UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

CATHOLIC CHARITIES OF JACKSON, LENAWEE AND HILLSDALE COUNTIES and EMILY MCJONES,

Plaintiffs,

v.

GRETCHEN WHITMER, ET AL.,

Defendants.

Civil No. 1:24-cv-00718-JMB-SJB

BRIEF OF DAVID WIEDIS AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae David Wiedis is the founder and Executive Director of ServingLeaders Ministries, a Christian ministry that provides counseling services to pastors, ministry leaders, and their families to help them deal with the pressures of ministry and the devastation to families and churches that results from the lack of pastoral care for ministry leaders. Mr. Wiedis founded ServingLeaders after twenty years of practicing law and obtaining a Masters in Christian Counseling from the Philadelphia Biblical University (now Cairn University), where he serves as an adjunct faculty member, teaching courses on ethical, moral, and legal issues in counseling.

Mr. Wiedis seeks to help other Christians through his ministry by providing biblical, Christ-centered counseling based on his and his clients' shared worldview. He and other counseling colleagues, including those who are licensed, both within his organization and within associated Christian institutions, provide their counseling services based on biblical precepts that many counselees specifically seek because of their own religious beliefs.

Mr. Wiedis seeks to bring to the Court's attention the scientific literature documenting the importance of integrating religious and spiritual beliefs into counseling practice to emphasize how the First Amendment guarantees of free speech and the free exercise of religion are necessary to ensure effective counseling for religious adherents.

[1] No party or counsel for a party authored this brief in whole or in part. No one other than *Amicus* or his counsel made a monetary contribution to preparing or submitting this brief.

SUMMARY OF ARGUMENT

This case involves the question of whether the state may censor discussions of religious beliefs in the context of one-on-one counseling between licensed mental health professionals and clients who share the same religious faith.

The Michigan Legislature recently said yes, if those discussions involve traditional religious beliefs about sexuality and gender. Michigan law now prohibits mental health professionals from offering "any practice or treatment," such as pure talk therapy, "that seeks to change an individual's sexual orientation or gender identity." Mich. Comp. Laws Serv. § 330.1100a(20). Thus, if a religious counselee is struggling with and wants to avoid a "gender-related self-identity," Mich. Comp. Laws Serv. § 37.2103(f), inconsistent with his or her religious beliefs, Michigan law now prohibits a licensed professional from offering pure talk therapy to assist in that effort.

The prohibition, however, goes only one way. Michigan law allows "counseling that provides assistance to an individual undergoing a gender transition, counseling that provides acceptance, support, or understanding of an individual or facilitates an individual's coping, social support, or identity exploration and development, … as long as the counseling does not seek to change an individual's sexual orientation or gender identity." *Id.* A therapist may, therefore, encourage the individual to adopt a gender identity inconsistent with the counselee's religious beliefs, but the therapist cannot provide counseling consistent with those beliefs.

In doing so, the statute prohibits responsible, scientifically supported therapeutic counseling. Hundreds of recent studies show that integrating discussions of religious beliefs and practices in mental health therapies leads to better outcomes. These studies have compelled the mental health professions to incorporate religious and spiritual concepts in their therapies. For instance, the World Psychiatry

Association now urges the inclusion of spirituality and religion in psychiatric clinical practice.

These studies recognize the importance of clients' religious identities. But by barring discussions based on the client's religious beliefs, Michigan law now denigrates the client's religious identity and restricts therapeutic religious speech. In effect, the statue elevates sexual and gender identities over religious identities. Under this reasoning, even if the client earnestly wants help to live out his or her faith, the statute prohibits mental health professionals from using therapies consistent with the client's religious beliefs.

By prohibiting speech consistent with traditional religious beliefs but expressly allowing contrary speech, the statute not only undermines sound therapeutic practices but is also unconstitutional. After all, the First Amendment was "written to quiet well-justified fears … arising out of an awareness that governments of the past had shackled men's tongues to make them speak only the religious thoughts that government wanted them to speak." *Engel v. Vitale*, 370 U.S. 421, 435 (1962).

