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# CONTROLLING DESIRES: SEXUAL ORIENTATION CONVERSION AND THE LIMITS OF KNOWLEDGE AND LAW\*

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## INTRODUCTION

Members of the mental health professions and the “lay” public are currently involved in a “noisy national debate”<sup>1</sup> about the efficacy and ethics of sexual orientation conversion techniques, methods designed to try to change gay and lesbian people into heterosexual ones.<sup>2</sup> In books, newspapers, and numerous nationally renowned television programs—including “Crossfire,”<sup>3</sup> “The McLaughlin Group,”<sup>4</sup> “The News Hour with Jim Lehrer,”<sup>5</sup> “Politically Incorrect,”<sup>6</sup> “Good Morning America,”<sup>7</sup> “Hard Copy,”<sup>8</sup> and “Nightline”<sup>9</sup>—partisans and opponents of orientation conversion level charges and countercharges. Each side accuses the other of betraying science<sup>10</sup> and, more tragically, of inflicting human casualties.<sup>11</sup>

1. Cf. Patricia Nell Warren, *Choice in Sexual Orientation: The Sword That Cuts Both Ways* (1997) (visited June 28, 1999) <<http://www.whosever.org/v2Issue2/warren.html>> (“‘Choice’ . . . is a key word in today’s noisy national debate about gay rights.”).

2. Given the history of the term “homosexual” and my sense of its rejection as the label of choice for most persons who do not identify as heterosexual, to the (quite limited) extent possible I will eschew using this deeply pathologized term. I will, however, use it on those occasions where appropriate for historical or technical reasons. Where feasible I will refer to “gays and lesbians,” “lesbians, gay men, and bisexual persons,” “lesbian, gay, and bisexual individuals,” and the like, or, collectively, “les/bi/gay” people, a syntactically artificial phrase to signal the complicated and contingent character of the categories of people or communities it denotes.

3. *Crossfire: Homosexual Rights: Should Gays and Lesbians Enjoy Legislative Protection?* (CNN television broadcast, July 22, 1998) (transcript available at <<http://www.cnn.com/transcripts/9807/22/cf.00.html>>).

4. *The McLaughlin Group: Issue Two: Praying Yourself Straight* (NBC television broadcast, July 17, 1998) (transcript available at <<http://www.mclaughlin.com/lla.cfm>>).

5. *The News Hour with Jim Lehrer: A Party Divided* (PBS television broadcast, July 22, 1998) (transcript available at <[http://www.pbs.org/newshour/bb/congress/july-dec98/gop\\_7-22a.html](http://www.pbs.org/newshour/bb/congress/july-dec98/gop_7-22a.html)>) (discussing the division within the GOP regarding homosexuality).

6. *Politically Incorrect* (ABC television broadcast, Aug. 12, 1998) (transcript available at <[http://www.abc.com/pi/forum/word\\_index.html](http://www.abc.com/pi/forum/word_index.html)>).

7. *Good Morning America: Homosexual Conversion?* (ABC television broadcast, Aug. 5, 1998) (transcript on file with author).

8. *Hard Copy: Top Copy* (television broadcast, Aug. 20, 1998) (transcript on file with author).

9. *Nightline: Homosexuality, Morality and Politics: The Political Fate of Homosexuality* (ABC television broadcast, July 30, 1998) (transcript available for order at <[http://www.abcnews.com/onair/nightline/transcripts/ntl\\_980730\\_trans.html](http://www.abcnews.com/onair/nightline/transcripts/ntl_980730_trans.html)> and on file with author).

10. See, e.g., JEFFERY SATINOVER, HOMOSEXUALITY AND THE POLITICS OF TRUTH 37 (1996) (referring to “the extent that politics has corrupted the scientific process”); SURINA KHAN, CALCULATED COMPASSION: HOW THE EX-GAY MOVEMENT SERVES THE RIGHT’S ATTACK ON DEMOCRACY 25 (1998) (visited July 1, 1999) <<http://www.nglrf.org/downloads/calcomp.pdf>> (accusing “Christian Right” of “promoting a false image of homosexual conversion that is at odds with mainstream psychological [and] psychiatric . . . institutions.”).

11. See, e.g., Charles Socarides, Benjamin Kaufman, Joseph Nicolosi, Jeffery Satinover & Richard Fitzgibbons, *Don’t Forsake Homosexuals Who Want Help*, WALL ST. J., Jan. 9, 1997, at A12 (“[M]any of the young men who [had] died of AIDS have sought treatment for their homosexuality and were denied knowledge and hope. Many of them would be alive today if they had only been told where to find the help they sought.”); Wendy Johnson, *A Cure for the ‘Cured’: Churches Reaching Out to*

Although attempts to “cure” people<sup>12</sup> of same-sex erotic desires have a long history in the practices of medicine, the removal of “homosexuality” from the rosters of mental illness by psy-professional organizations<sup>13</sup> in the 1970s<sup>14</sup> may have at one time substantially contributed to a lower public profile for such “change” efforts.<sup>15</sup> Despite the dismissal of “homosexuality” as a mental illness by professional organizations, conversion efforts did not disappear from the scene and, as noted above, are even enjoying a current resurgence in national attention.

One reason for their persistence is that some mental health professionals still believe that lesbians and gay men are mentally disordered.<sup>16</sup> In addition, the recent public defenses of sexual reorientation popularize the view that sexual orientation conversion techniques should be made available to people as a matter of choice, regardless of whether “homosexuality” is properly characterized as pathological.<sup>17</sup>

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*Unhappy ‘Ex-Gays’*, WASH. BLADE, Aug. 29, 1997, at 1, 22 (discussing two men who left a support group for people who had been in ex-gay groups to return to one such ministry, but “did not discover their own sense of self worth” and “ultimately committed suicide”); JONATHAN NED KATZ, *GAY AMERICAN HISTORY: LESBIANS & GAY MEN IN THE U.S.A.* 133-34 (rev. ed. 1992) (discussing case where aversion therapy with drugs killed a patient with a heart condition).

12. The published research literature on sexual reorientation efforts overwhelmingly concentrates on male homosexuality, with bisexual men and women, in general, discussed to a much lesser extent. Cf. KENNETH LEWES, *THE PSYCHOANALYTIC THEORY OF MALE HOMOSEXUALITY* 20 (1988) (noting gender skew of the analytic literature on homosexuality).

13. By “psy-professional” I will generally mean “psychological, psychiatric, psychoanalytic, and/or, more generally, psychotherapeutic.”

14. See, e.g., SIMON LEVAY, *QUEER SCIENCE: THE USE AND ABUSE OF RESEARCH INTO HOMOSEXUALITY* 222-30 (1996); Eve Kosofsky Sedgwick, *How to Bring Your Kids Up Gay*, in *FEAR OF A QUEER PLANET: QUEER POLITICS AND SOCIAL THEORY* 69, 70 (Michael Warner ed., 1993) (referring to “the American Psychiatric Association’s much-publicized 1973 decision to drop the pathologizing diagnosis of homosexuality from its next Diagnostic and Statistical Manual (DSM-III)”).

15. Advances in the legal and social situation of les/bi/gay people in the U.S. may also have played a role. See, e.g., David B. Cruz, *Piety and Prejudice: Free Exercise Challenges to Laws Prohibiting Sexual Orientation Discrimination*, 69 N.Y.U. L. REV. 1167, 1181-83 (1994) (discussing statewide antidiscrimination laws adopted starting in 1981).

16. See, e.g., Part II.A *infra*. See also JOSEPH NICOLOSI, *REPARATIVE THERAPY OF MALE HOMOSEXUALITY: A NEW CLINICAL APPROACH* xvi (1991) (“In reality, the homosexual condition is a developmental problem—and one that often results from early problems between father and son.”); *id.* at 8 (“Although homosexuality may be compatible with the *conscious* ego, it can never be compatible on the deepest levels of self, for homosexuality is symptomatic of a failure to integrate self-identity. Symptoms will always emerge to indicate its incompatibility with the true self.”).

17. See, e.g., Timothy F. Murphy, *Redirecting Sexual Orientation: Techniques and Justifications*, 29 J. SEX RES. 501, 507 (1992) (“Some recent justifications merely appeal to the preference of men and women who would like to rid themselves of homoerotic traits and do not invoke the language of pathology or psychological dysfunction”); *id.* at 518 (“[R]eorientation therapy is now defended as a matter belonging to the domain of individual conscience: if a person would like to have a sexual orientation other than the one he or she does have, then therapy ought to be pursued and provided.”).

Yet even this facially more moderate “pro-choice” approach to sexual orientation conversion is not without opposition. For more than twenty-five years some have argued that reorientation efforts are unethical and harmful and should not be countenanced. Both the American Psychological Association (APIA) and the American Psychiatric Association (APtA) have considered resolutions to such effect, although neither adopted the resolutions at issue.<sup>18</sup>

Any attempt to respond appropriately to sexual orientation conversion efforts raises potentially intractable epistemological and conceptual difficulties.<sup>19</sup> Examination of orientation conversion is conceptually elusive insofar as society lacks a clearly useful definition of sexual orientation, and, indeed, it may be that a unitary concept of sexual orientation may prove inadequate for any of the purposes for which a person’s sexual orientation might matter. Examination of orientation conversion is epistemologically challenging insofar as contemporary technological and social forces render ascertainment of sexual orientation difficult, if not impossible, in many cases. Yet much of the value of the project of appraising orientation conversion lies squarely in identifying and confronting these difficulties. A richer appreciation of the intricacies of sexual orientation definition and measurement, including any relationships between sexual orientation and gender, appears necessary for an informed response to orientation conversion efforts. More fundamentally, how people think about homosexuality and gender in general should inform how people think about gay men, les-

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18. “A more strongly worded resolution that would have deemed such therapy plainly unethical failed to pass muster at an [APIA] convention two years ago, as did a similar resolution proffered by the more conservative American Psychiatric Association in 1994.” Rick Weiss, *Psychologists Reconsider Gay “Conversion” Therapy; Group’s Proposal Seeks to Curb Such Treatment*, WASH. POST, Aug. 14, 1997, at A8. Despite such failures, the APtA, in September of 1998, did adopt a less sweeping policy statement condemning certain conversion efforts. See AMERICAN PSYCHIATRIC ASS’N, POLICY STATEMENT ON PSYCHIATRIC TREATMENT AND SEXUAL ORIENTATION (Sept. 11, 1998), (visited June 24, 1999) <[http://www.psych.org/news\\_stand/rep\\_therapy.html](http://www.psych.org/news_stand/rep_therapy.html)> [hereinafter APTA] (“oppos[ing] any psychiatric treatment, such as ‘reparative’ or ‘conversion’ therapy[,] which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation”).

19. The manifold questions of the appropriate responses to sexual orientation conversion efforts are profoundly complex and difficult, encompassing a number of dimensions. One dimension that I do not consider here is the age of the person subject to conversion efforts. Although the issue of youth undergoing these procedures at the behest of parents or guardians is a vitally important one, see, e.g., Thomas Mournian, *Hiding Out*, S.F. BAY GUARDIAN, Apr. 8, 1998 (visited July 1, 1999) <<http://www.sfbg.com/News/32/27/Features/out.html>> (describing San Francisco network of “safe houses” sheltering queer youth, many of whom reportedly escaped from institutions); Lyn Duff, *I Was a Teenage Test Case*, CAL. LAW., May 1996, at 47 (personal narrative), the additional considerations raised by questions of parental rights, minors’ maturity, and substituted judgment complicate the investigation of conversion efforts in ways that demand careful treatment in their own right.

bians, bisexuals, and transgendered persons along with our relative positions in contemporary U.S. society.

To further these ends and to organize the present exploration of sexual orientation conversion efforts, this Article brings into the legal literature and attempts to clarify various critiques of the psychological, psychiatric, and psychoanalytic literature on conversion efforts from approximately the past quarter century to consider what regulatory approach, if any, should be taken with respect to sexual orientation conversion efforts.<sup>20</sup> Part I surveys the history of conversion efforts and illustrates the techniques actually used to try to produce change, thus revealing some of the extremes to which the medical professions have gone in the quest to eradicate “homosexuality,” providing reason to adopt “doubt as a posture toward” contemporary efforts to convert lesbians and gay men.<sup>21</sup>

Next, Part II considers the claim that sexual orientation conversion is an appropriate response to a mental illness, and concludes that the proponents of this argument have failed to establish homosexuality’s pathology. Part III then turns to the anti-conversion argument that people do not voluntarily consent to sexual reorientation efforts, and concludes that it is unlikely that current social conditions allow for truly voluntary consent and thus, in light of these conditions, one cannot know whether an individual decision to pursue sexual reorientation is voluntary. That conclusion, however, does not entail banning sexual reorientation efforts entirely, and Part III proposes the less drastic measure of requiring psy-professionals with unhappy les/bi/gay clients to attempt to treat unhappiness first for a significant period of time before attempting reorientation.

Part IV of the Article examines the harms associated with sexual orientation conversion techniques to determine if regulation is necessary, and argues that any established harmful effects alone do not at this point warrant outright prohibition of sexual reorientation efforts, but perhaps might be addressed by protecting informed consent. Finally, Part V considers issues of informed consent and raises questions about the limits of knowledge and their repercussions for the law’s ability to protect patient autonomy in circumstances presented by sexual orientation conversion efforts.

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20. Cf. Charles W. Socarides, *More on the Debate*, 2 NARTH BULLETIN 14, 14 (Dec. 1994) (contending that the APtA effort to declare sexual orientation conversion efforts as unethical “was meant to influence state and federal legislation”).

21. I have borrowed the quoted phrase from Ron Garet, who has used it in discussing projects toward transsexual embodiment. See Ronald R. Garet, *Self-Transformability*, 65 S. CAL. L. REV. 121, 201 (1991).

## I. THE QUEST FOR “CURES”

Many scholars believe that Western societies witnessed “an *incorporation of perversions*,”<sup>22</sup> a conceptual shift<sup>23</sup> from acts to actors, that is, from viewing same-sex eroticism as something constituted by same-sex genital conduct to something constitutive of persons, part of their selves, their psyches, their bodies,<sup>24</sup> and thus subject to the discipline of medicine. With the increased acceptance of the homosexual person and “homosexuality” as something other/more than a set of sexual acts, the medical world commenced a large and to date mostly unilluminating quest to uncover the causes of this deviant “condition,”<sup>25</sup> to locate and name that which prevented certain individuals from reaching the promised land, the “proper” state of human development that heterosexuality was held to be.<sup>26</sup>

As diverting and disturbing as that search has been, the primary focus of this Article, and especially of this Part, is not on the search for *causes* of “homosexuality.” Rather, this Part looks to the history of the search for *cures* for “homosexuality,” which has often proceeded independent of the search for causes.<sup>27</sup> As will be evident, many of the most grisly techniques

22. 1 MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY* 42 (Robert Hurley trans., Vintage Books 1990) (1976).

23. See, e.g., Naomi Mezey, *Dismantling the Wall: Bisexuality and the Possibilities of Sexual Identity Classification Based on Acts*, 10 BERKELEY WOMEN’S L.J. 98, 101-02 (1995) (making this general point). The nearly canonical quotation for describing this view comes from Foucault:

As defined by the ancient civil or canonical codes, sodomy was a category of forbidden acts; their perpetrator was nothing more than the juridical subject of them. The nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology. Nothing that went into his total composition was unaffected by his sexuality. It was everywhere present in him . . . . It was consubstantial with him, less as a habitual sin than as a singular nature[,] . . . constituted . . . less by a type of sexual relations than by a certain quality of sexual sensibility . . . . The sodomite had been a temporary aberration; the homosexual was now a species.

FOUCAULT, *supra* note 22, at 43.

24. See, e.g., George W. Henry & Hugh M. Galbraith, *Constitutional Factors in Homosexuality*, 90 AM. J. PSYCHIATRY 1249 (1934) (concluding that homosexual men and women are characterized by deviance from ostensibly gender-correlated bodily characteristics such as torso-leg and shoulder-hip ratios); Nicolai Gioscia, *The Gag Reflex and Fellatio*, 107 AM. J. PSYCHIATRY 380 (1950) (concluding that presence or absence of gag reflexive response to tongue depressor effectively distinguishes heterosexual from homosexual males).

25. I am not contending that a search for determinants of homosexuality is *necessarily* destined to failure or practical irrelevance. Rather, I am making the more modest claim that medicine has established little practical significance to date about the origins of sexual orientations.

26. Cf. Gore Vidal, *Foreword* to JONATHAN NED KATZ, *THE INVENTION OF HETEROSEXUALITY* vii, viii (1995) (referring to “heterosexuality[] as the grail, the ultimate in human maturity and happiness”).

