their peers who did
19 not undergo SOCE. (14-15)

16 43. Sullins goes on to observe that “On the question of SOCE and
17 suicidality, in fact Blosnich et al. may have stated the case exactly backwards.” (15).

18 44. Finally, Sullins goes on to provide an illustrative analogy:

19 “Imagine a study that finds that most persons using anti-
20 depressants also have had depressive symptoms, thereby
21 concluding that persons “exposed” to anti-depressants were
22 much more likely to experience depression, and recommending
23 that anti-depressants therefore be banned. This imagined
24 study would have used the same flawed logic as Blosnich et al.’s
25 study, with invidious consequences for persons suffering from
26 depression.” (20)

1 45. More scholarly criticism of these and other recent studies that suffer
2 from these profound methodological flaws continues to emerge.⁶

3 **III. Available evidence indicates that voluntary counseling to change**
4 **sexual orientation can be effective in motivated individuals.**

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

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

11 47. The 2009 APA Task Force report acknowledged that “There are no
12 studies of adequate scientific rigor to conclude whether or not recent SOCE do or do
13 not work to change a person’s sexual orientation.” (120) More specifically:

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

19 48. The Task Force report further stated:

20 “Former participants in SOCE reported diverse evaluations of
21 their experiences: Some individuals perceived that they had
22 benefited from SOCE, . . . [These] individuals reported that
23 SOCE was helpful—for example, it helped them live in a
24 manner consistent with their faith. Some individuals described
25 finding a sense of community through religious SOCE and
26 valued having others with whom they could identify.” (3)

25 ⁶ D’Angelo et al., 2021 (critique of Turban et al.’s (2020) study on the effects of gender identity
26 conversion efforts); Kalin, 2020 (critique of Bränström & Pachankis (2019) study on the mental
27 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”).

1 B. Available evidence shows that voluntary counseling is effective for
2 some individuals.

3 49. Authors from a variety of perspectives acknowledge that there is
4 evidence that voluntary counseling is effective for at least some individuals who are
5 highly motivated to change sexual attractions and behaviors.

6 50. A six-year longitudinal study considering willing participants who
7 were motivated at least in part by religious beliefs and goals concluded that “The
8 attempt to change sexual orientation did not appear to be harmful on average for
9 these participants. The only statistically significant trends that emerged...indicated
10 improving psychological symptoms.” (Jones & Yarhouse, 2011, p.424).

11 51. This longitudinal study found that about half of participants reported
12 progress toward their desired goal, with 23% of study participants reporting
13 substantial reduction in homosexual attraction and substantial increase in
14 heterosexual attraction and functioning, while an additional 30% of participants
15 reported that same-sex attraction remained present only incidentally or in a way
16 that did not seem to bring about distress.

17 52. A 2010 study surveyed 117 men who participated in some form of
18 secular or religious counseling or support group activities designed to reduce same-
19 sex attraction. Of these, some were single and some were in heterosexual
20 marriages. 88% were motivated at least in part by what they perceived as conflict
21 between their same-sex desires and conduct and the teachings of their faith. Within
22 the whole study group, responses indicated a “large effect” in decrease of same-sex
23 attractions and behavior, and also a “large effect” in increase of heterosexual
24 attraction and behavior. (Karten & Wade, 2010).

1 53. Looking at a very different population, well-received studies on
 2 voluntary, talk-based therapy pursued with gay and bisexual men with the
 3 treatment goal of suppressing or decreasing casual same-sex behavior to reduce
 4 HIV transmission risk reported success in decreasing same-sex behavior over an
 5 extended period of time.⁷ Standard therapies, culturally adapted standard therapy,
 6 and lay peer counseling were shown in replicated, randomized, control trials to
 7 significantly decrease casual same-sex behavior and maintain gains at 6 to 12
 8 month follow up. The goal behind these studies was to reduce HIV transmission
 9 among this population, but the success of these studies contradicts the hypothesis
 10 that counseling with a goal of reducing same-sex behavior is necessarily ineffective.
 11 In addition, none of these studies reported adverse effects from the counseling on
 12 the mental health of the subjects.

I declare under penalty of perjury that the foregoing is true and correct.




Dr. Christopher 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

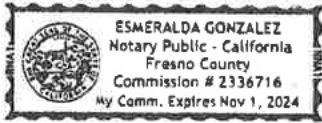
⁷ Nyamathi et al., 2017; Shoptaw et al., 2005; Shoptaw et al., 2008; Reback & Shoptaw, 2014.

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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.



(Seal)

Signature [Handwritten Signature]

Appendix A: Curriculum Vitae

Christopher Hastings Rosik

1734 W. Shaw Avenue
Fresno, California 93711

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.

Rosik, C.H. (1992). Multiple personality disorder: An introduction for pastoral counselors. The Journal of Pastoral Care, 46, 291-298.

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Rosik, C. H. (1998). Religious Contributions to the Healing of Dissociative Disorders. Many Voices, 10, 6-8.

Rosik, C.H., & Killbourne-Young, K. (1999). Dissociative disorders in adult missionary kids: Report on five cases. Journal of Psychology and Theology, 27, 163-170.

Rosik, C.H. (2000). Utilizing religious resources in treating dissociative trauma symptoms: Rationale, current status, and future directions. Journal of Trauma and Dissociation, 1, 69-89.

Rosik, C. H. (Ed.) (2000). Dissociative Identity Disorder [Special Issue]. Journal of Psychology and Christianity, 19(2).

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Brown, S. W., Gorsuch, R. L., Rosik, C. H., & Ridley, C. R. (2001). The development of a forgiveness scale. Journal of Psychology and Christianity, 20, 40-52.

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Rosik, C. H. (2003). Motivational, ethical, and epistemological foundations in the treatment of unwanted homoerotic attraction. Journal of Marital and Family Therapy, 29, 13-28.

Rosik, C. H. (2003). When therapists do not acknowledge their moral values: Green's response as a case study. Journal of Marital and Family Therapy, 29, 39-46.

- 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.
- Rosik, C. H. (2005). Psychiatric symptoms among prospective bariatric patients: Rates of prevalence and their relation to social desirability, pursuit of surgery and follow-up attendance. Obesity Surgery, 15(5), 677-683.
- Rosik, C. H., Griffith, L. K., & Cruz, Z. (2007). Homophobia and conservative religion: Toward a more nuanced understanding. American Journal of Orthopsychiatry, 77, 10-19.
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- Rosik, C. H., & Pandzic, J. (2008). Marital satisfaction among missionaries: A longitudinal analysis from candidacy to second furlough. Journal of Psychology and Christianity, 27, 3-15.
- Rosik, C. H., & Smith, L. L. (2009). Perceptions of religiously-based discrimination among Christian students in a secular versus Christian university setting. Psychology of Religion and Spirituality, 1(4), 207-217.
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- Rosik, C. H., Renteria, T., & Pitman, A. (2012). Psychological Profiles of Individuals Seeking Ordination in the Episcopal or Presbyterian (PCUSA) Churches: Comparisons and Contrasts. Pastoral Psychology, 61(3), 359-373.
- Rosik, C. H. (2012). Opposite-gender identity states in Dissociative Identity Disorder: Psychodynamic insights into a subset of same-sex behavior and attractions. Journal of Psychology and Christianity, 31(3), 278-284.
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