ARGUMENT

I. The statute censors vitally important religious speech.

The relationship between religion and mental health treatment has a long history. Appalled by the barbaric treatment of patients at Bedlam, the leading psychiatric institution in the late 1700s, William Tuke established York Retreat based on the Quaker religious conviction that the mentally ill are equal human beings, to be treated with gentleness, humanity, and respect. *See* Harold G. Koenig, *Religion, Spirituality, and Health: The Research and Clinical Implications*, ISRN Psychiatry, Vol. 2012, Article ID 278730, at 1–2 ("Koenig 2012"). Instead of shackles, squalor, and torture, Tuke's "moral treatment" was based on personalized attention,

conversation, religious services, prayer, and benevolence, all provided in a bucolic setting. Tanaquil Taubes, *"Healthy Avenues of the Mind": Psychological Theory Building and the Influence of Religion During the Era of Moral Treatment*, 155(8) Am. J. Psychiatry 1001, 1003-1007 (1998); *see also* Louis C. Charland, *Benevolence and discipline: the concept of recovery in early nineteenth-century moral treatment*, *in* Recovery of People with Mental Illness: Philosophical and Related Perspectives 66–67, 74–75 (Abraham Rudnick, ed., 2012).

In the early 1800s, Quakers brought the moral treatment philosophy to the United States, founding mental health facilities in Pennsylvania. The Quakers' religious principles not only "played a very significant role in the development of the humane treatment of the mentally ill," they also "laid the foundation for modern psychiatric medicine in the United States." Debbie Price, *For 175 Years: Treating Mentally Ill With Dignity*, N.Y. Times, sec. 1, p. 48 (Apr. 17, 1988).

Psychoanalytic theory developed in the 20th century, however, became hostile to religion, drawing "parallels between religion and both neurosis and psychosis." David Lukoff, et al. *Toward a more culturally sensitive DSM-IV*, 180(11) J. Nervous and Mental Disease 673, 674 (1992) ("Lukoff 1992"). The leading theoreticians viewed religion as a "universal obsessional neurosis," "irrational," and an "emotional disturbance." *Id.* at 674. Indeed, in a 1980 article, the founder of rational emotive behavior therapy, Albert Ellis, asserted that "[t]he less religious [patients] are, the more emotionally healthy they will tend to be." Albert Ellis, *Psychotherapy and atheistic values: A response to A. E. Bergin's "Psychotherapy and Religious Issues,"* 48 J. Consult. Clin. Psychol. 635 (1980).

As hundreds of scientific studies have now shown, Ellis and the other leading theoreticians were dead wrong. Not only are religious beliefs and practices associated

with *better* mental and physical health, but the mental health professions now recognize the need to incorporate religious concepts in their therapies.

Despite this recognition, most mental health professionals still do not incorporate religious concepts in their practices. In contrast, religious counselors, already equipped with knowledge and understanding of an adherent's religious convictions, can speak to their religious client's deepest needs.

Yet it is this very religious speech that the Defendants seek to censor.

A. The scientific consensus recognizes religion's important role in mental health therapy.

1. Studies show that religious belief and practice are associated with better mental health.

Scientific studies have consistently found religious practices and beliefs are associated with better mental health outcomes. For example, a 2012 review of 454 studies showed how religious and spiritual beliefs and practices helped people cope with a wide range of illnesses and stressful situations, including chronic pain, kidney disease, diabetes, pulmonary disease, cancer, blood disorders, cardiovascular diseases, neurological disorders, psychiatric illness, bereavement, and end-of-life issues. *See* Koenig 2012, *supra*, at 4. By 2014, more than 3,000 empirical studies showed, in general, that individuals who have more religious and spiritual belief and practice "have less depression, anxiety, suicide attempts, and substance use/abuse, and experience a better quality of life, faster remission of depressive symptoms, and better psychiatric outcomes." Alexander Moreira-Almeida, et al., *Clinical implications of spirituality to mental health: review of evidence and practical guidelines*, 36 Brazilian J. Psychiatry 176, 176 (2014). Similarly, a 2021 review of the scientific literature showed that higher levels of religiosity and spirituality are associated with lower depressive symptoms, lower suicidality, lower substance abuse, better outcomes related

to bipolar disorder, and serve as a buffer against post-traumatic stress. *See* Giancarlo Lucchetti, et al., *Spirituality, religiousness, and mental health: A review of the current scientific evidence*, 9(26) World J. Clin. Cases 7620, 7622–625 (2021) ("Luchetti 2021").