27. See TIMOTHY F. MURPHY, *GAY SCIENCE: THE ETHICS OF SEXUAL ORIENTATION RESEARCH* 79-81 (1997).

of the past are no longer in use, despite calls to resuscitate them.<sup>28</sup> Nonetheless, “a burgeoning historical appreciation of the mistreatment of entire classes of persons offers cautionary tales for our own times, even if it is sometimes difficult to recognize oppression in and of the present.”<sup>29</sup> The history of sexual reorientation efforts, although less gruesome in recent times, is rife with mistreatment of people with same-sex desires.<sup>30</sup> An examination of psychotherapeutic practices offers countless horrors, “a litany of atrocities.”<sup>31</sup> “In general, the greater an evil therapists and their patients and/or clients thought homoeroticism to be, the greater were the excesses committed against it.”<sup>32</sup>

“Homosexuality” has historically been regarded as so loathsome that medical authorities have literally tried to excise it from subjects. Given the beliefs that homosexuality was a mental illness, and the brain the seat of the mind, psychosurgery was a plausible (though not necessarily successful<sup>33</sup>) means of attacking the problem.<sup>34</sup> Lobotomy was not an uncommon approach.<sup>35</sup> Some conversionists targeted other portions of the brain, performing surgical hypothalamotomies on seventy-five men in Germany—starting in 1962—before a moratorium was imposed.<sup>36</sup>

28. See, e.g., SATINOVER, *supra* note 10, at 189 (“Although research on the use of medications to change homosexuality would be quite difficult to accomplish in the current environment, there are nonetheless some indications that such an approach might help.”); *id.* at 192 (presenting “a plea to the disinterested research community to begin adequately controlled investigations in the hopes of helping those who struggle”).

29. MURPHY, *supra* note 27, at 227.

30. Furthermore, I do not even consider here beliefs such as the heterosexual male “rape fantasy: all [a lesbian] needs is a good fuck to straighten her out.” Andrew Koppelman, *Why Discrimination Against Lesbians and Gay Men Is Sex Discrimination*, 69 N.Y.U. L. REV. 197, 248 (1994).

31. RONALD BAYER, *HOMOSEXUALITY AND AMERICAN PSYCHIATRY: THE POLITICS OF DIAGNOSIS* 110 (1981) (quoting psychoanalyst Robert Seidenberg at a panel on homosexuality at the 1972 American Psychiatric Association convention).

32. MURPHY, *supra* note 27, at 83-84. Interestingly, while the law journal literature occasionally adverts to orientation conversion efforts, it contains few if any concrete descriptions of such practices. The most notable exception, published while this Article was in the editorial process, is Laura A. Gans, *Inverts, Perverts, and Converts: Sexual Orientation Conversion Therapy and Liability*, 8 B.U. PUB. INT. L. J. 219 (1999).

33. See *infra* text accompanying notes 409-411.

34. See, e.g., Murphy, *supra* note 17, at 514 (“There have even been reports of lobotomies carried out in the hope of extinguishing homoerotic drives.”) (citing ROBERT KRONEMEYER, *OVERCOMING HOMOSEXUALITY* (1980)).

35. See, e.g., KATZ, *supra* note 11, at 175-81 (reprinting Joseph W. Friedlander & Ralph S. Banay, *Psychosis Following Lobotomy in a Case of Sexual Psychopathology: Report of a Case*, 59 ARCHIVES OF NEUROLOGY & PSYCHIATRY 302 (1948)); *id.* at 192-93 (reprinting Moses Zlotlow & Albert E. Paganini, *Autoerotic and Homoerotic Manifestations in Hospitalized Male Postlobotomy Patients*, 33 PSYCHIATRIC Q. 490 (1959)).

36. See Charles Silverstein, *Psychological and Medical Treatments of Homosexuality*, in *HOMOSEXUALITY: RESEARCH IMPLICATIONS FOR PUBLIC POLICY* 101, 107 (John C. Gonsiorek & James D. Weinrich eds., 1991) [hereinafter GONSIOROK & WEINRICH] (citing I. Rieber & V. Sigusch,



But homosexuality was not viewed as simply an abstract mental illness; it was a *sexual* illness, and other surgical interventions targeted genitalia and reproductive anatomy. One researcher attempted and purported to make effectual sexual reorientations to heterosexuality by implanting testicles from heterosexual men into gay ones.<sup>37</sup> At least eleven men received testicular tissue transplants from 1916 to 1921.<sup>38</sup> Simple castration was also used.<sup>39</sup> And although males have been subject to the majority of attempts to “treat” homosexuality, women’s anatomies—their ovaries, uteruses, and clitorises—were also not spared the scalpel.<sup>40</sup> Even body parts such as the neck and lower back have been targets of medical attempts (in the form of cauterization) to extinguish homosexuality.<sup>41</sup>

Even if bodily extractions were inefficacious for eliminating same-sex sexual desires and behaviors, medicine could and did engage in other corporeal interventions for the purpose of overcoming homosexuality. One once popular approach was the use of electricity. In electrical aversion therapy, electrical shocks were (and might still be<sup>42</sup>) administered in conjunction with homoerotic stimuli and withheld in conjunction with heteroerotic stimuli—often nude images—in order to “reinforce heterosexual de-

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*Guest Editorial: Psychosurgery on Sex Offenders and Sexual “Deviants” in West Germany*, 8 ARCHIVES OF SEXUAL BEHAV. 523-27 (1979); G. Schmidt & E. Schorsch, *Psychosurgery of Sexually Deviant Patients: Review and Analysis of New Empirical Findings*, 10 ARCHIVES OF SEXUAL BEHAV. 301-23 (1981); V. Sigusch, E. Schirsch, M. Dannecker & G. Schmidt, *Guest Editorial: Official Statement by the German Society for Sex Research on the Research of Prof. Dr. Guner Doerner on the Subject of Homosexuality*, 11 ARCHIVES OF SEXUAL BEHAV. 445-49 (1982).

37. See LEVAY, *supra* note 14, at 31-33.

38. See Silverstein, *supra* note 36, at 107 (citing G. Schmidt, *Allies and Persecutors: Science and Medicine in the Homosexual Issue*, 10 J. HOMOSEXUALITY 127-40 (1984)).

39. See, e.g., KATZ, *supra* note 11, at 141 (reprinting E.S. Talbot & Havelock Ellis, *A Case of Degenerative Insanity, with Sexual Inversion, Melancholia, Following Removal of Testicles, Attempted Murder and Suicide*, 42 J. MENTAL SCI. 340 (1896)); *id.* at 153, 155 (reprinting Charles H. Hughes, *An Emasculated Homo-sexual. His Antecedent and Post-Operative Life*, 35 ALIENIST & NEUROLOGIST 277 (1914)).

40. Cf. Murphy, *supra* note 17, at 513 (“The scalpel has also been put to use against homoeroticism.”).

On surgical castration of women, see, e.g., *id.* (citing Anonymous, *Results of Castration in Sexual Abnormalities*, 22 THE UROLOGIC & CUTANEOUS REV. 351 (1929)); *id.* at 514 (citing Denslow Lewis, *The Gynecologic Consideration of the Sexual Act*, 250 JAMA 222-27 (1983 [originally 1899])); *id.* (citing JONATHAN NED KATZ, *GAY/LESBIAN ALMANAC* (1983); KATZ, *supra* note 11, at 129).

41. See Murphy, *supra* note 17, at 514 (citing C.P. Oberndorf, *Diverse Forms of Homosexuality*, 33 UROLOGIC & CUTANEOUS REV. 518 (1929)).

42. See, e.g., Anonymous, *Aaron’s Story* (visited Nov. 23, 1998) <<http://members.aol.com/exexgay/page16.html>> (personal narrative with name withheld for confidentiality, on file with author) (“Sadly, a friend who was in the same exgay program [as I was in] committed suicide after 2 years of electroshock. He had burns on his arms where they would shock him for showing sexual response to pictures.”).

sire.”<sup>43</sup> In more extreme forms, electricity has been used to shock usually unconscious patients to the point where they suffer grand mal convulsions<sup>44</sup> in the hope that homosexuality would be extinguished.<sup>45</sup>

Chemicals have also been used to “treat” homosexuality, both in aversive conditioning and to produce seizures. “In one kind of aversion therapy the unpleasant stimulus was an injection of the drug apomorphine, which induces nausea or vomiting.”<sup>46</sup> Other approaches have used the drug Metrazol to induce grand mal seizures.<sup>47</sup>

Drugs have also been used in other ways. One conversionist used a variety of approaches, including cocaine solutions and strychnine injections.<sup>48</sup> Hormones have also been repeatedly used to attempt to change people’s sexual orientation. Men have been treated with androgens, estrogens, and antiandrogens (such as Depo-Provera). Women have also been subjected to hormonal interventions.<sup>49</sup>

The imagination of those seeking to curtail homosexuality has been fantastically impressive. Other recommended or attempted “cures” have included rest,<sup>50</sup> “severe and fatiguing bicycle riding,”<sup>51</sup> masturbatory con-

43. Murphy, *supra* note 17, at 505 (citing R.J. McGuire & M. Vallance, *Aversion Therapy by Electric Shock: A Simple Technique*, 1 BRIT. MED. J. 151-53 (1964); D.F. Clark, *A Note on Avoidance Conditioning Techniques in Sexual Disorders*, 3 BEHAV. RES. & THERAPY 203-06 (1965)). See also KATZ, *supra* note 11, at 164-65 (reprinting Louis William Max, *Breaking Up a Homosexual Fixation by the Conditioned Reaction Technique: A Case Study*, 32 PSYCHOL. BULL. 734 (1935)); LEVAY, *supra* note 14, at 93. Aversive conditioning has also been used not for the purpose of transforming les/bi/gay persons into heterosexual ones, but to produce “a reduction in the strength of homosexual urges” so that they would not be “uncontrollable” in certain patients. Nathaniel McConaghy, Michael S. Armstrong & Alex Blaszczyński, *Controlled Comparison of Aversive Therapy and Covert Sensitization in Compulsive Homosexuality*, 19 BEHAV. RES. & THERAPY 425, 427 (1981).

44. See Murphy, *supra* note 17, at 506.

45. See, e.g., KATZ, *supra* note 11, at 170, 172-73 (reprinting Samuel Liebman, *Homosexuality, Transvestism, and Psychosis: Study of a Case Treated with Electroshock*, 99 J. NERVOUS & MENTAL DISEASE 945 (1944)); *id.* at 201-07 (interview with an involuntary recipient of electroshock).

46. LEVAY, *supra* note 14, at 92 (citing Kurt Freund, *Some Problems in the Treatment of Homosexuality*, in BEHAVIOR THERAPY AND THE NEUROSES 312-26 (H. Eysenck ed., 1960)).

47. See, e.g., KATZ, *supra* note 11, at 165-67 (reprinting Newdigate M. Owensby, *Homosexuality and Lesbianism Treated with Metrazol*, 92 J. NERVOUS & MENTAL DISEASE 65 (1940)). It is not apparent that Metrazol convulsions were induced in unconscious patients. See, e.g., BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 88 (1997) (“[Electroconvulsive therapy] proved easier to administer and more predictable in its effects than the pharmacological convulsive agents; it induced immediate loss of consciousness, sparing the patient much discomfort . . . .”) (emphasis added).

48. See Murphy, *supra* note 17, at 510.

49. See, e.g., KATZ, *supra* note 11, at 162 (reprinting LA FOREST POTTER, STRANGE LOVES: A STUDY IN SEXUAL ABNORMALITIES 161-62 (1933)).

50. See Murphy, *supra* note 17, at 502 (citing JONATHAN NED KATZ, GAY/LESBIAN ALMANAC 185-87 (1983)).

51. *Id.* (citing G.M. Hammond, *The Bicycle Treatment in the Treatment of Nervous Diseases*, 8 J. NERVOUS & MENTAL DISEASE 34-46 (1892 [reprinted in vol. 19 (1986)])).

ditioning,<sup>52</sup> male patronization of female prostitutes,<sup>53</sup> exorcism,<sup>54</sup> “X-ray treatment, douches, anaphrodisiacs, and various forms of hydrotherapy . . . .”<sup>55</sup>

In addition to the various types of surgical, electrical, pharmacological, and behavioral approaches that have been tried, numerous psychotherapeutic techniques have been deployed in the fight against homosexuality. “Some theorists advocated, for example, the mental equivalent of physical exercise. This has taken such forms as the severe study of abstract subjects like mathematics, science, literature, and sociology from the evolutionary viewpoint. Hypnosis was put to the same use.”<sup>56</sup> “Fantasy satiation,” which “involves bombarding a subject with images and language that he or she finds sexually arousing to the point of utter satiation,” has also been tried.<sup>57</sup>

But perhaps the most enduring psychic approaches besides aversive techniques have been psychoanalytic in nature.<sup>58</sup> In classical psychoanalysis, “the analyst attempts to trace the patient’s emotions and behavior to the influence of repressed instinctual drives and defenses in the unconscious.”<sup>59</sup> At various points in the therapy, “the analyst offers interpretations of what the patient has revealed, designed to enable the patient to understand a particular aspect of his or her problem or behavior.”<sup>60</sup> “Psychoanalytic treatment of homosexuality is exemplified by the work of [Irving Bieber and his colleagues], who advocate intensive, long-term therapy aimed at resolving the unconscious anxiety stemming from childhood

52. See, e.g., LEVAY, *supra* note 14, at 91 (discussing R.J. McGuire, J.M. Carlisle & B.G. Young, *Sexual Deviation as Conditioned Behavior: A Hypothesis*, 2 BEHAV. RES. & THERAPY 185-90 (1965)).

53. See Murphy, *supra* note 17, at 502 (citing Vern Bullough, *The Physician and Research into Human Sexual Behavior in Nineteenth-Century Germany*, 63 BULL. HIST. MED. 247-67 (1989)). Cf. *Roy v. Hartogs*, 381 N.Y.S.2d 587 (1976) (male psychiatrist had sex with female patient ostensibly to cure her lesbianism).

54. See Michael W. Ross & Olli W. Stålström, *Exorcism as Psychiatric Treatment: A Homosexual Case Study*, 8 ARCHIVES OF SEXUAL BEHAV. 379 (1979) (discussing procedures conducted in 1976).

55. MURPHY, *supra* note 17, at 520 (citing JONATHAN NED KATZ, GAY/LESBIAN ALMANAC (1983), and ROBERT KRONMEYER, OVERCOMING HOMOSEXUALITY (1980)).

56. *Id.* at 507 (internal quotation marks and citation omitted). See also KATZ, *supra* note 11, at 194-96 (reprinting Michael M. Miller, *Hypnotic-Aversion Treatment of Homosexuality*, 55 J. NAT’L MED. ASS’N 411-13 (1963)).

57. Murphy, *supra* note 17, at 508.

58. Of course, “psychoanalysis *per se* is neither gay-affirming nor condemning, although practitioners may fall into either of these categories.” Jack Drescher, *I’m Your Handyman: A History of Reparative Therapies*, 36 J. HOMOSEXUALITY 19, 39 (1998).

59. WINICK, *supra* note 47, at 31.

60. *Id.*

conflicts that supposedly cause homosexuality.”<sup>61</sup> Bieber’s approach “involved that long course of self-examination and interpretation that is the hallmark of psychoanalysis.”<sup>62</sup>

One variant popular today among practicing conversion technicians is so-called “reparative therapy.” “[D]epart[ing] from strict psychoanalytic technique,”<sup>63</sup> reparative therapy “is pro-active and more involving of the therapist.”<sup>64</sup> As summarized by its progenitor, Joseph Nicolosi,

[o]ne of the first goals in [reparative] therapy is to clarify the family dynamics that may have led to a man’s homosexual condition. Making peace with father is one early issue. Preliminary treatment goals include growth in self-acceptance and an alleviation of excessive guilt. There is considerable discussion of gender difference, and an acknowledgment of the empowering effects of growing fully into one’s gender. Growing out of the false self of the compliant “good little boy” is a goal for many clients. There are many initiatory challenges for ego-strengthening and self-assertion. In group therapy the client is challenged to develop self-assertion through effective verbalization. Male bonding is an especially important goal through the development of mutuality in nonerotic same-sex friendships.<sup>65</sup>

Finally, it is important not to overlook expressly religion-based conversion efforts, which are today practiced by numerous “‘ex-gay’ ministries.”<sup>66</sup> These are “pastoral care providers or Christian support groups whose aim is to re-orient gay men and lesbians” by “divest[ing] the individual of his or her ‘sinful’ feelings or at least . . . mak[ing] the pursuit of a heterosexual or celibate lifestyle possible.”<sup>67</sup> “Exodus International, the largest transformation network, has 100 referral agencies around the world . . . .”<sup>68</sup> Exodus maintains that

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61. Douglas C. Haldeman, *The Practice and Ethics of Sexual Orientation Conversion Therapy*, 62 J. CONSULTING & CLINICAL PSYCHOL. 221, 222 (1994) (citing IRVING BIEBER, HARVEY J. DAIN, PAUL R. DINCE, MARVIN G. DRELLICH, HENRY G. GRAND, RALPH H. GUNDLACH, MALVINA W. KREMER, ALFRED H. RIFKIN, CORNELIA B. WILBUR & TOBY B. BIEBER, *HOMOSEXUALITY: A PSYCHOANALYTIC STUDY* (1962)).

62. Murphy, *supra* note 17, at 508.

63. SATINOVER, *supra* note 10, at 184.

64. *Id.* (quoting Joseph Nicolosi, *Intervention Techniques of Reparative Therapy*, Address to the Second National NARTH Conference (May 20, 1993)).