A few examples illustrate the point:

Self-esteem. Critics have claimed that religion "adversely affects self-esteem because it emphasizes humility rather than pride in the self" and "could exacerbate guilt in some for not living up to the high standards of conduct prescribed by religious traditions, resulting in low self-esteem." Koenig 2012, *supra*, at 4. But in an analysis of 69 studies, "42 (61%) found greater self-esteem among those who were more [religious or spiritual] and two (3%) reported lower self-esteem." *Id.*

Suicide. Numerous studies find that religious beliefs and practices reduce attempted suicides. *See* Lucchetti 2021, *supra*, at 7623. For instance, a 2016 systematic review of 89 studies found that religious affiliation and attending religious services are associated with decreased attempted suicide, even after adjusting for social support measures. Ryan E. Lawrence, et al., *Religion and Suicide Risk: A Systematic Review*, 20(1) Arch Suicide Res. 1, 5, 7 (2016). A 14-year study of 89,708 women in the United States aged 30 to 55 years found that attending religious services was associated with a five-fold lower incidence of suicide compared to never attending religious services. Tyler J. VanderWeele, et al., *Association Between Religious Service Attendance and Lower Suicide Rates Among US Women*. 73(8) JAMA Psychiatry 845, 845 (2016). And a study of data from 22 European countries found that "religiousness is associated with lower suicide rates," even "in secularized European nations, where there is a relatively weak moral community to reinforce religion." Steven Stack &

Frederique Laubepin, *Religiousness as a Predictor of Suicide: An Analysis of 162 European Regions*, 49(2) Suicide and Life-Threatening Behavior 371 (2019).

Depression. A 2003 meta-analysis of the results of 147 studies, which included almost 100,000 participants, found that those with religious and spiritual beliefs and practices were less likely to suffer from depression. T.B. Smith, et al., *Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events*, 129(4) Psychol. Bull. 614 (2003). More recently, a 14-year follow-up study in Canada that included 12,583 participants found that monthly religious attenders had a 22% lower risk of depression compared to non-attenders. Lloyd Balbuena, et al., *Religious Attendance, Spirituality, and Major Depression in Canada: A 14-Year Follow-up Study*, 58(4) Can. J. Psychiatry 225 (2013). Similarly, a 20-year follow up study in the United States found that increased religious attendance was associated with a 43% lower risk of developing mood disorders and a 53% lower risk of developing any psychiatric disorder. S. Kasen, et al., *Religiosity and resilience in persons at high risk for major depression*, 42(3) Psychol. Med. 509 (2012).

2. The mental health professions recognize the importance of incorporating religion and spirituality in counseling.

Not surprisingly, the mental health professions now recognize the need to integrate religious and spiritual beliefs and practices in therapies. Numerous studies have shown that "clients utilizing religiously-integrated therapies or relying on their religious beliefs and practices experience fewer depressive symptoms and faster recoveries, less anxiety, lower suicide rates, and lower overall mortality." Holly K. Oxhandler, et al., *The Religious and Spiritual Beliefs and Practices among Practitioners across Five Helping Professions*, 8 Religions 237 (2017) (citations omitted). Based on the scientific evidence, the World Psychiatry Association urges the inclusion of spirituality and religion in psychiatric clinical practice and training to provide a more

holistic and comprehensive form of mental health care. Alexander Moreira-Almeida, et al., *WPA Position Statement on Spirituality and Religion in Psychiatry*, 15(1) World Psychiatry 87 (2016).

As summarized in an article published in an American Psychological Association journal, in light of the close connection between religion and positive mental health, the scientific literature and experts in the area identified a number of recommendations for psychotherapists, including:

- using "clients' religious beliefs to help inform therapy decisions";
- including "religious dimensions in case conceptualization";
- helping "clients explore their religious questions in therapy";
- integrating "religious resources into treatment";
- using "prayer as a psychotherapy intervention";
- citing "religious texts (i.e., scripture) in treatment";
- helping "clients deepen their religious beliefs"; and
- modifying "treatment plans to account for clients' religious concerns."

Royce E. Frazier & Nancy Downing Hansen, *Religious/Spiritual Psychotherapy Behaviors: Do We Do What We Believe To Be Important?*, 40(1) Prof. Psychol.: Res. and Prac., 81, 83 (2009); *see also* Laura E. Captari, et al., *Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis*, 74 J. Clin. Psychol. 1938, 1941-42 (2018) (providing case examples).