65. NICOLOSI, *supra* note 16, at xviii.

66. See, e.g., Lou Chibarro, Jr., *Anti-Gay Conference Slated for Georgetown*, WASH. BLADE, May 30, 1997, at 8.

67. Haldeman, *supra* note 61, at 224.

68. Yonat Shimron, *The Quest for “Transformation”: Can Faith Make Gays Go Straight?*, THE NEWS & OBSERVER Aug. 4, 1997. Jeffrey Satinover asserts that Exodus “represent[s] over two hundred separate ministries nationwide . . . .” SATINOVER, *supra* note 10, at 200. In at least one place Exodus itself claims “[o]ver 95 U.S. member ministries and applicants.” Exodus Int’l, *Exodus Organizational*

Christ offers a healing alternative to those with homosexual tendencies. Exodus upholds redemption for the homosexual person as the process whereby sin's power is broken, and the individual is freed to know and experience true identity as discovered in Christ and His Church. That process entails the freedom to grow into heterosexuality.<sup>69</sup>

Other religion-based groups include Evergreen International,<sup>70</sup> Desert Stream Ministries, Love in Action International, Transformation Ex-Gay Christian Ministries, and Homosexuals Anonymous (HA).<sup>71</sup> HA, "a Christian fellowship of men and women who have chosen to help each other to live free from homosexuality,"<sup>72</sup> holds that "the grace of God through Christ brings freedom and recovery from the spiritual, psychological and relational distortions of homosexuality."<sup>73</sup> It uses a fourteen-step approach that is adopted from Alcoholics Anonymous' twelve-step program<sup>74</sup> and includes "steps" such as "admitt[ing] that we were powerless over our homosexuality and that our emotional lives were unmanageable" and "learn[ing] to claim our true reality that as humankind, we are part of God's heterosexual creation and that God calls us to rediscover that identity in Him through Jesus Christ."<sup>75</sup>

The psychic, primarily verbal conversion techniques in current circulation avoid the appearance of outright torture that marked many past prac-

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*Details* (visited Apr. 1, 1999) <<http://www.messiah.edu/hpages/facstaff/chase/h/exodus/exodinfo.htm>>. But see Kyle Young, *The Ex Files: A Former Follower Sheds the Light on Ex-Gay Ministries* (visited Apr. 1, 1999) <<http://www.outsmartmagazine.com/exex.html>> (reprinted from OUTSMART) (on file with author) (recounting research conclusion, disputed by Exodus, that "[b]y early 1995, Exodus had started 210 different agencies around the [U.S.] since its inception [but] only 63 agencies remained").

69. Exodus Int'l, *Policy Statement* (visited Apr. 1, 1999) <<http://www.messiah.edu/hpages/facstaff/chase/h/exodus/doctrin.htm>>.

70. See Carrie A. Moore, *People Who Struggle to Overcome Same-sex Attraction Find Safe Haven: Evergreen International Says Spirituality Is a Tool It Uses to Change Lives*, DESERET NEWS (Salt Lake City), Sept. 6, 1997, at E2.

71. See *Christian Ministries for People Wanting Help in Dealing with Homosexuality* (visited Apr. 1, 1999) <<http://www.messiah.edu/hpages/facstaff/chase/h/helplis.htm>>.

72. Homosexuals Anonymous, *About HAFS* (visited Apr. 1, 1999) <<http://members.aol.com/HAwebpage/AboutHA/AboutHA.html>>.

73. Homosexuals Anonymous, *Statement on the Healing of Homosexuality* (visited Apr. 5, 1999) <<http://members.aol.com/HAwebpage/AboutHA/AboutHA.html>>.

74. See SATINOVER, *supra* note 10, at 197-200; Homosexuals Anonymous, *Questions Frequently Asked HA* (visited Apr. 2, 1999) <<http://members.aol.com/HAwebpage/faq/faq.html>>.

75. Homosexuals Anonymous, *The Fourteen Steps of HA* (visited Apr. 1, 1999) <<http://members.aol.com/HAwebpage/14steps/14steps.html>>. Actually, step 6 is: "We learned to claim our true reality that as humankind, we are part of God's heterosexual creation and that God calls us to rediscover that identity in Him through Jesus Christ, as our faith perceives Him." *Id.* (emphasis added). This is apparently an attempt to retain some of the ecumenicism of Alcoholics Anonymous—which prescribes reliance on a higher power that need not be a Christian God—while maintaining an explicitly Christian identity.

tices.<sup>76</sup> Yet we should be wary of too readily distancing ourselves from our past, indeed our recent past, to reassure ourselves that we today have clearly advanced beyond the excesses of that past.<sup>77</sup> Like medical ethicist Timothy Murphy has concluded of sexual orientation research, contemporary conversion attempts should be regarded with “the suspicion that [their] purposes are not substantially different from those of a prevailing order that has not found an equitable place for gay people in its midst.”<sup>78</sup> This “suspicion” should lead people to regard with skepticism modern claims about homosexuality’s pathology and attendant treatability as well as claims of treatment efficacy, for such claims have been made before under heterosexual social circumstances that facilitated widespread acceptance of unscientific propositions about the teachings of sexual science.<sup>79</sup>

Much of the history recounted above could have come from a general history of psychiatry, one not focusing on homosexuality, and I do not mean to say that systemic abuse by one field of medicine of one group of people ought to forever disbar professionals in that field from serving that group. Such an approach could, for example, rule women patients entirely out of psychiatry’s realm, depriving many people of legitimate help that neither is intended nor has the effect of reinforcing their subordinated position in society. But unwarranted pronouncements of the psychopathology of homosexuality<sup>80</sup> long afforded a scientific rationalization for the abjection of les/bi/gay people.<sup>81</sup> To avoid repeating these injustices in a setting

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76. See, e.g., BAYER, *supra* note 31, at 103 (recounting les/bi/gay activists’ interruption of a presentation of aversive techniques at the 1970 APtA convention with “[s]houts of ‘vicious,’ ‘torture!’”); *id.* at 115 (describing organizing flier entitled “Torture Anyone?”); *Pitcherskaia v. INS*, 118 F.3d 641 (9th Cir. 1997) (describing allegations of forced treatment, including psychotropic and electric shock procedures, of lesbians in Russia).

77. Cf. Reva Siegel, *Why Equal Protection No Longer Protects: The Evolving Forms of Status-Enforcing State Action*, 49 STAN. L. REV. 1111 (1997); Ann L. Stoler, *Racial Histories and Their Regimes of Truth*, 11 POL. POWER & SOC. THERAPY 183 (1997).

78. MURPHY, *supra* note 27, at 225.

79. See *infra* Part II.A.

80. See *id.*

81. Part of this shameful history, that dealing specifically with psychoanalysis, is described by Kenneth Lewes:

[S]uspicious and distrust of psychoanalysis are, in many ways, well founded . . . [T]oo many analysts have violated basic norms of decency in their treatment of homosexuals . . . [H]omosexuals have been and continue to be the victims of prejudice and discrimination both subtle and blatant. While the deepest roots of this animus lie in intrapsychic fears and defensiveness, the intellectual rationalizations that have been invoked to justify such unreasoning hatred and fear have frequently been psychoanalytic in nature. Official discriminatory immigration policies, the slow and grudging governmental response to the AIDS epidemic, and the vulnerability many homosexuals must suffer on their jobs have all been justified by recourse to psychoanalytic ideas, and analysts, for their part, have generally been content to have their work misunderstood and pressed into the service of prejudice.

where les/bi/gay persons are still discriminated against and attacked because of sexual orientation, people should in contests over the validity and ethics of sexual orientation conversion efforts be prepared in the face of inconclusive judgments to adopt a posture of doubt toward those who would defend the efficacy and morality of these latest conversion methodologies—and their defense is necessary as the disputes rage on.

## II. FAILED EFFORTS TO MAKE “HOMOSEXUALS” SICK

Although the “talk therapies” offered by some psychologists, psychiatrists, and psychoanalysts as well as by religion-based groups may seem less intrusive than their more physical counterparts, they are far from uncontroversial, occasioning impassioned and sometimes acrimonious debates. In the past few years the American Psychiatric Association and the American Psychological Association have both been pressed to take positions on the ethics of attempting sexual orientation conversion. One recent episode in this saga occurred on August 14, 1997 when the APIA adopted a Resolution on Appropriate Therapeutic Responses to Sexual Orientation.<sup>82</sup> As summarized in the APIA’s press release on the resolution, the organization affirmed or reaffirmed<sup>83</sup> “four basic principles,” the first of which is that “homosexuality is not a mental disorder . . . and the AP[1]A opposes all portrayals of lesbian, gay and bisexual [people] as mentally ill [and in need of treatment] due to their sexual orientation . . . .”<sup>84</sup> This position was not

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That groups of homosexuals see the analytic community as aligned with those who seek to legitimate prejudice and hatred is understandable, and the historian must acknowledge the substantial reasons for this view.

LEWES, *supra* note 12, at 21.

82. See American Psychol. Ass’n, *Resolution on Appropriate Therapeutic Responses to Sexual Orientation*, Aug. 14, 1997.

83. See *id.* The vast majority of the principles affirmed by the resolution had already been articulated elsewhere, for example in American Psychol. Ass’n, *Ethical Principles of Psychologists and Code of Conduct*, 47 AM. PSYCHOLOGIST 1597 (1992).

84. American Psychol. Ass’n, *APA Council of Representatives Passes Resolution on Appropriate Therapeutic Responses to Sexual Orientation: Resolution Reaffirms Psychology’s Opposition to Homophobia and Client’s Rights to Unbiased Treatment*, Aug. 14, 1997 (on file with author). The other principles are that “psychologists do not knowingly participate in or condone unfair discriminatory practices [with Lesbian, Gay and Bi-sexual clients]”; that “psychologists respect the rights of individuals, including Lesbian, Gay and Bi-sexual clients, to privacy, confidentiality, self-determination and autonomy”; and that “psychologists obtain appropriate informed consent to therapy [in their work with Lesbian, Gay and Bi-sexual clients.]” *Id.*

This measure did not declare sexual reorientation efforts to be unethical, leading some to “criticize the APA’s failure to plainly condemn the practice.” Rick Weiss, *Psychologists’ Society Adopts Resolution Seeking to Limit Gay “Conversion” Therapy*, WASH. POST, Aug. 15, 1997, at A14. It still incensed some pro-conversionists, however. See, e.g., NARTH, *NARTH’s Response to: The American Psychological Association’s “Resolution on Appropriate Therapeutic Responses to Sexual Orientation”* (Aug. 14, 1997) and APA Public Affairs Office: “Resolution: Questions and Answers” (Aug. 14, 1997)

a *fin de siècle* innovation. Since the 1970s the American Psychological Association and the American Psychiatric Association have held that lesbian, gay, and bisexual people are not mentally ill merely because of their sexual orientation.<sup>85</sup>

In contrast to the position of the APIA, however, the National Association for the Research and Treatment of Homosexuality (NARTH) maintains that “homosexuality” is a “sexual disorder[.]”<sup>86</sup> More colorfully, NARTH President Charles Socarides characterizes homosexuality as “a psychological and psychiatric disorder, . . . a purple menace.”<sup>87</sup>

While homosexuality’s being a mental disorder is neither a necessary nor a sufficient condition for the propriety of sexual reorientation, it is a relevant factor. If “homosexuality” were properly considered a mental disorder, that would seem to constitute a *prima facie* case for the propriety of attempting sexual orientation conversion with voluntary patients.

Moreover, the question of homosexuality’s pathology or lack thereof bears legal significance for other reasons. A belief that homosexual people were mentally ill served for many years as the basis for excluding les/bi/gay people from immigrating to the U.S. under a provision in the immigration laws that excluded non-citizens “afflicted with psychopathic personality.”<sup>88</sup> In the 1967 case *Boutilier v. INS*, the U.S. Supreme Court held that the provision included gay men,<sup>89</sup> and Congress did not repeal this exclusion until 1990.<sup>90</sup> A similar belief is still held in some countries,<sup>91</sup> which can and has given rise to coerced “treatment” and attendant

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(visited Apr. 1, 1999) <<http://www.narth.com/docs/apa-response.html>>; John Paulk, *Letter: Gay Subculture Convinces Man That He Is Gay; Therapy Overturns Concept*, OREGONIAN (Portland), Aug. 31, 1997, at E5. Joseph Nicolosi, for instance, called it “intimidating and discouraging.” Weiss, *supra* note 18, at A8 (quotation marks omitted).

85. See, e.g., American Psychol. Ass’n, *APA Policy Statements on Lesbian and Gay Issues* (visited April 1, 1999) <<http://www.apa.org/pi/statemen.html>> (recounting January 1975 decision of APIA’s governing body endorsing APTA’s December 1973 removal of homosexuality from its official list of mental disorders).

86. NARTH, *Statement of Policy* (visited April 1, 1999) <<http://www.narth.com/statement.html>>.

87. Weiss, *supra* note 18, at A8.

88. Immigration and Nationality Act of 1952 § 212(a)(4), 8 U.S.C. § 1182(a)(4) (1952), quoted in *Boutilier v. INS*, 387 U.S. 118, 118 n.\* (1967).

89. *Boutilier*, 387 U.S. at 118.

90. See Immigration Act of 1990, 104 Stat. 4978, 5067.

91. See, e.g., Scott Sleek, *Chinese Psychiatrists Debate Meaning of Sex Orientation: APA Backs Effort to End Discrimination Against Homosexuals*, AM. PSYCHOL. ASS’N MONITOR, Sept. 1998, at 33 (noting that, while “Chinese psychiatrists have recently opened debate about the classification of homosexuality in the Chinese Classification of Mental Disorders,” nonetheless “China’s medical community—not to mention its general public—widely brand [sic] gay men, lesbians and bisexuals as mentally ill”); Aras van Hertum, *Many Psychiatrists Still See Homosexuality as an Illness*, WASH. BLADE, Sept.



claims of persecution and requests for asylum.<sup>92</sup> For these reasons, including the relevance of the characterization of homosexuality to the propriety of attempting sexual orientation conversion, this Part considers arguments about whether homosexuality should or should not be considered a mental disorder.

Section A below briefly considers the general question, what is mental illness? Section B then affirms the modern psy-professional organizations' determination that, various flawed studies notwithstanding, homosexuality is not a mental disorder. Section C provides a brief glance at the fundamentally circular claims of some conversionists that homosexuality's root causes render it disordered. Finally, Section D addresses certain theoretical arguments for the disordered nature of homosexuality popular with some conversionists. Section D argues that these approaches are grounded in a prescriptive view of "natural" gender differences, an ideology that is not a proper basis in contemporary U.S. society to ground a judgment of mental illness.<sup>93</sup> Thus, one possible reason for attempting sexual reorientation and eschewing restrictive regulation of orientation conversion efforts—that they are ways of treating a mental illness—is not available, and it will be necessary to consider different arguments about regulation in Part III.

#### A. WHAT MAKES A PERSON MENTALLY ILL

The issue of what constitutes a mental illness (or how to define "mental illness") has been and remains a point of tremendous contention within the psy-professions;<sup>94</sup> indeed, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) confesses forthrightly "that no definition adequately specifies precise boundaries for the concept of 'mental disorder.'"<sup>95</sup> On one side of the debate are people such as Thomas Szasz, whose 1960 article *The Myth of Mental Ill-*

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17, 1993, at 31 (reporting that, in response to survey by the APTA, "[p]sychiatric groups in Belarus, Brazil, China, India, Poland, Romania, Spain, and Venezuela said most psychiatrists in these countries still consider homosexuality to be an illness.").

92. See, e.g., *Pitcherskaia v. INS*, 118 F.3d 641, 644 (9th Cir. 1997) (describing allegations of forced treatment, including psychotropic and electric shock procedures, of lesbians in Russia).

93. Accepting for purposes of argument that there are, properly speaking, conditions that are mental illnesses, Section D argues that deviations from prescriptive gender norms are not properly a mental illness. The argument therefore need not and does not take a position on the foundational issue of whether there are *any* mental illnesses.

94. Cf. AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* xxi, xvi (4th ed. 1994) ("The need for a classification of mental disorders has been clear throughout the history of medicine, but there has been little agreement on which disorders should be included . . .").

95. *Id.* at xxi.

ness<sup>96</sup> and 1961 book by the same title,<sup>97</sup> whether endorsed or repudiated, have been tremendously influential in American psychiatry.<sup>98</sup> Szasz believes that there is no such thing as mental illness, that such terminology is metaphorical and refers to people who engage in socially undesirable behaviors.<sup>99</sup> Psychiatric diagnostic categories and mental illnesses thus are created, made up, by psy-professionals, not discovered by them in some apolitical, value-free process.<sup>100</sup>

On the other side are arrayed people holding diverse beliefs about mental illness while maintaining that there properly are mental illnesses. However, members of this group might not and often do not agree on what should count as a mental illness, or what diagnostic categories should be recognized based on what principles. Attempts to define "mental illness" are thus legion.<sup>101</sup> "[V]arying criteria have been used to define mental illness, including deviation from statistical and/or social norms, the use of psychological theory, and the presence of a patient's subjective discomfort."<sup>102</sup> Perhaps the most widely used definition, that of the DSM-IV, treats a mental disorder as

96. Thomas S. Szasz, *The Myth of Mental Illness*, 15 AMER. PSYCHOLOGIST 113 (1960).

97. THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (rev. ed. 1974) (1961).

98. See Eric J. Dammann, "*The Myth of Mental Illness*": *Continuing Controversies and Their Implications for Mental Health Professionals*, 17 CLINICAL PSYCHOL. REV. 733, 733-34 (citing E. Fuller Torrey, *quoted in ONE ON ONE: CONVERSATIONS WITH THE SHAPERS OF FAMILY THERAPY* 61 (R. Simon ed., 1992)).

99. "This does not mean there is no such thing as suffering . . . However, it is how we label these behaviors, and the consequences of labeling, that are his main concerns." *Id.* at 736.

100. For work influenced by Szasz, see, e.g., Henry B. Adams, "*Mental Illness*" or *Interpersonal Behavior?*, 19 AM. PSYCHOLOGIST 191 (1964); Ronald Leifer, *The Medical Model as Ideology*, 9 INT'L J. PSYCHIATRY 13 (1971); R.H.S. Mindham et al., *Diagnoses Are Not Diseases*, 161 BRIT. J. PSYCHIATRY 686 (1992); Theodore R. Sarbin, *On the Futility of the Proposition That Some People Should Be Labeled "Mentally Ill,"* 31 J. CONSULTING PSYCHOL. 447 (1967).

101. See, e.g., BLACK'S LAW DICTIONARY 794, 986 (6th ed. 1990) (defining "insanity" as "a social and legal term rather than a medical one" "more or less synonymous with mental illness or psychosis."); Dammann, *supra* note 98, at 738 (quoting WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 648 (1986)) (defining "mental disease" as "'a disease characterized by mental symptoms,'" where "disease" means either "'an impairment of the normal state of the living animal . . . body or of any of its components that interrupts or modifies the performance of vital functions being a response to environmental factors . . . , to specific infective agents . . . , to inherent defects of the organism . . . , or to a combination of these factors'" or "'disorder or derangement (as of the mind, moral character, public institutions, or the state)."); Samuel B. Guze, *Nature of Psychiatric Illness: Why Psychiatry Is a Branch of Medicine*, 19 COMPREHENSIVE PSYCHIATRY 295, 296 (1978), *quoted in* Dammann, *supra* note 98, at 739 (contending that "any condition associated with discomfort, pain, disability, death, or an increased liability to these states, regarded by physicians and the public as properly the responsibility of the medical profession, may be considered a disease").

102. Dammann, *supra* note 98, at 737-38 (internal citations omitted).

a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.<sup>103</sup>

The DSM cautions, however, that “[n]either deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual . . . .”<sup>104</sup>

What is reasonably clear to most practitioners is that there can be no value-free approach to the issue.<sup>105</sup> This is not surprising, for “the notion of disease is, in varying degrees, always value-laden, even outside of psychiatry.”<sup>106</sup> The question remains, what role should values (and which values) play in definitions of mental illness?

In light of “the wide range of phenomena that can be subsumed under the rubric of ‘mental illness,’” and the fact that so far even within the professions there is no “consensus on what constitutes illness,”<sup>107</sup> this Article does not offer a comprehensive answer to the question of value use in mental illness definition, for such a treatment is not necessary to the argument. Given that a judgment of mental illness is a restriction on ways of being in the world that are considered normal or healthy, the burden rests in the first instance on those who would treat some conditions or ways of being as mental illnesses to offer convincing reasons that are rationally persuasive for so classifying them.<sup>108</sup> The examination in the following three

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103. AMERICAN PSYCHIATRIC ASS’N, *supra* note 94, at xxi.

104. *Id.* at xxii.

105. See, e.g., Dammann, *supra* note 98, at 739 (noting that it is “impossible” for psychiatry to “be value neutral” because it “is always somewhat subjective”); Linda Ames Nicolosi, *The Myth of a Value-Free Psychology*, at 7 (visited Apr. 1, 1999) <<http://www.narth.com/docs/myth.html>> (“Instead of claiming to be ‘neutral,’ and dismissing those with an explicit moral philosophy as ‘biased,’ the psychological profession must acknowledge that there are values inherent in any system which attempts to guide human lives.”). Cf. BAYER, *supra* note 31, at 179-80 (“Efforts on the part of psychiatrists to articulate a theory of mental health . . . by which to evaluate behavior have been marked by unmistakably normative assertions regarding the appropriate relationship between the healthy individual and the society in which he or she lives.”); *id.* at 181 (“Even psychiatrists unwilling to assent to [Fritz] Redlich’s more global propositions have been forced to acknowledge that at least with regard to the ‘character disorders,’ social values play a significant role.”).

106. Dammann, *supra* note 98, at 738. Cf. BAYER, *supra* note 31, at 186 (stating that concepts of mental health and illness are intimately linked to the prevailing sociocultural standards of appropriate behavior).

107. Dammann, *supra* note 98, at 740.

108. I therefore need not affirmatively establish that homosexuality is “normal” or “mentally healthy,” for that should be the default assumption for any condition at least in the absence of a compelling prima facie case to the contrary.

Sections of the types of secular arguments that have been made for why homosexuality should be considered a mental illness provides negative arguments, partial constraints limiting in some ways what should count as an acceptable argument for establishing even provisionally that something is a mental illness. These suffice to show the inadequacy of the arguments that have been made for homosexuality's pathology, so that it may properly be concluded that homosexuality is not a mental illness.

#### B. THE DEPATHOLOGIZATION OF HOMOSEXUALITY

Before the APTA decided in 1973 to remove homosexuality from the DSM, its official roster of mental illnesses, the most influential piece of evidence that it *was* a disorder was a study published in 1962 by psychoanalyst Irving Bieber and colleagues.<sup>109</sup> Reflecting ten years of work on the etiology of homosexuality in male analysands, “[this study] came to be regarded, shortly after its publication, as vindicating the psychoanalytic theory of male homosexuality. Almost every analytic writer . . . refer[red] to it approvingly, and [at least as of the late 1980s] it continue[d] to be read and taught in psychopathology courses in universities.”<sup>110</sup>

Although even in 1971 not all members of the APTA were followers of Bieber,<sup>111</sup> his study enjoys continued adherence by conversionists today<sup>112</sup> and is often invoked in support of generalizations about “homosexuals” or, only slightly more cautiously, “homosexual” males.<sup>113</sup> The study was, however, deeply flawed, and its acceptance as “evidence” for the psychopathology of homosexuality was not neutral, apolitical, or scientifically sound.<sup>114</sup>

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109. See BIEBER ET AL., *supra* note 61.

110. LEWES, *supra* note 12, at 206-07.

111. See BAYER, *supra* note 31, at 107.

112. See, e.g., Charles Socarides, *A Survey of Treatment Results* (visited Apr. 1, 1999) <<http://www.narth.com/docs/1996papers/socarides.html>>; NARTH, *supra* note 86 (characterizing study as “highly regarded . . . research”); Homosexuals Anonymous, *Can Homosexuals Change?* (visited June 28, 1999) <<http://members.aol.com/HAwebpage/change/change.html>>.

113. See, e.g., Joseph Nicolosi, *A Critique of Bem's E.B.E. Theory* (visited Apr. 1, 1999) <<http://www.narth.com/docs/critique.html>> (citing Bieber as supporting “the well-documented, poor father-son relationship for the male homosexual”) (emphasis added).

114. Cf. BAYER, *supra* note 31, at 144 (“[I]t has been the unscientific inclusion of homosexuality per se in a list of mental disorders which has been the main ideological justification for the denial of the civil rights of individuals whose only crime it is that their sexual orientation is to members of the same sex.”) (quoting Freedman et al., *PSYCHIATRIC NEWS*, Feb. 6, 1974, at 3).

As many critics have noted,<sup>115</sup> Bieber's sample of "homosexual" subjects consisted solely of men undergoing psychoanalysis. Thus, they were "preselected for psychopathology, so the question of the emotional disturbance of the homosexual population at large could not really be addressed."<sup>116</sup> Moreover, Bieber assumed from the outset that homosexuality was "psychopathic."<sup>117</sup> "Thus," as Kenneth Lewes succinctly notes, "beginning with the assumption that all homosexuals were disturbed and using a preselected disturbed sample, [Bieber] found that indeed all homosexuals were disturbed."<sup>118</sup> The scientific case for the per se psychopathology of homosexuality was thus shaky at best,<sup>119</sup> as some psychoanalysts recognized.<sup>120</sup>

In rejecting conclusions, such as Bieber's or Joseph Nicolosi's<sup>121</sup> that homosexuality was always a mental disorder, the APTA relied not only on pure methodological criticisms like that expressed by Lewes above, but also on implications from the empirical work of Evelyn Hooker.<sup>122</sup> Starting in the mid-1950s, Dr. Hooker studied gay men who were not seeking

115. See, e.g., LEWES, *supra* note 12, at 210 (discussing R. Friedman, *Psychodynamics and Sexual Object Choice III: A Reply to Drs. I. Bieber and C.W. Socarides*, 12 CONTEMP. PSYCHOANALYSIS 379 (1976)).

116. *Id.* at 209.

117. See *id.* at 210.

118. *Id.* Cf., e.g., Drescher, *supra* note 58, at 28 (quoting BIEBER ET AL., *supra* note 61, at 140-41, 319) (internal citations omitted). Drescher states:

The [1962 Bieber study's] authors' initial assumptions were consistent with the theory that they subsequently claimed to confirm: "We have selected the patient-mother-father unit for analysis . . . We believe that personality for the most part is forged within the triangular system of the nuclear family. It follows then that personality maladaptation must also be primarily rooted here." "We assume that heterosexuality is the biologic norm and that unless interfered with all individuals are heterosexual."

*Id.*

119. Cf. Gary Greenberg, *Right Answers, Wrong Reasons: Revisiting the Deletion of Homosexuality from the DSM*, 1 REV. GEN. PSYCHOL. 256, 260 (1997) ("This was not a scientific debate, at least as that term is normally understood. It was an ideological debate in which both sides took their conclusions as their premises to advance their cause.").

120. See LEWES, *supra* note 12, at 214-15.

121. See NICOLOSI, *supra* note 16. Nicolosi states:

The problem lies not in the person's attitude toward his homosexuality, but in the homosexuality itself. Although homosexuality may be compatible with the *conscious* ego, it can never be compatible on the deepest levels of self, for homosexuality is symptomatic of a failure to integrate self-identity. *Symptoms will always emerge* to indicate its incompatibility with the true self.

*Id.* at 8 (second emphasis added).

122. Cf. BAYER, *supra* note 31, at 49 ("It was Evelyn Hooker who . . . pioneered in a form of research that would in later years provide the richest source of material for those who challenged the assumption that homosexuality was a pathological condition."). In addition, "[a]mong the most important studies for" Robert Spitzer, leading member of the APTA's Nomenclature Committee that produced the recommendation for depathologizing homosexuality, was MARCEL SAGHIR & ELI ROBINS, *MALE AND FEMALE HOMOSEXUALITY: A COMPARATIVE INVESTIGATION* (1973). BAYER, *supra* note 31, at 206 n.54.

therapy. Her sample was not random; she compared gay and heterosexual men matched for age, I.Q. scores, and level of education, purposely “excluding from both groups those she considered manifestly pathological.”<sup>123</sup> Hooker discovered that people trained in interpreting projective psychological tests such as the Rorschach “were unable to distinguish the homosexuals from the heterosexuals in the matched pairs” and rated two-thirds of *each* group “as of average adjustment or better.”<sup>124</sup> These findings, dramatically different from the received “wisdom” about the supposed psychopathology of *the* homosexual, “stood as a challenge to orthodox psychiatric thinking about homosexuality.”<sup>125</sup> And the APtA met the challenge by removing homosexuality *per se* from the DSM.

Perhaps unsurprisingly given the lucrative practices, professional reputations, and other personal investments involved, that decision did not conclude consideration of the question whether homosexuality is a mental disorder. Rather, Hooker’s striking work notwithstanding, many critics have charged that the APtA’s decision to depathologize homosexuality was a political decision made by a professional organization cowed by gay activists.<sup>126</sup>

The more substantive of the common attacks on the decision often focus on the evidence relied on by the APtA leadership—including Hooker’s studies. Some conservative attacks<sup>127</sup> on Hooker’s work on projective psychological profiles<sup>128</sup> could perhaps be appropriate responses to more extreme readings of her work as affirmatively establishing that homosexuality was in fact “*normal*,” rather than simply not a mental illness within the

123. BAYER, *supra* note 31, at 50.

124. *Id.*

125. *Id.*

126. See, e.g., Charles W. Socarides, *Sexual Politics and Scientific Logic: The Issue of Homosexuality*, 19 J. PSYCHOHISTORY 307, 307, 315-17 (1992); BAYER, *supra* note 31, at 151 (“Those who opposed the nomenclature change believed that . . . those who voted to affirm [the decision to remove homosexuality from the DSM] were guilty of attempting to impose their own social values under the guise of science.”); SATINOVER, *supra* note 10, at 32 (“The APA vote to normalize homosexuality was driven by politics, not science.”).

127. See, e.g., Reuben Fine, *Homosexuality in the Male: A Report of a Psychiatric Study Group*, 11 INT’L J. PSYCHIATRY 460 app. A at 471 (1973); Toby B. Bieber, *id.* at app. AA at 475; Stanton L. Jones & Don E. Workman, *Homosexuality: The Behavioral Sciences and the Church*, 17 J. PSYCHOL. & THEOLOGY 213 (1989).

128. See, e.g., Evelyn Hooker, *The Adjustment of the Male Overt Homosexual*, 21 J. PROJECTIVE TECH. 18 (1957); Evelyn Hooker, *Male Homosexuality in the Rorschach*, 22 J. PROJECTIVE TECH. 33 (1958); Evelyn Hooker, *What Is a Criterion*, 23 J. PROJECTIVE TECH. 278 (1959); NATIONAL INST. OF MENTAL HEALTH, *HOMOSEXUALITY: FINAL REPORT AND BACKGROUND PAPERS* (1969).

meaning of the most common definitions.<sup>129</sup> Steven Goldberg, for example, argues that:

Professor Hooker *selected for* individuals who did not manifest any of a number of signs of pathology . . . . [T]o invoke this study as demonstrating that homosexuals demonstrate no greater pathology than heterosexuals is like selecting a sample of thirty six-foot-tall women and six-foot-tall men and concluding that women are as tall as men.<sup>130</sup>

But this criticism does not fatally undermine the value of Hooker's work for the negative case that "homosexuality" was not a mental illness. One need not claim that "homosexuals demonstrate no greater pathology than heterosexuals" to argue that lesbians and gay men *had not been empirically demonstrated* to be mentally ill.<sup>131</sup>

Suppose instead that the question at issue was whether femaleness is itself pathological. A showing that women as a group demonstrated more eating disorders than men as a group would not and should not be taken as showing that femaleness is pathological. In the face of claims that it was, research selecting for non-symptomatic females that showed equal non-pathology between the female subjects and the male subjects should not be understood as offered for support of the proposition that women and men as groups are equally afflicted with eating disorders. Rather, the research would quite properly suggest that femaleness is not itself a sufficient cause of pathology.<sup>132</sup> If the "women are pathological" camp then tried to claim that femaleness is pathological but for complicated and not well understood reasons some females manifest no symptoms, it would be reasonable (especially given the sordid history of psychiatry's complicity in the subordination of women) to suspect that this approach presupposes the pathology of femaleness that it sets out to establish, since symptoms alone do not make its case.

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129. See, e.g., Joseph Berger, *A Critique of the Writings of Richard Isay* (visited Apr. 1, 1999) <<http://www.narth.com/docs/1996papers/berger.html>> (asserting, without documentation, that "Hooker's claims are frequently cited as proof of the psychological 'normality' of homosexuals").

130. STEVEN GOLDBERG, *WHEN WISH REPLACES THOUGHT* 57 (1991), *quoted in* Linda Nicolosi, *Understanding How We Think About Homosexuality*, (visited July 1, 1999) <<http://www.narth.com/docs/howthink.html>>.

131. Cf. John C. Gonsiorek, *The Empirical Basis for the Demise of the Illness Model of Homosexuality*, in GONSIOROK & WEINRICH, *supra* note 36, at 119 [hereinafter *Demise of the Illness Model*] ("The illness model of homosexuality maintains that the existence of persistent homosexual feelings in an individual is *in and of itself* absolutely predictive of psychological disturbance. It is important to note that findings supportive of the existence of *any* group of homosexual individuals who are not psychologically disturbed refutes this model.")

132. Of course, this argument would not address claims that femaleness *by definition* is pathological. The next subsections consider arguments that homosexuality is a mental disorder by definition.