The desire to incorporate religious and spiritual beliefs and practices in mental health treatment comes from patients as well. A national survey of current mental health patients found two out of three indicating that their religious and spiritual beliefs "are important to them during difficult times." Holly K. Oxhandler, et al., *Current Mental Health Clients' Attitudes Regarding Religion and Spirituality in Treatment: A National Survey*, 12 Religions 371 (2021). Three-quarters of patients

agreed that a good therapist is sensitive to clients' religious beliefs (75.6%, with 7.3% disagreeing). *Id.* at 7. Over seventy percent were open to discussing their religious and spiritual beliefs in therapy (71.0%, with 12.0% disagreeing). *Id.* And a majority agreed that discussing their religious and spiritual beliefs in treatment improves their mental health outcomes. *Id.*

Consistent with these finding, guidelines from the American Counseling Association provide that counselors should "a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint." Assoc. for Spiritual, Ethical, and Religious Values in Counseling, *Competencies for Addressing Spiritual and Religious Issues in Counseling*, Competency 13 (2009) ("*Competencies*").

B. Despite this recognition, the mental health professions have failed to adequately integrate religion into counseling.

Although the mental health professions recognize the need to integrate religious and spiritual beliefs and practice into counseling, progress has been slow to nonexistent. A 2023 study based on interviews of mental health professionals showed that "most professionals" favor "incorporating the spiritual dimension into clinical practice; however, few professionals" do so. Rocío de Diego-Cordero, et al., "*More Spiritual Health Professionals Provide Different Care": A Qualitative Study in the Field of Mental Health*, 11 Healthcare 303 (2023). Despite the "recognition by professionals of spiritual practices, little attention is paid to the spiritual approach in clinical practice or professional training due to the entrenchment of the biomedical model in our health care system." *Id.*

As another study indicated, although the "disciplines that provide psychotherapy agree about the importance of addressing religion and spirituality," "mental

health professions, in general, have fallen short with sufficiently addressing religious and spiritual identities in practice and education." Waleed Y., Sami, et al., *Disenchantment, Buffering, and Spiritual Reductionism: A Pedagogy of Secularism for Counseling and Psychotherapy*, 12 Religions 612 (2021) ("Sami 2021"). Many clinicians "report feeling unprepared to implement religious/spiritual competencies." *Id.*

This failure is not simply the result of a lack of training. Despite the evidence, there remains an "ongoing hostility (or indifference) to religion and religious worldviews within …. psychiatry, psychology, psychotherapy, and psychoanalysis." Rob Whitley, *Religious competence as cultural competence*, 49(2) Transcultural Psychiatry 245, 249 (2012). Professionals in these fields "are much more likely to be atheists than both other health care professionals and the general population." *Id.* And mental health professionals "have tended to ignore or pathologize the religious and spiritual dimensions of life, partly as a consequence of their own personal belief systems." *Id.* (quotation omitted). Indeed, doctoral students in counseling programs still report being "misunderstood," "judg[ed]," and being made to feel they are "not fit for the profession" because of their religious beliefs. Sami 2021, *supra.*

C. Religious mental health professionals can best fill the gap, but the statute censors this critically needed religious-based counseling.

Religious mental health professionals can fill what's been called the "'religiosity gap' between clinicians and patients." Lukoff 1992, *supra*, at 673. For religious clients, it is critical to use a therapist who is not only familiar with their religion, but who also does not dismiss (or worse, pathologize) their religious beliefs and worldview. As recognized in the mental health literature,

> Clients can't check their worldviews, spirituality, or values at our door. … A religious identity and worldview

> are integral aspects of how religious clients think about, experience, respond to, and take action upon their world.

Holly K. Oxhandler, et al., *Current Mental Health Clients' Attitudes Regarding Religion and Spirituality in Treatment: A National Survey*, 12 Religions 371 (2021) (quoting Michelle J. Pearce, Cognitive Behavioral Therapy for Christians with Depression: A Practical Tool-Based Primer (2016)).

Simply put, because they share the client's faith and worldview, religious mental health professionals can speak to the client's needs in a way that other counselors who do not share the client's faith cannot. In keeping with ethical guidelines, which require counselors to respect the client's freedom of choice as to a counseling plan and to avoid imposing their own beliefs, religious mental health counselors are best equipped to set "goals with the client that are consistent with the client's spiritual and/or religious perspectives" and "therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices." Assoc. for Spiritual, Ethical, and Religious Values in Counseling, *supra*, Competencies 12 and 14; *see also* App. 145a (Petitioner helps clients "identify their own objectives" so they can "work together to accomplish" the client's goals).