Indeed, this is close to the response of those arguing homosexuality's pathology, for what the research of Hooker and others did was reduce the issue to the question whether "homosexuality . . . is *in itself* an illness."<sup>133</sup> The issue thus was whether homosexuality could properly be classified as a mental illness without regard to symptoms or consequences, but merely as a result of *what it is*, for as Jud Marmor summarized relatively shortly after the APtA removal of "homosexuality" from the DSM, "[m]any homosexuals, both male and female, function responsibly and honorably, often in positions of the highest trust, and live emotionally stable, mature and well-adjusted lives, psychodynamically indistinguishable from well-adjusted heterosexuals, except for their alternative sexual preferences [sic]."<sup>134</sup>

### C. CAUSAL THEORIES OF DISORDER

It was and is not now possible to responsibly tar all lesbian, gay, and bisexual people as mentally ill on the basis of symptomatic factors such as psychological well-being or unimpaired cognitive functioning. Unsurprisingly, various psychodynamic theories contend that homosexuality is a disorder due to its being rooted in pathological causes. As mentioned earlier, this Article does not focus primarily on causation of homosexuality. It would consume far too many pages to detail the range of theories purporting to derive conclusions of the psychopathology of homosexuality from supposed etiologies. But anyone assessing the characterization of homosexuality as a mental illness should not entirely overlook these causal theories, which have played an important role in more modern U.S. psychoanalytic theory and practice and form the "scientific" basis for many of the "ex-gay" ministries that have so recently purchased their way to public prominence.<sup>135</sup> The predominating problem with most, if not all, such theories is their circularity, that is, the heteronormative premises that are built into the analyses.

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133. Richard Green, *Homosexuality as a Mental Illness*, 10 INT'L J. PSYCHIATRY 77, 90 (1972), quoted in Greenberg, *supra* note 119, at 260.

134. LEWES, *supra* note 12, at 215 (quoting Jud Marmor, *Sexual Disorders: Homosexuality and Sexual Orientation Disturbances*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY (A. Freedman & H. Kaplan eds., 2d ed. 1975)).

135. See, e.g., Homosexuals Anonymous, *supra* note 112 (quoting, in section captioned "What Went Wrong?," secular psy-professionals' conclusions about family dynamics of les/bi/gay persons); Bob Davies & Lori Rentzel, *Roots of Homosexuality* (visited June 28, 1999) <<http://www.messiah.edu/hpages/facstaff/chase/h/articles/roots.htm>> (contending that "family dynamics . . . strongly shape a person's sexual identity") (excerpted from BOB DAVIES & LORI RENTZEL, COMING OUT OF HOMOSEXUALITY (1993)); Alan P. Medinger, *Healing Growth: Breaking the Link* (visited June 28, 1999) <<http://www.messiah.edu/hpages/facstaff/chase/articles/regenera/11.htm>> (relying on Elizabeth Moberly's family dynamics theory of homosexual etiology) ("published by Regeneration, Inc., a non-profit, tax-exempt Christian ministry . . .").



Eve Kosofsky Sedgwick has noted such bias in recent biological accounts of homosexuality. Professor Sedgwick observes that biological etiological claims about the origins of homoeroticism are “invariably couched in terms of ‘excess,’ ‘deficiency,’ or ‘imbalance’—whether in the hormones, in the genetic material, or, as is currently fashionable, in the fetal endocrine environment.”<sup>136</sup> How can these factors be deemed deficient or imbalanced, rather than merely *less* in magnitude or *different* in proportion, unless there is already a norm in place? Distributions are descriptive, and a mere statistical deviation from the most common biofactors cannot, without some normative standard, ground judgments of inadequacy sufficient to justify denominating any associated mental conditions “disordered.” A pre-existing norm of heterosexuality is necessary to maintain that a statistical deviation of a certain magnitude marks a *disorder* of sexual orientation rather than simply a *difference*.

Similarly, psychological environmental theories of homosexual disorder underlying psychoanalytic and “reparative” conversion efforts incorporate heteronormative premises. These kinds of theories maintain that the causes of the mental disorder contributing to homosexuality lie in early family interactions. These supposed causes typically involve poor relationships with mothers and/or fathers<sup>137</sup>—referred to by some as “[t]he homo-

136. Sedgwick, *supra* note 14, at 79. See, e.g., Mark F. Schwartz & William H. Masters, *The Masters and Johnson Treatment Program for Dissatisfied Homosexual Men*, 141 AM. J. PSYCHIATRY 173, 173 (1984) (“Excess fetal androgenization . . . has been implicated as an etiologic factor in predisposing homosexual preference”). Cf. Eugenia Kaw, *Medicalization of Racial Features: Asian-American Women and Cosmetic Surgery*, 7 MED. ANTHROPOLOGY Q. 74, 81 (1993) (“For instance, many patients were told that they had ‘excess fat’ on their eyelids and that it was ‘normal’ for them to feel dissatisfied with the way they looked.”). Kaw argues that “[b]y using words like ‘without,’ ‘lack of,’ ‘flat,’ ‘dull,’ and ‘sleepy’ in his description of Asian features, Dr. Smith perpetuates the notion that Asian features are inadequate.” *Id.* Another example of such “metaphors of inadequacy or excess” comes from a 1990 book on cosmetic surgery on Asian faces, where the author claims that “certain facial features do form a distinct basis for surgical intervention . . . . These facial features typically include the upper eyelid, characterized by an *absent or poorly defined* superior palpebral fold . . . and a small *flattened* nose with poor lobular definition.” *Id.* at 82 (quoting John A. McCurely, *Cosmetic Surgery of the Asian Face* 1 (1990)) (emphases added).

137. See, e.g., NICOLOSI, *supra* note 16, at xvi (“[T]he homosexual condition is a developmental problem—and one that often results from early problems between father and son. Heterosexual development necessitates the support and cooperation of both parents as the boy disidentifies from mother and identifies with father. Failure in relationship with father may result in failure to internalize male gender-identity.”). Nicolosi states:

As a consequence of his early sense of rejection by father [sic] and resulting defensive detachment from masculinity, the homosexual carries a sense of weakness and incompetence with regard to those attributes associated with masculinity, that is, power, assertion, and strength. He is attracted to masculine strength out of an unconscious striving toward his own masculinity. At the same time, because of his hurtful experience with father, he is suspicious of men in power. Homosexual contact is used as an erotic bridge to gain entry into the special male world.

sexogenic family environment”<sup>138</sup>—or sometimes poor heterosexual interactions.

But “causes” of these sorts ought not be deemed sufficiently pathological that any of their consequences (such as, supposedly, homosexuality) are pathological. Rather, these causal theories depend on prior judgment that the consequences of the causes are disordered. As Gerald Davison explains:

For example, Bieber et al. found that what they call a “close-binding intimate mother” was present much more often in the life of the analytic male homosexual patients than among the heterosexual controls. But what is wrong with such a mother unless you happen to find her in the background of people whose current behavior you judge *beforehand* to be pathological?<sup>139</sup>

These causal theories are thus unpersuasively circular, purporting to deduce the psychopathology of homosexuality from unstated premises of homosexuality’s psychopathology.

#### D. DISORDERS OF GENDER BY DEFINITION

Some theories of disorder take gender, rather than homosexuality, as their basic unit of analysis. These approaches avoid facially circular derivations of the “problem(s)” of homosexuality based upon negative normative premises about homosexuality. Yet their foundations do not succeed in demonstrating that homosexuality should be considered disordered, for these theories are premised on a prescriptive view of gender that is inappropriate, in light of the gender-egalitarian norms of contemporary U.S. society, as a ground for judgments of mental illness.

##### 1. *The Normative Nature of the Gender Disorder Argument*

Conversionist Joseph Nicolosi and others argue that homosexuality is disordered because it “disregards” what they see as the “natural” “reality” of the gendered order of the world, independent of human cultures or values. Part of their argument makes teleological claims about sexuality

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*Id.* at 103. See also, e.g., Socarides et al., *supra* note 11, at A12 (maintaining that “the disorder [i.e., homosexuality] is characterized by a constellation of symptoms, including excessive clinging to the mother during early childhood”).

138. Socarides, *supra* note 126, at 319.

139. Gerald C. Davison, *Construction and Morality in Therapy for Homosexuality*, in GONSIORREK & WEINRICH, *supra* note 36, at 141 (1991).

grounded in reproduction, and part of the argument relies on a prescriptive view of gendered social orderings.<sup>140</sup>

For example, Nicolosi relies on a robust view of gendered “reality” to conclude that homoeroticism is inherently pathological. Based on his evaluation of an unspecified “majority” of his clinical patients,<sup>141</sup> he believes that homosexual males suffer a “deficit in male gender-identity,” that is, of “a man’s awareness—both conscious and unconscious—that he is masculine or manly.”<sup>142</sup> They recognize that they *are* male, yet “there remains a private and subjective sense of simply not feeling fully male-identified.”<sup>143</sup> Nicolosi is quick to insist that this deficit is not merely a matter of failure to conform to crass stereotypes of masculinity. “Rather, it refers to an inadequacy in the inner sense of maleness or femaleness, . . . the internal, private sense of incompleteness or inadequacy about one’s maleness.”<sup>144</sup>

Of course, this raises the question how the supposed “deficit” is to be assessed. Nicolosi recognizes this obstacle when he states that “[m]any scales [for measuring gender identity] have been criticized for confusing gender-role and gender-identity” and concedes that “it is difficult to sort out culturally stereotypic notions of male and female from the inner experience of gender-identity.”<sup>145</sup> Yet in the end he offers no way out of this difficulty, no definition of maleness or masculinity free of cultural prescription.<sup>146</sup>

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140. The latter is true as well of some writings of Socarides, for example, who does not think that “heterosexuality” is “natural” but must be institutionally and adaptationally inculcated in human society. See, e.g., Charles Socarides, *Exploding the Myth of Constitutional Homosexuality* (visited Apr. 15, 1999) <<http://www.narth.com/docs/exploding.html>> (“In man, heterosexual object choice is neither innate nor instinctual; neither is homosexual object choice or any other perverse behavior—all are learned . . . [H]eterosexual functioning is outlined from birth by anatomy and then reinforced by cultural and environmental indoctrination and buttressed—until recently—by a social system of rewards and punishments.”).

141. See NICOLOSI, *supra* note 16, at 22.

142. *Id.* at 94.

143. *Id.*

144. *Id.* at 95. Nicolosi at least recognizes that some “homosexual men” do not suffer this lack, though the generalizations about “the homosexual” in his work are largely unmarred by attention to this complicating fact. See *id.* at 96.

145. *Id.* at 95.

146. Thus, for example, he insists that “[s]exuality and aggression characterize *the* masculine identity.” *Id.* at 243 (emphasis added). Similarly, Elaine Siegel, who has made a name for herself in the analysis of female homosexuality, regards as symptomatic of developmental arrest her women patients’ failure as children to play with dolls and their “substitut[ion]” of the sorts of physical activity deemed appropriate for boys. ELAINE V. SIEGEL, *FEMALE HOMOSEXUALITY: CHOICE WITHOUT VOLITION—A PSYCHOANALYTIC STUDY 5* (1988).

Nevertheless, Nicolosi maintains that this psychic gender deficit is grounded in denial of biological realities. "To believe in the concept of a *gay identity as valid*, a person must necessarily deny significant aspects of human reality."<sup>147</sup> According to Nicolosi, "the boy who is sensitive, passive, gentle, and esthetically oriented may be most susceptible to retreat from the developmental challenge to gender-identify with his father."<sup>148</sup> Unable to accept his maleness yet not female, this boy supposedly decides: "I will remain in my own androgynous world, my secret place of fantasy."<sup>149</sup> And, Nicolosi maintains, "[t]his fantasy contains within it, not only the narcissistic refusal to identify with a gendered culture, but also the refusal to identify with the *human biological reality* upon which our gendered society is based."<sup>150</sup> This supposed refusal to acknowledge the biological reality of gender dimorphism has also been attributed to lesbians undergoing analysis.<sup>151</sup>

This supposedly denied "biological reality" has enormous consequences for what is taken to be healthy human functioning. Some theologians such as C. David Hess are quite explicit about this:

The truth is, all of us, straight and gay, know fundamentally that the natural purpose of sex, though not the only one, is biological reproduction . . . . The homosexual knows that, in light of that most basic fact his or her sexuality is distorted, and he or she grieves over that. They grieve that they will never be able to know the full complementary love of a person of the opposite sex. They grieve that they can never have children.<sup>152</sup>

Setting aside the problematic notion of "opposite" sexes, the many gay and lesbian people who do have and raise children,<sup>153</sup> and use of the definite article when Hess concedes more than one purpose to sexual activity, it is clear that Hess claims to speak the truth about lesbians and gay men as a

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147. Joseph Nicolosi, *Gay as Self-Reinvention* (visited Apr. 15, 1999) <<http://www.narth.com/docs/selfreinvention.html>>.

148. *Id.*

149. *Id.*

150. *Id.*

151. See, e.g., SIEGEL, *supra* note 146, at 3.

152. C. David Hess, *Gays: No Easy Answers . . . A Christian Response*, 1 GAY THEOLOGICAL J. 32, 33 (Jan./Apr. 1998). Cf. Ann E. Kornblut, *Boston Doctor Says Ads Distort His Work on Gays*, BOSTON GLOBE, Aug. 4, 1998, at B1 ("Everyone in their heart knows the behavior is wrong." (quoting "Robert Knight, director of cultural studies at the Family Research Council"))).

153. Reproductive possibilities aside, the argument seems to assume that everyone does, or *should*, want to have children. If the former, it seems erroneous; if the latter, improperly arrogant in the U.S. constitutional order wherein "decision[s] whether to bear or beget a child" are so important and personal that they are presumptively protected against governmental intrusion. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

psychological matter, perhaps in his view establishing sufficient distress attributable to homosexuality to render it psychopathological. Yet there is no empirical basis offered for the conclusion that all of us who are gay or lesbian “grieve[] over that.” This is not truly a descriptive psychological claim, but a prescriptive one. It takes a teleological premise about “the purpose” of presumed gender dimorphism<sup>154</sup> and sexual activity and transforms it into a universal proposition about the way lesbians and gay men feel. Since there is no evidence offered to buttress this claim, it should be interpreted as a proposition about the way gay and lesbian persons *should* feel if we would just not kid ourselves and instead admit the premise everyone is claimed to really “know.”

Ostensibly secular conversionists distinctly echo this theological approach in their work. In a mystical passage,<sup>155</sup> Nicolosi argues:

Each one of us, man and woman alike, is driven by the power of romantic love. These infatuations gain their power from the unconscious drive to become a complete human being. In heterosexuals, it is the drive to bring together the male-female polarity through the longing for the other-than-me. But in homosexuals, it is the attempt to fulfill a deficit in wholeness of one’s original gender.<sup>156</sup>

The source of these imperatives, Nicolosi postulates, is not God, but nature. “Nature made man complementary to woman, and to cling to the sameness of one’s own sex is to look at the world with one eye.”<sup>157</sup> Any lack of distress, any subjective sense of naturalness gay men might feel with their sexual orientation, desires, attractions, and so on, is—unlike the subjective gender-identity deficit that most homosexual males in analysis are said to suffer—not real, but a misrecognition of their true desires and indeed self. “[W]hat feels ‘normal,’ we believe, is the unconscious striving to heal oneself through sexual intimacy. What feels ‘natural’ is the symbolic search for wholeness of gender.”<sup>158</sup> But Nicolosi presupposes rather than defends the normalcy of heterosexuality and unnaturalness of homo-

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154. Contrary to popular belief, human bodies are not born in just one of exactly two genital/chromosomal/gonadal configurations. See generally, e.g., Alexander Morgan Capron & Richard D’Avino, *Legal Implications of Intersexuality*, in *THE INTERSEX CHILD* 218 (Nathalie Josso ed., 1981); Ruth Hubbard, *Gender and Genitals: Constructs of Sex and Gender*, 14 *SOC. TEXT* 157 (1996); Ann Fausto-Sterling, *The Five Sexes: Why Male and Female Are Not Enough*, *THE SCIENCES*, Mar.-Apr. 1993, at 20; Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 *ARIZ. L. REV.* 265 (1999).

155. Jack Drescher characterizes the passage from which this quotation comes as “a deliberate fusion of spiritual and psychoanalytic thought.” Drescher, *supra* note 58, at 34.

156. NICOLOSI, *supra* note 16, at 109.

157. *Id.* at 149.

158. *Id.* at 132.

sexuality upon which he is basing his argument that homosexuals are disordered.

Even bracketing Nicolosi's claims grounded in a telos of body configurations,<sup>159</sup> he still insists that homosexuals are mentally ill. Why? "Not only is there a natural anatomical unsuitability, but an *inherent* psychological insufficiency as well."<sup>160</sup> What is this alleged insufficiency? "Both partners are coming together with the same deficit. Each is symbolically and sexually attempting to find fulfillment of gender in the other person."<sup>161</sup> Similarly, conversionist Charles Socarides insists that "[t]he female homosexual seeks femininity in the body and personality of her female partner."<sup>162</sup> But of course this is a restatement of his conclusion, not an argument to support it and certainly not supporting evidence. We are thus left with the *premise* that men and women *must have* different desires and attractions, and that the failure to have the "proper" feelings is a disability attributable to homosexuality sufficient to render it psychopathological.

It is clear, then, that conversionists like Nicolosi are not simply relying on descriptive statements about gender. Rather, they operate with gender as a prescriptive, social organizing force. One could concede that, as a descriptive matter, "[g]ender identity structures every man's and woman's way of being and defines each person's participation in society."<sup>163</sup> It does not follow, however, that it is in any sense wrong to "deny [that] inherent gender differences and . . . sex-role concepts"<sup>164</sup> *ought* to be considered a pathology-qualifying disability, that is, a limit on healthy human functioning.

## 2. *Gender Freedom and Equality*

To the contrary, it is improper, certainly in the aspirationally gender-egalitarian United States, to make normative judgments of mental health on the basis of prescribed differences in how men and women are supposed to feel—which is what gender-based theories of homosexuality's pathology

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159. Cf. Peter M. Cicchino, *Reason and the Rule of Law: Should Bare Assertions of "Public Morality" Qualify as Legitimate Government Interests for the Purposes of Equal Protection Review?*, 87 GEO. L.J. 139, 163 (1998) (describing prominent natural lawyers' "reli[ance] on a kind of 'organ teleology,' the belief that the penis and vagina are somehow uniquely and exclusively intended for human sexual intercourse").

160. NICOLOSI, *supra* note 16, at 109-10 (emphasis added).

161. *Id.* at 110.

162. Socarides, *supra* note 126, at 318.

163. NICOLOSI, *supra* note 16, at 154.

164. *Id.*

do. The conversionist claims that les/bi/gay people have a mental illness, a malaise of gender, prompt several collectively dispositive objections.

First, these conversionists err in instituting the gendered processes of reproduction as the touchstone of mental health in the realm of human sexuality. Even if it were the case that most people view reproduction as an important goal of sexual relations, mere statistical minority does not establish deviance amounting to pathology (else a great many groups, possibly including Jews and Libertarians in the U.S., would be mentally ill). Indeed, many heterosexually identified people do not wish to and do not ever reproduce, and not all of them engage in a lifetime of celibacy. Even those who do reproduce frequently seek quite deliberately to pursue sexual activity independent of reproduction, whether through condom or diaphragm use, oral contraceptives, the rhythm method, or other techniques. Moreover, not all sexual acts performed by mixed-sex couples are even *potentially* reproductive, yet most people would likely agree that it would be a mistake to classify the vast majority of Americans who have oral sex as mentally ill. Conversionists who seek to treat homosexuals as “sick” so that they may be “cured” have simply not provided an adequate rationale for viewing the non-procreative character of women’s attractions to and desires for women or men’s attractions to and desires for men as pathological gender deviations.<sup>165</sup>

Second, even distress and disability, contested though widely used markers of mental illness,<sup>166</sup> do not establish that homosexuality is a gender-disordered form of mental illness. There are many happy les/bi/gay people in the U.S. today—despite numerous forms of state-sanctioned discrimination and the ever-present threat of private and sometimes governmental violence.<sup>167</sup> Same-sex attractions, desires, sexual acts, relationships, fantasies, and the like need not occasion distress and thus do not furnish a basis for concluding that homosexuality is a mental illness. Nor should homosexuality be thought to entail a gender-based reproductive disability sufficient to qualify homosexuality as pathological. Certainly some if not many or most les/bi/gay persons *could*, and do, engage in mixed-sex sex and/or reproduction—and peno-vaginal intercourse is assuredly not necessary to reproduction today. Moreover, even if the human species

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165. Cf. Ronald Garey, *Deposing Finnis*, 4 S. CAL. INTERDISC. L.J. 605 (1995) (refuting new natural law argument that only sex acts of “a procreative type” are potentially moral); Andrew Koppelman, *Is Marriage Inherently Heterosexual?*, 42 AM. J. JURIS. 51 (1997).

166. Cf. BAYER, *supra* note 31, at 139 (“On a conceptual level, opponents of the [APtA] board’s decision [to remove homosexuality from the DSM] found it utterly astonishing that ‘subjective distress’ could provide a standard by which to determine the presence or absence of psychopathology.”).

167. See *infra* Part III.A

needed incidence of heterosexual sex for reproduction and attendant survival of the species, not all humans would need to indulge in it, so lack of sexual attraction to persons of another sex is not a disability on species propagation grounds.<sup>168</sup> Furthermore, exclusive heterosexuality is as much a constraint on potential sexual/emotional responsiveness as exclusive homosexuality, so if there were a disability lurking in sexual orientations, monosexuality seems a stronger candidate for that dubious distinction than homosexuality, and anyone who was not bisexual perhaps might be considered mentally ill. But it seems rather unlikely that terribly many people would be willing to call heterosexuality a mental illness and encourage people to seek therapy to bring out same-sex attractions and desires.

Third and finally, in order to treat homosexuality as a gender disorder, conversionists rely on a normative premise of the form “women are/must be X while men are not,” which should be considered inadmissible as a basis for a judgment of mental illness in the U.S. if not any aspirationally gender-egalitarian society.<sup>169</sup> Conversionist theories of mental illness treating homosexuality as a disorder of gender, like those outlined in this Section, make normative judgments of mental health on the basis of prescribed differences in how men and women are supposed to feel.<sup>170</sup> As discussed in the introduction to this Part, judgments of mental illness *are* normative; it therefore should not be surprising that gender equality norms should constrain what counts definitionally as a mental illness.

The psy-professions recognize the dependency of judgments of mental illness on local norms as reflected, for example, in the DSM’s caution that culturally sanctioned expressions of grief are not a mark of depression disorders.<sup>171</sup> In the United States, constitutional equality norms are sufficiently strong that they should be able to constrain nonconsequential definitions of mental illness. I am not trying to make a strong state action

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168. Cf. Socarides, *supra* note 126, at 318. Socarides states:

Pathology, organically and psychologically, may be defined as a failure to function, with concomitant pain and/or suffering. It is this failure, its significance and manifold consequences that are so obvious in obligatory homosexuality—a failure in functioning which, if carried to its extreme, would mean the death of the species.

*Id.*

169. The argument may well work internationally, as there are strong international norms of gender equality and liberty. See, e.g., Convention on the Elimination on All Forms of Discrimination Against Women, Dec. 18, 1979, art. 2, 19 I.L.M. 33 (1980); International Covenant on Civil and Political Rights, Dec. 16, 1966, arts. 3 & 26, 999 U.N.T.S. 171.

170. I focus here on desires in part because those who argue that homosexuality is a mental illness generally see same-sex attractions as a mental illness regardless of whether one ever acts on them by having sex with another person of one’s own sex or by proclaiming a les/bi/gay identity.

171. See AMERICAN PSYCHIATRIC ASS’N, *supra* note 94, at xxi (warning that a “syndrome or pattern” that constitutes a mental disorder “must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one”).



argument that were the APtA, say, to reclassify homosexuality as a mental illness this action alone would violate the Constitution.<sup>172</sup> I am, however, suggesting that constitutional equality norms provide what might be thought of as a constitutional public policy limitation, properly restricting appropriate definitions of mental illness.

For example, suppose that there were a group of psy-professionals who believed that “miscegenality” was a mental illness, that a person of one race with desires for and attractions to members of another race was suffering from a mental disorder because it violated a concept these professionals call core racial identity (CRI). That is, despite the empirical evidence that people do in fact experience cross-race desires and attractions, these professionals maintain that such persons are denying their CRI, and that, normatively speaking, mentally healthy people (ought to) experience desires and attractions only for persons of the same race. I believe that constitutional norms of race equality are adequate (though most likely not necessary) to justify U.S. society, including the psy-professions and legal systems, in rejecting that premise. It should not be considered mentally ill for an African American person to be attracted to an American Indian person when an American Indian person attracted to another American Indian person is not by definition considered mentally ill.

Similarly, it should not be considered mentally ill for a woman to be attracted to a woman irrespective of any consequences of such attraction when a man attracted to a woman is not considered by definition mentally ill.<sup>173</sup> The contrary judgment maintained by many conversionists is as much a normative constraint on people based on their gender as the hypothetical judgment that miscegenality is a mental illness is a normative constraint based on people’s race. Either one conflicts with constitutional equality norms and is properly rejected on that basis.

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172. *But cf.* Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSYCHOL. PUB. POL’Y. & L. 534 (1995). Winick states:

What constitutes mental illness for [involuntary commitment to a psychiatric hospital] is a constitutional question. A *state* could not define belief in voodoo or communism as a mental illness justifying hospitalization without violating the First Amendment, and the Constitution does not permit the *state* to define eccentricity, laziness, habitual lateness for appointments, vegetarianism, or homosexuality as mental illnesses and to hospitalize individuals so labeled on the ground that it would be in their best interests.

*Id.* at 556 (emphasis added).

173. While one might object on the basis that sex is clearly related to sexuality in ways that race is not, such a response is too facile. Sex and race have long been seen as closely related, as reflected, for example, in the antimiscegenation laws that were not held invalid in the U.S. by the Supreme Court until 1967. *See* *Loving v. Virginia*, 388 U.S. 1 (1967). *See also, e.g.*, ANN LAURA STOLER, *RACE AND THE EDUCATION OF DESIRE: FOUCAULT’S HISTORY OF SEXUALITY AND THE COLONIAL ORDER OF THINGS* (1995). Moreover, since the reproduction-based arguments for homosexuality’s pathology fail, relevance to potential for procreation does not dispositively distinguish race and sex in this context.

Indeed, the Supreme Court has often articulated a robust view of constitutional sex equality norms that are inconsistent with any premise that women *are/must* be one way psychologically and men another.<sup>174</sup> For example, in *Mississippi University for Women v. Hogan*, the Supreme Court held that denying men admission to a state-supported university nursing school violated the Equal Protection Clause.<sup>175</sup> In so doing, the Court explicitly repudiated “fixed notions concerning the roles and abilities of males and females” and “archaic stereotypic notions.”<sup>176</sup> It cautioned against “mechanical application of traditional, often inaccurate, assumptions about the proper roles of men and women.”<sup>177</sup> The conversionist premise that to be a woman (or man) entails not loving women (or men) clearly is a fixed notion of the proper roles of women and men.<sup>178</sup>

In *J.E.B. v. Alabama*, the Court held that intentional discrimination on the basis of gender by state actors in their use of peremptory strikes in jury selection violates the Equal Protection Clause.<sup>179</sup> It disparaged the notion reflected in Justice Bradley’s 1872 concurring opinion in *Bradwell v. Illinois* that women’s “paramount destiny and mission” are “to fulfill the noble and benign offices of wife and mother.”<sup>180</sup> The court also contrasted constitutional values with a trial manual’s declaration that “there is at least the chance with the woman juror (particularly if the [male plaintiff] happens to be handsome or appealing) [that] the plaintiff’s derelictions in and out of court will be overlooked.”<sup>181</sup> Such gendered presumptions, *even where at-*

174. The following argument is doctrinal in character. The reader who desires in addition a more psychological justification for the conclusion that gender equality and liberty norms protect lesbians and gay men may consult Koppelman, *supra* note 30.

175. 458 U.S. 718, 720-25 (1982).

176. *Id.* at 725.

177. *Id.* at 726.

178. I confess to not knowing what *accurate* “assumptions about the proper roles of men and women” would be. Short of biological functions perhaps unalterable by (current) medical technology, there is no compelling reason to limit any person’s life course by the accident of their genitals, gonads, chromosomes, “secondary sex characteristics,” or other anatomical features taken to define a person’s sex. *See, e.g.*, Greenberg, *supra* note 154, at 278 (enumerating eight factors involved in defining person’s sex).

179. 511 U.S. 127 (1994).

180. *Id.* at 132 (quoting *Bradwell v. Illinois*, 83 U.S. 130, 141 (1872)). Some conversionists echo this rejected “separate spheres” ideology in their theories of the process of becoming heterosexual:

In freeing himself from his bond with mother, the boy needs help in becoming fully male. He needs to know who he is, and only another man can tell him. Mother, by her grounding in human nature, has told him *what* he is. But father—through his grounding in the outside world—can tell him *who* he is.

NICOLOSI, *supra* note 16, at 154-55.

181. *J.E.B.*, 511 U.S. at 140 n.10 (quoting 3 MELVIN BELLI, MODERN TRIALS § 51.6, at 447 (2d ed. 1982)).

*traction is concerned*, are not a proper basis for limiting a person's life activities.

In *United States v. Virginia* the Court held that Virginia violated the Equal Protection Clause by excluding women from its "incomparable military college, Virginia Military Institute (VMI)."<sup>182</sup> The Court noted that "[n]either the goal of producing citizen-soldiers nor VMI's implementing methodology [was] inherently unsuitable to women."<sup>183</sup> The Court detailed what it took to be the old and discriminatory view of women, quoting Thomas Jefferson, whose concern with sexuality and gender was apparent on the face of his words: "Were our State a pure democracy . . . there would yet be excluded from their deliberations . . . women, who, to prevent depravation of morals and ambiguity of issue, should not mix promiscuously in the public meetings of men."<sup>184</sup> Moreover, in condemning Virginia's actions, the Court proscribed governmental reliance on "overbroad generalizations about the different talents, capacities, or preferences of males and females."<sup>185</sup> Granted, the opinion of the Court did contrast gender with race, noting that "[s]upposed 'inherent differences' are no longer accepted as a ground for race or national origin classifications" while "[p]hysical differences between men and women, however, are enduring."<sup>186</sup> The Court cautioned, however, that any such "'[i]nherent differences'" are not to be allowed to justify "artificial constraints on an individual's opportunity."<sup>187</sup>

A nontrivial number of women in the U.S. do in fact prefer the intimate company of women to that of men, and similarly with men. Thus, the fact of differing anatomies ought not be translated into a gender constraint on the opportunities of members of social classes (here, men and women) to select intimate partners, which is what a judgment that homosexuality is a mental illness would accomplish.

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182. 518 U.S. 515, 519 (1996).

183. *Id.*

184. *Id.* at 532 n.5 (internal quotation marks omitted; ellipses in opinion of the Court).

185. *Id.* at 533 (emphasis added). While the Court's allusion to preferences was probably not referring to sexual preferences, its general principle remains sound and applicable. Moreover, in discussing outmoded views of women, the Court included an ostensibly scientific nineteenth century text proclaiming that women who study with men "do it at a cost to their strength and health which entails life-long suffering, and even incapacitates them for the adequate performance of the natural functions of their sex," reflecting a historical gender constraint tied to sexuality. *Id.* at 537 n.9 (internal quotation marks omitted). See also *id.* at 543-44 (recounting argument that "[i]f women were admitted to the Columbia Law School, . . . then the choicer, more manly and red-blooded graduates of our great universities would go to the Harvard Law School!") (internal quotation marks omitted).

186. *Id.* at 533.

187. *Id.*

As a final example, in *Planned Parenthood v. Casey*<sup>188</sup> the Supreme Court reaffirmed *Roe v. Wade*<sup>189</sup> and a woman's right to choose an abortion in the early stages of pregnancy as an aspect of "liberty" protected by the Due Process Clause of the Fourteenth Amendment.<sup>190</sup> "At the heart of liberty," the controlling joint opinion in *Casey* wrote, "is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."<sup>191</sup> The Court recognized that

[t]here was a time, not so long ago, when a different understanding of the family . . . prevailed . . . . Only one generation has passed since this Court observed that "woman is still regarded as the center of the home and family life," with attendant "special responsibilities" that precluded full and independent legal status under the Constitution. [Such] views, of course, are no longer consistent with our understanding of the family, the individual, or the Constitution.<sup>192</sup>

Neither is a belief that unless a woman is attracted to men, or a man to women, she or he is mentally ill. This conversionist view is a gender prescription inconsistent with the aspirations toward gender equality and liberty deeply embedded in the U.S. constitutional order,<sup>193</sup> and it should be rejected as the unsupported fiat that it is.<sup>194</sup>

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In sum, the primary arguments that homosexuality is a mental disorder suffer from a variety of flaws. Some rely on bad science which is based on faulty logic. Some are circular, presupposing the normative judgments they purport to demonstrate. And some inappropriately presuppose that men and women must differ in their preferences, attractions, or life aspirations. Collectively they fail to establish that homosexuality is pathological, and thus deprive conversionists of the argument that orientation conversion efforts are proper and should be unrestricted because they treat a mental disorder.

188. 505 U.S. 833 (1992).

189. 410 U.S. 113 (1973).

190. See *Casey*, 505 U.S. at 846 ("The controlling word in the cases before us is 'liberty.'").

191. *Id.* at 851.

192. *Id.* at 896-97 (internal citation omitted).

193. See generally DAVID A.J. RICHARDS, WOMEN, GAYS, AND THE CONSTITUTION: THE GROUNDS FOR FEMINISM AND GAY RIGHTS IN CULTURE AND LAW (1998).