The inclusion of religious beliefs and practices in therapy is especially important for Christian professionals counseling fellow Christians. The Christian faith requires them to "instruct one another" in biblical knowledge (Rom. 15:14), "encourage one another with" Scripture (1 Thess. 4:18), "exhort one another" so that none "may be hardened by the deceitfulness of sin" (Heb. 3:13), and "stir up one another to love and good works" (Heb. 10:24).

For Christian counselors and their Christian counselees, counseling sessions may therefore become more than the application of secular therapy techniques. The sessions may also be an exercise in the Christian religion, seeking to fulfill these

commandments. Christian counselees often request, and Christian counselors often provide, spiritual support through prayer, bible reading, meditation, and devotional materials.

But the Michigan statute outlaws this sort of pure talk therapy if it is consistent with traditional religious teachings regarding gender identity or sexuality. In fact, it limits speech motivated by the teachings of several of the world's major religions, including Christianity.

By barring discussions consistent with the client's religious beliefs, the statute elevates sexual and gender identity over religious identity, which is contrary to the scientific literature. Religious adherents who want to live out their faith are left in the cold. The statute prevents them from finding help from a mental health professional who would speak to them about their religious beliefs or help them achieve goals based on their sincerely held religious beliefs. And mental health professionals are forced to provide substandard care.

II. By banning religious-based talk therapy, the statute violates the First Amendment.

In effect, the statute is an unconstitutional ban on religious speech. "The First Amendment ensures that religious … persons are given proper protection as they seek to teach the principles that are so fulfilling and so central to their lives and faiths." *Obergefell* v. *Hodges*, 576 U.S. 644, 679-80 (2015). Religious teaching, such as the one-on-one counseling at issue in this case, is speech. And, as this Court recently recognized, the First Amendment "doubly protects religious speech." *Kennedy* v. *Bremerton Sch. Dist.*, 597 U.S. 507, __, 142 S. Ct. 2407, 2421 (2022). The "Free Exercise Clause protects religious exercises," including those that are "communicative." *Ibid.* And "the Free Speech Clause provides overlapping protection for expressive religious activities." *Ibid.*

This double protection "is a natural outgrowth of the framers' distrust of government attempts to regulate religion and suppress dissent." *Kennedy*, 142 S. Ct. at 2421. For instance, the Virginia Statute for Religious Freedom, adopted in 1786, recognized that "to restrain the *profession or propagation* of [religious] principles on supposition of their ill tendency, is a dangerous fallacy, which at once destroys all religious liberty." Va. Code Ann. § 57-1 (emphasis added).

The First Amendment was therefore written to prevent government from "shackl[ing] men's tongues to make them speak only the religious thoughts that government want[s] them to speak." *Engel*, 370 U.S. at 435. The underlying principle is that "religious expression [is] too precious to be either proscribed or prescribed by the State." *Lee* v. *Weisman*, 505 U.S. 577, 589 (1992).

The protection of religious speech is thus central to the promises of the First Amendment. "Indeed, in Anglo-American history, at least, government suppression of speech has so commonly been directed precisely at religious speech that a free-speech clause without religion would be Hamlet without the prince." *Capitol Square Review & Advisory Bd.* v. *Pinette*, 515 U.S. 753, 760 (1995).

Despite these principles, traditional religious beliefs about sexuality and gender are increasingly viewed by many as harmful. Thirty years ago, the "message of contemporary culture" was "that it is perfectly all right to believe that [religious] stuff—we have freedom of conscience, folks can believe what they like but you really ought to keep it to yourself, especially if your beliefs are the sort that cause you to act in ways that are ... well ... a bit unorthodox." Stephen L. Carter, The Culture of Disbelief 24 (1993). Today, the state has mandated that religious mental health counselors cannot even discuss those religious beliefs in one-on-one counseling sessions with fellow religious adherents.

CONCLUSION

The statute is not only unconstitutional, it is outright harmful. The Court should grant the preliminary injunction.

Dated: August 9, 2024

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief contains 3,621 words. The brief was prepared, and the word count generated, using Microsoft Word.

Dated: August 9, 2024

/s/ *Sean P. Gates*
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