194. The foregoing argument almost certainly has ramifications for the relatively recent psychiatric diagnosis of "gender identity disorder" (GID). See, e.g., Sedgwick, *supra* note 14; Eliva R. Arriola, *The Penalties for Puppy Love: Institutionalized Violence Against Gay, Bisexual, and Transgendered Youth*, 1 J. GENDER RACE & JUST. 429 (1998). An exploration of this issue, however urgent, is beyond the scope of this Article.

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The fact that sexual orientation conversion efforts do not treat a mental illness does not, however, necessarily entail that they should be regulated. Rather, proponents of regulation must articulate grounds for concluding that some kind of intervention is appropriate. There are several concerns about the current efforts to convert les/bi/gay persons, including that one cannot conclude that anyone voluntarily consents to reorientation, that the attempts at sexual reorientation cause harms to their subjects and to third parties, and that, even if consent were possible, conversionists are failing to obtain *informed* consent from their clients. The next three Parts of this Article treat these objections in turn, arguing that none warrants outright prohibition of sexual orientation conversion efforts. They do, however, justify other regulations, such as a requirement that psy-professionals with an unhappy les/bi/gay patient treat the unhappiness first before attempting to change the patient's sexual orientation, as well as detailed required informed consent disclosures.

### III. THE POSSIBILITY OF "CONSENT" TO CONVERSION?

One ought take seriously the argument that, given the history and present extent of maltreatment of non-heterosexual persons, one cannot meaningfully conclude that any decision to attempt sexual orientation conversion is voluntary. This formulation, however, like many of the claims made about human sexuality, is deeply equivocal.

On one possible reading, it is a moral ontological claim: Given current circumstances, no one who seeks sexual orientation conversion does so voluntarily because that is not possible. This argument does not insist that it is logically or necessarily the case that no person anywhere could ever voluntarily seek to have her or his sexual orientation changed to heterosexual. Its proponents make no such universal moral claim, but rather a more modest one contingent upon social history and present conditions. Moreover, the claim is implicitly practical in that it must maintain that a decision to seek assistance in attempting to become heterosexual ought not count as sufficiently voluntary, or ought count as sufficiently involuntary, for some purpose or other.<sup>195</sup> It is an important question whether current conditions, under which some people have sought sexual reorientation, ought to be considered sufficiently inhospitable to voluntary choice to justify prohibition of conversion efforts or some other form of regulation.<sup>196</sup>

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195. If it were not, why would anyone bother pressing the claim outside purely academic fora?

196. Although I will not attempt to "quantify" voluntariness, it seems plausible to me that a lesser degree or kind of involuntariness might warrant mental health professional organizations' declaring sexual reorientation practices unethical (which could be expected to *reduce* their practice, perhaps se-

Another possible interpretation of the consent objection, in some sense weaker than the moral ontological claim but not necessarily without practical ramifications, is primarily epistemological: Given current circumstances, we cannot determine, cannot *know*, whether someone who presents for sexual reorientation is doing so in a meaningfully voluntary fashion or is succumbing to “compulsory heterosexuality.”<sup>197</sup> Even if it were possible that someone today might be able to seek sexual orientation conversion voluntarily, the accuracy of this claim of “unknowability” also may bear upon whether sexual orientation conversion should be prohibited or otherwise regulated.

Section A below addresses the argument about the conditions of consent, concluding that there is serious reason to doubt that current conditions allow for meaningfully voluntary “choices” to try to become heterosexual. Section B then argues that, whether voluntary consent to sexual orientation conversion efforts is *ever* possible in the contemporary United States, it generally is not possible to tell whether particular individuals’ decisions to attempt reorientation were voluntary. Accordingly, Section C proposes that such deep uncertainty counsels less for a ban on sexual reorientation efforts than for a requirement that therapists attempt to treat a patient’s unhappiness before attempting to convert her or his orientation.

#### A. THE CONDITIONS OF MEANINGFUL CONSENT TO SEXUAL ORIENTATION CONVERSION

Put most succinctly, the moral ontological consent objection to sexual orientation conversion holds that, given social circumstances, “no one is a

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verely) than would be needed to warrant governmental attempts to *prohibit* them entirely, a further reaching action to which I will next turn.

As a preliminary matter, however, it might be objected that society not uncommonly treats people involuntarily for various mental illnesses such as schizophrenia. Why then should sexual reorientation attempts be forbidden by the state even if people did not seek them out in a meaningfully voluntary fashion? Well, beyond the fact that homosexuality has not been shown to be a mental illness, compare *Foucha v. Louisiana*, 504 U.S. 71 (1992) (holding that involuntary confinement requires mental illness), society properly requires dangerousness to self or others (or perhaps violations of relevant criminal law) before subjecting adults to involuntary mental health treatments. *Cf. Kansas v. Hendricks*, 521 U.S. 346 (1997). Homosexuality does not present that sort of danger. As for criminal violations, it is quite unlikely that a state retaining a criminal prohibition on certain sexual acts between consenting adults of the same sex would be moved seriously to consider enacting a prohibition on sexual orientation conversion. (I do recognize, however, that Massachusetts has both a criminal anti-sodomy law and a statewide law prohibiting sexual orientation discrimination. *See* MASS. GEN. LAWS. ANN. ch. 272, § 35 (West 1999) (Unnatural & Lascivious Acts); MASS. GEN. LAWS. ANN. ch. 151B, § 4 (West 1999) (Unlawful Practices)).

197. Adrienne Rich, *Compulsory Heterosexuality and Lesbian Existence*, 5 SIGNS 631 (1980).

‘voluntary’ patient for sexual orientation change.”<sup>198</sup> Thus, at the 1972 convention of the Association for Advancement of Behavior Therapy, Charles Silverstein argued:

To suggest that a person comes voluntarily to change his<sup>[199]</sup> sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change. To grow up in a family where the word “homosexual” was whispered, to play in a playground and hear the words “faggot” and “queer,” to go to church and hear of “sin” and then to college and hear of “illness,” and finally to the counseling center that promises to “cure,” is hardly to create an environment of freedom and voluntary choice. The homosexual is expected to want to be changed and his application for treatment is implicitly praised as the first step toward “normal” behavior.<sup>200</sup>

The implication, then, is that sexual reorientation attempts should not be offered.<sup>201</sup> So, with respect to the question of consent, this raises the ques-

198. Charles Silverstein, *Homosexuality and the Ethics of Behavioral Intervention: Paper 2*, 2 J. HOMOSEXUALITY 205, 206 (1977).

199. Silverstein noted that the majority of “people who present themselves as candidates for sexual orientation change” were men. *Id.* at 207.

200. Davison, *supra* note 139, at 144 (quoting Charles Silverstein, *Behavior Modification and the Gay Community*, Paper presented at the Annual Convention of the Association for the Advancement of Behavior Therapy, New York City, October 1972).

201. See, e.g., Silverstein, *supra* note 198, at 206 (suggesting that he may be “agreeing with [Gerald] Davison’s . . . position” that psy-professionals should “refuse” to attempt sexual orientation conversion).

This argument might be charged with having a built-in bias, in that it might presume the normative neutrality of the choice in question, effectively postulating that a choice is autonomous or fully voluntary only if it is the choice that would be made in a society without pressure one way or another. Perhaps certain pressures are appropriate, normatively desirable. In that case, why shouldn’t voluntariness be defined in terms of the choice one would make in normatively appropriate social circumstances? If that were so, this framework would require determining what the appropriate social treatment of les/bi/gay persons or “homosexuality” should be before one could ascertain whether certain current choices can be meaningfully free.

It may be that I am, in effect, assuming the propriety of neutrality in the first place. (Of course, this is the goal Judge Richard A. Posner sets in his 1992 book *Sex and Reason*. See Martha Ertman, *Denying the Secret of Joy: A Critique of Posner’s Theory of Sexuality*, 45 STAN. L. REV. 1485, 1491 (1993). After all, this Article implicitly presupposes that sexual orientation conversion ought not be required, instead dealing solely with the question whether (and how) sexual reorientation ought to be restricted. This might seem to stack the deck or otherwise incorporate circularity.

I think, however, that this is not quite accurate. Even coercion that is “appropriate” or justified is still coercive and cannot be justified on the ground that people consent to it.

Moreover, the “pro-choice” argument about sexual orientation conversion claims that society ought not attribute a desire to be heterosexual to negative social pressures, that people might simply make a choice out of positive values that they hold. Given this line of defense of allowing unfettered choices about whether to pursue sexual reorientation, the pro-choice camp itself seems at times to assume—at least for sake of public argument—the propriety of sexual orientation neutrality. That is, the pro-choice argument gets its moral punch from the value of “a free-will choice.” (This phrase comes

tion, what would this person choose in a world without pressure to be heterosexual?

Others who support the availability of at least some forms of treatment question the scope of this argument. Everyone is influenced by friends, family, and society in forming one's values.<sup>202</sup> Given such influences, are *all* choices determined or, at least, not voluntary? Or rather, are things a matter of degree, and, if so, why can there not be *any* people with same-sex desires/attractions/affections who might voluntarily choose treatment?<sup>203</sup> The lack-of-meaningful-consent argument thus raises the question "whether [it] leave[s] any room at all for human agency and decision."<sup>204</sup>

If the argument that conversion efforts are not voluntarily chosen were simply based on acceptance of determinism, people responsible for setting policy in the world everyone inhabits might take note of the philosophical objection but would still be left with the practical question of what to do about such efforts. To do nothing is a course of action as much as is regulation. To the extent that a society aspires to identify reasons for its actions (even if in some deep sense the reasons identified were determined), it must try to differentiate among different degrees or kinds of constraint on human agency, identifying forces that negate the possibility of meaningful consent. And this latter task—determining the preconditions for meaningful consent—is the thrust of the argument against the possibility of voluntarily choosing sexual orientation conversion.

#### 1. "Individual Choices" and Social Forces

The argument against the possibility of meaningful consent to sexual reorientation is an argument about the *conditions* for meaningful consent. For example, society would not doubt the sincerity of someone who expresses a preference for handing over her or his money to an armed robber rather than being shot, but neither is society likely to conclude that the robbery victim's decision was as voluntary (or as determined) as that of someone choosing a flavor of ice cream on a hot summer day. The best version of the argument against the possibility of consent to sexual orientation conversion would insist that the conditions under which a decision to pursue reorientation is formed are, like the situation of one who has a gun to one's

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from Eli Coleman, *Changing Approaches to the Treatment of Homosexuality*, 25 AM. BEHAV. SCIENTIST 397, 403 (1982)).

202. See McConaghy et. al., *supra* note 43, at 426; NARTH, *supra* note 84.

203. See NARTH, *supra* note 84.

204. Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503, 552 (1994). Professor Halley was writing more generally of social constructionist arguments.



head, not adequately conducive to the exercise of free consent. Anti-conversionists thus would focus on coercion as a result of societal pressure.

In contrast, the pro-choice argument fails to take coercion into account, or at least to consider it problematic, in part because of the notion that all of a person's values are influenced by others. Indeed, even some les/bi/gay-positive individuals, such as author Patricia Nell Warren, subordinate social forces to an individualized view of people's decisionmaking, arguing that sexual orientation conversion efforts should remain available because both heterosexual "and gay people have a RIGHT to make choices about their sexual orientation."<sup>205</sup> Thus, changing one's orientation is treated like changing anything relatively inconsequential about oneself: simply a matter of preference. On this view, sexual orientation conversion might be compared to selecting a new wardrobe, hairstyle,<sup>206</sup> or, more extensively, cosmetic surgery. There is nothing necessarily wrong with the pre-intervention condition, yet the individual nonetheless wishes to alter that aspect of her- or himself.<sup>207</sup>

The problem with this view, however, is that it ignores the issues of group subordination that drive the consent objection. Were those not at issue, the availability of a reliable "treatment" would not be as great a concern. For example, elective cosmetic surgery to reduce the extent to which one's ears stick out does not imply that protruding ears are disordered and *should be* "fixed." In the absence of an antecedent, systemic devaluation of protruding ears, the availability of surgery will not likely connote that such features are undesirable and likely will not create strongly coercive pressure for people to elect surgical ear adjustment. This is less true of breast implants or liposuction, where there is significant social devaluation of small-breasted women and overweight people<sup>208</sup> and documented discrimination against the obese.<sup>209</sup> And it seems even less true of les/bi/gay peo-

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205. Warren, *supra* note 1 (emphasis added).

206. *But see* Paulette M. Caldwell, *A Hair Piece: Perspectives on the Intersection of Race and Gender*, 1991 DUKE L.J. 365 (discussing, *inter alia*, the significance of black women's hair braiding); *Kelly v. Johnson*, 425 U.S. 238, 249-56 (1976) (Marshall, J., dissenting from rejection of claim that limit on policeman's hair length unconstitutionally deprived him of liberty without due process of law).

207. *See, e.g.*, Murphy, *supra* note 17, at 518:

[R]eorientation therapy is now defended as a matter belonging to the domain of individual conscience: if a person would like to have a sexual orientation other than the one he or she does have, then therapy ought to be pursued and provided. Sexual orientation is thus no different from the other products consumers may find on the shelves of medical practitioners.

208. *See, e.g.*, RUTH COLKER, *HYBRID: BISEXUALS, MULTIRACIALS, AND OTHER MISFITS UNDER AMERICAN LAW* 165 (1996) (discussing social attitudes pressuring people to reduce their weight).

209. *See id.* at 173-75.

ple,<sup>210</sup> who are constantly subjected to demands that we make a better choice than we supposedly have, that we *should* “choose” heterosexuality.<sup>211</sup>

A more apt analogy might be to racially inflected cosmetic surgery. A study by Eugenia Kaw showed that her Asian American women subjects sought surgical interventions to make them appear more Caucasian “because they associate the features considered characteristic of their race with negative traits.”<sup>212</sup> She notes that “[t]he aesthetic results of surgery are not an end in themselves but rather a means for these women as racial minorities to attain better socioeconomic status.”<sup>213</sup> Hence, “the standard of beauty they try to achieve through surgery is motivated by a racial ideology that infers negative behavior or intellectual characteristics from a group’s genetic physical features.”<sup>214</sup> And, Kaw argues, this link “stem[s] directly from stereotypes created by the dominant culture in the United States and by Western culture in general, which historically has wielded the most power and hegemonic influence over the world.”<sup>215</sup>

The problem is that the medical system, by offering these interventions, is “individualizing the social problems of racial inequality.”<sup>216</sup> The doctors who perform them “encourage Asian American women to believe that undergoing cosmetic surgery is merely a way of beautifying themselves and that it signifies their ability to exercise individual freedom”:<sup>217</sup>

[T]hrough its highly specialized and validating forms of discourses and practices, medicine, along with a culture based on endless self-fashioning, is able to motivate women to view their feelings of inadequacy as individually motivated, as opposed to socially induced, phenomena, thereby effectively convincing them to participate in the production and reproduction of the larger structural inequalities that continue to oppress them.<sup>218</sup>

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210. I disagree in this respect with Timothy Murphy, who seems to take the position that liposuction and sexual orientation conversion efforts are not ethically distinguishable. See Murphy, *supra* note 17, at 96-97.

211. Cf. Cal Thomas, *The Gay Establishment Is Anti-Choice*, NEWSDAY (New York), Aug. 19, 1997, at A30 (contending that the ability to change would destroy case for laws prohibiting sexual orientation discrimination).

212. Kaw, *supra* note 136, at 79.

213. *Id.* at 81.

214. *Id.*

215. *Id.* at 80.

216. *Id.* at 84-85.

217. *Id.* at 85.

218. *Id.* at 87.

Moreover, Kaw also argues from the asymmetry in availability and consumption of cosmetic surgery techniques that these interventions are not likely “voluntary”:

If the types of cosmetic surgery Asian Americans opt for are truly individual choices, one would expect to see a number of Asians who admire and desire eyes without a crease or a nose without a bridge. Yet the doctors can refer to no cases involving Asian Americans who wanted to get rid of their creases or who wanted to flatten their noses.<sup>219</sup>

Like these self-transforming Asian American women, the les/bi/gay persons who seek sexual reorientation are subject to a vast range of anti-gay social forces. Similarly, psy-professionals who offer conversion techniques—always from gay to heterosexual and not vice versa<sup>220</sup>—might be thought to encourage clients to believe that trying to achieve heterosexuality is a form of exercising individual freedom in accord with the client’s own individual desires and motivations.<sup>221</sup> These heterosexual aspirants would profit from heterosexual privilege in various of the many ways that are possible in our society,<sup>222</sup> arguably “participat[ing] in the production and reproduction of the larger structural inequalities that continue to oppress” les/bi/gay persons.<sup>223</sup>

Yet it is not clear that persons who seek sexual reorientation regard heterosexuality solely as a means for attaining privilege or status of various sorts and not (also) as an end in itself. To the extent that they may believe God’s plan for them was to be heterosexual, they may regard heterosexuality as an intrinsically worthwhile goal.<sup>224</sup> This then raises the questions whether the sexual orientation values at issue were formed under circumstances adequately conducive to the exercise of meaningful choice and whether the relative influence of “values” and “pressures” can be disentangled.

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219. *Id.* at 86.

220. The one reported exception that I have found in the literature is the case of the one college-aged man who worked as a hustler and sought to convert from heterosexuality to homosexuality because of his belief that he would be able to have sex more easily were he a gay man. See Frederick Suppe, *The Diagnostic and Statistical Manual of the American Psychiatric Association: Classifying Sexual Disorders*, in 2 *SEXUALITY AND MEDICINE* 111, 133 n.7 (Earl E. Shelp ed. 1987).

221. See, e.g., MacIntosh, *infra* note 421; NARTH, *supra* note 86.

222. See, e.g., STEPHANIE M. WILDMAN, *PRIVILEGE REVEALED: HOW INVISIBLE PREFERENCE UNDERMINES AMERICA* 10-11, 17-19, 35 (1996).

223. Kaw, *supra* note 136, at 87.

224. Cf. Frederick Suppe, *Curing Homosexuality*, in *PHILOSOPHY & SEX* 391, 400 (Robert Baker & Frederick Elliston eds., rev. ed. 1984) (recounting similar arguments that homosexuality is intrinsically undesirable).

## 2. *Compulsion to Heterosexuality*

Contemporary U.S. society does not do what it could to enable les/bi/gay people to live fulfilling lives, and this affects the prospect of anyone's being able to "consent" to sexual reorientation. Although not focusing on the plight of the lesbian or bisexual woman who pursues sexual orientation conversion, Adrienne Rich in her landmark essay, *Compulsory Heterosexuality and Lesbian Existence*,<sup>225</sup> details at length many reasons why a heterosexual orientation or identity should not be considered "voluntary" for *any* woman. To a significant degree, she argues, "heterosexual 'preference' has actually been imposed on women" through a variety of means.<sup>226</sup>

Rich's argument is one about the circumstances under which "choices" may properly be considered voluntary; hence, she emphasizes the importance of "'ask[ing] whether, under conditions of male supremacy, the notion of 'consent' has any meaning.'"<sup>227</sup> "Within the institution [of heterosexuality] exist, of course, qualitative differences of experience," Rich admits, "but the absence of choice remains the great unacknowledged reality, and in the absence of choice, women will remain dependent upon the chance or luck of particular relationships and will have no collective power to determine the meaning and the place of sexuality in their lives."<sup>228</sup> A similar point may be made about conditions of heterosexual supremacy and their effects on both women and men, but I will start with Rich's arguments specifically addressing women's situations.

Rich describes some of the many societal obstacles to women's living a lesbian existence: "[F]ew women have been in an economic position to resist marriage[.]" and "attacks against unmarried women have ranged from aspersion and mockery to deliberate gynocide, including the burning and torturing of millions of widows and spinsters during the witch persecutions of the fifteenth, sixteenth, and seventeenth centuries in Europe, and the practice of suttee on widows in India."<sup>229</sup> Among the sundry forced measures that have been arrayed against women's loving women are: "clitoridectomy and infibulation; chastity belts; punishment, including death, for female adultery; punishment, including death, for lesbian sexuality; psychoanalytic denial of the clitoris; strictures against masturbation;

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225. Rich, *supra* note 197.

226. *Id.* at 652.

227. *Id.* at 642 (quoting CATHARINE A. MACKINNON, *SEXUAL HARASSMENT OF WORKING WOMEN: A CASE OF SEX DISCRIMINATION* 298 (1979)).

228. *Id.* at 659.

229. *Id.* at 635.

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denial of maternal and postmenopausal sensuality; unnecessary hysterectomy; [and] pseudolesbian images in media and literature . . . .”<sup>230</sup>

In addition, heterosexual interactions have been forced on women by “rape (including marital rape) and wife beating; father-daughter, brother-sister incest; the socialization of women to feel that male sexual ‘drive’ amounts to a right; . . . child marriage; arranged marriage; prostitution; the harem; [and] psychoanalytic doctrines of frigidity and vaginal orgasm.”<sup>231</sup> All these and more form “a pervasive cluster of forces, ranging from physical brutality to control of consciousness,”<sup>232</sup> that render deeply problematic any claim that heterosexuality might be voluntarily undertaken by women.

Although an important weapon in the arsenal of compulsory heterosexuality, and one to which I return below, violence against women is far from the only force making women desire heterosexual relationships with men. According to Rich, “covert socializations and . . . overt forces . . . have channelled women into marriage and heterosexual romance”.<sup>233</sup>

Women have married because it was necessary, in order to survive economically, in order to have children who would not suffer economic deprivation or social ostracism, in order to remain respectable, in order to do what was expected of women because coming out of “abnormal” childhoods they wanted to feel “normal,” and because heterosexual romance has been represented as the great female adventure, duty, and fulfillment.<sup>234</sup>

As Jonathan Katz summarizes Rich’s argument, “[u]nder such coercion . . . heterosexuality is not accurately called ‘choice’ or ‘preference.’ Those terms suggest a free, unpressured access to alternative possibilities. The idea that heterosexuality is women’s ‘choice’ obscures the social forces converging on women to heterosexualize them.”<sup>235</sup>

Prominent among the social forces pressuring women and men toward heterosexuality is discrimination, both by individuals and in laws. Les/bi/gay people are largely vulnerable to discrimination in private housing, employment, and public accommodations. “Lesbians, gay men, and bisexuals confront significant discrimination, both explicit and subtle, in

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230. *Id.* at 638.

231. *Id.* at 638-39 (footnote omitted).

232. *Id.* at 640.

233. *Id.* at 636.

234. *Id.* at 654.

235. KATZ, *supra* note 11, at 163.

the workplace. Some employers refuse to hire or fire individuals solely on the basis of their articulated or perceived sexual orientation.”<sup>236</sup>

Even where government is concerned, les/bi/gay people are not safe from discrimination that often works to make heterosexuality more attractive:

The second-class status of gays and lesbians persists today inasmuch as laws which prevent them from exercising the same rights as other citizens are still on the books and are often enforced. Discrimination continues with respect to membership in the armed forces, security clearances, immigration and naturalization, child custody and visitation rights, adoption and foster care, housing and public accommodations, marriage, and inheritance.<sup>237</sup>

Beyond all this, the unpredictable yet very real threat of anti-les/bi/gay violence is another force tending to make heterosexuality compulsory and not simply a matter of free “choice” for les/bi/gay persons who might “choose” to pursue sexual orientation conversion. Kendall Thomas has documented that U.S. society has suffered “a persistent and pervasive practice of homophobic violence on the part of public officials and private citizens alike.”<sup>238</sup> The purpose and effect of this intimidating harassment and violence are to coerce les/bi/gay people into leading at least publicly heterosexual lives and, “ideally,” eradicating homosexuality even in people’s private lives.

The range and rage, the sheer ferocity, of anti-les/bi/gay violence occupy a chilling niche in U.S. history:

Gay men and lesbians in America have been “condemned to death by choking, burning and drowning; . . . executed, [castrated], jailed, pilloried, fined, court-martialed, prostituted, fired, framed, blackmailed, disinherited, [lobotomized, shock-treated, psychoanalyzed and] declared insane, driven to insanity, to suicide, murder, and self-hate, witch-hunted, entrapped, stereotyped, mocked, insulted, isolated . . . castigated . . . despised [and degraded].”<sup>239</sup>

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236. WILLIAM B. RUBENSTEIN, *CASES AND MATERIALS ON SEXUAL ORIENTATION AND THE LAW* 416 (2d ed. 1997).

237. Peter M. Nardi & Ralph Bolton, *Gay Bashing: Violence and Aggression Against Gay Men and Lesbians*, reprinted in *SOCIAL PERSPECTIVES IN LESBIAN AND GAY STUDIES: A READER* 412, 424 (Peter M. Nardi & Beth E. Schneider eds., 1998) (internal citation omitted) (citing THOMAS B. STODDARD ET AL., *THE RIGHTS OF GAY PEOPLE: AN AMERICAN CIVIL LIBERTIES UNION HANDBOOK* (rev. ed. 1983)).

238. Kendall Thomas, *Beyond the Privacy Principle*, 92 COLUM. L. REV. 1431, 1435 (1992).

239. *Id.* at 1462 (footnotes omitted, alterations in original).

Nor is such violence merely an exhibit in a retrospective on an ostensibly meaner, harsher past beyond which the U.S. has supposedly moved.

Both women and men in the contemporary U.S. are subject to horrific violence because they are or are perceived to be les/bi/gay, and the recent highly publicized cases of Matthew Shepard and Billy Jack Gaither, while serving to drive home the dangers of living as a les/bi/gay person in this society, are merely the tip of the iceberg. A *New York Daily News* story “recounted an incident in which a motorist ‘who saw a lesbian standing on a sidewalk in [Manhattan] stopped his car, got out and beat her so badly (while shouting anti-lesbian epithets) that she suffered broken facial bones and permanent nerve damage.’”<sup>240</sup> In another recent attack, “two lesbians were hiking along the Appalachian trail in Pennsylvania when they were shot by an assailant who had been stalking them for a day.”<sup>241</sup> His reason for attacking them? Unbeknownst to the women, he saw them making love by their relatively isolated campfire.<sup>242</sup> “One of the women died at the campsite of back and head wounds; the other walked four miles with wounds in the head, face, upper arm, and neck before she got help.”<sup>243</sup>

One need not always identify as les/bi/gay to be a victim of heterosupremacist violence; it is sometimes enough that a les/bi/gay identity is ascribed by an assailant. For example, one man who apparently did not consider himself gay visited

San Francisco in July, 1987 [and] was stabbed in the face and abdomen. He died two hours later. His attackers had shouted “faggot” and “fruit” at him during the assault, mistakenly identifying him as gay. The police determined that he had done nothing to provoke the attack: He was, in their words, “at the wrong place at the wrong time.”<sup>244</sup>

The viciousness of the attacks recounted above, their “characteristic ‘overkill and excessive mutilation,’”<sup>245</sup> is hardly anomalous. Quoting “[a] report issued by the Community United Against Violence,” an organization concerned with anti-les/bi/gay violence, Kendall Thomas, taking just a few out of many examples, sketches some of the barbarous atrocities to which les/bi/gay people have been subjected:

One man’s body was discovered with his face literally beaten off. Another had his jaw smashed into eight pieces by a gang of youths taunting

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240. *Id.* at 1463 (alterations in the original).

241. Nardi & Bolton, *supra* note 237, at 414.

242. *See id.*

243. *Id.*

244. *Id.* at 414-15 (internal citation omitted).

245. *Id.* at 1467 (quoting GARY O. COMSTOCK, VIOLENCE AGAINST LESBIANS AND GAY MEN 47 (1991)).

“you’ll never suck another cock, faggot!” Another had most of his lower intestine removed after suffering severe stab wounds in the abdomen. Another was stabbed 27 times in the face and upper chest with a screwdriver, which leaves a very jagged scar. Another had both lungs punctured by stab wounds, and yet another had his aorta severed.<sup>246</sup>

Beyond whatever pathologies such sadistic excesses might reflect about their perpetrators, these acts of heterosupremacist vigilantism are quite functional: As Thomas argues, “the horror and sinister efficacy of homophobic violence are in many ways like those of racist violence. Like people of color, gay men and lesbians always and everywhere have to live their lives on guard, knowing that they are vulnerable to attack at any time.”<sup>247</sup> Indeed, “much of the efficacy of homophobic violence lies in the message it conveys to those who are not its immediate victims.”<sup>248</sup> “[I]ndividuals may know that the assertion or ascription of gay or lesbian identity marks them as potential targets of homophobic violence, but they cannot know until too late whether or when they will actually be hit.”<sup>249</sup>

One can scarcely imagine a more terrorizing way to control human sexuality. That is, after all, “the objective and outcome of violence against lesbians and gays.”<sup>250</sup> “Homophobic violence aims to regulate the erotic economy of contemporary American society, or more specifically, to enforce the institutional and ideological imperatives of . . . ’compulsory heterosexuality.’”<sup>251</sup>

In the face of these arbitrary, life-threatening, and significantly unpredictable risks, it would be astounding if no one felt impelled to put on a heterosexual face. At least some individuals are likely to be so petrified by this regime that a publicly heterosexual relationship would seem the best hope for avoiding serious bodily harm. These are *not* conditions conducive to consent and voluntary election among sexual orientations.

Hence, given historical and present social circumstances, I gravely *doubt* that a person’s “choice” to submit to sexual reorientation can be voluntary.<sup>252</sup> Indeed, given the strength of compulsory heterosexuality, it

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246. Thomas, *supra* note 238, at 1463.

247. *Id.* at 1465.

248. *Id.*

249. *Id.* at 1465-66.

250. *Id.* at 1467.

251. *Id.* (footnote omitted).

252. See, e.g., Richard C. Pillard, *Psychotherapeutic Treatment for the Invisible Minority*, 25 AM. BEHAV. SCI. 407, 420 (1982) (“When the social oppression of gay people is over they will be able to make truly voluntary decisions to keep or to change their sexual orientation and to judge what such a change is worth in money and suffering.”).



seems likely that far fewer people would be seeking sexual reorientation if les/bi/gay people were not subject to legal and other social sanctions. Even if some people are drawn to heterosexuality in part due to reasons other than social opprobrium of homosexuality, I do not believe that the relative influence of pressures to be heterosexual and of “values” could be meaningfully quantified. Every person in the U.S. lives under compulsory heterosexuality every day, and even the most strongly les/bi/gay-affirming families and communities are affected. If nothing else (but, of course, there is much else, including the wanton violence described above), the refusal to admit les/bi/gay persons to the state-controlled institutions of marriage and the military clearly demonstrate a valorization of heterosexuality and concomitant devaluation of homosexuality on a grand scale. Exclusion from two of the most important civil institutions in the nation is a materially and symbolically powerful, *coercive* action in the service of heterosupremacy. The psychological need to belong is powerful, and it would be a mistake to think that les/bi/gay persons are so different in kind from the rest of humanity that we are immune to its effects.<sup>253</sup> That many religious denominations also exclude les/bi/gay persons from marriage only further undermines the possibility of parsing motivations to convert to heterosexuality into quantifiable components. In the end, I am certain that one cannot *know* whether a decision for sexual reorientation is voluntary, in a given case, any more than one can know that an Asian American would choose cosmetic surgery to produce more Caucasian features in the absence of racism and racist standards of physical attractiveness. The following Section further explains why.

#### B. THE EPISTEMIC INDETERMINACY OF “CONSENT” TO SEXUAL ORIENTATION CONVERSION

When considering whether individuals can voluntarily seek sexual reorientation, society is hobbled by the lack of technologies that would enable one to know the objective truth of people’s thoughts and wishes, both conscious and unconscious. Looking to the statements of people who have sought sexual reorientation is necessary, but distinctly problematic. Even if, for sake of argument, one took their words as true, as accurate reflec-

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253. Cf. Jallen Rix, “Ex-Gays”—*Sincerely Wrong: My Own Experience and Thoughts About the “Ex-Gay” Movement*, at 1 (visited Apr. 1, 1999) <[http://members.aol.com/\\_ht\\_a/exexgay/Jallen.htm](http://members.aol.com/_ht_a/exexgay/Jallen.htm)> (“[M]y main motivation [for joining an ex-gay group] was the desire for acceptance. I wanted to fit in. I wanted to be the best person possible, thus deserving of all the love that God and others had for me.”).

tions of their sincere beliefs,<sup>254</sup> and even if one assumed for the moment that they in fact had unobscured access to the reality of their own psyches, one would run into vexing questions of interpretation.<sup>255</sup>

Consider, for example, the words of one “homosexual in a Christian church,” who offered encouragement to others in similar circumstances.<sup>256</sup> This heterosexually married man who nonetheless experienced “[i]ntense homosexual desires”<sup>257</sup> both before and during his marriage for many years before eventually discovering “reparative therapy,” repeatedly writes that he “wanted to be normal.”<sup>258</sup> He also makes a point of clarifying that he is not “actively involved in the ‘gay’ lifestyle”: “I do not subscribe to any of the gay agenda. I reject all their arguments, as I must, being a Christian.”<sup>259</sup> The difficulties he identified in his life lay in “reconciling the fact that [he] was a Christian with the fact there was something in [him] that [he] didn’t initiate, didn’t want, and prayed and fasted fervently for God to remove.”<sup>260</sup>

“I reject all their arguments, *as I must*, being a Christian.” Should this be understood as the statement of a person who is voluntarily seeking to change his sexual orientation? One interpretation of this proclamation might stress the presumptive virtue of a person striving to live according to a set of religious values, going to great lengths to remedy a situation that he “didn’t want.” He knows what he wants, it is consistent with his religious values, and he chooses to engage in a course of conduct to bring about his desired result. This is arguably the sort of person who should be “celebrated as a kind of existential hero who takes personal responsibility for the choice of his or her [sexual orientation].”<sup>261</sup>

Yet another interpretation, however, might emphasize the lack of volition and the sense of constraint that the author feels by virtue of being a Christian. He accepts that he is a Christian, indeed, treats it as a simple

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254. Cf. Garet, *supra* note 21, at 179 (“The language that transsexuals use to describe their nature or condition should be canvassed not only on the theory that it reveals the inmost personal identity of the speaker but also on the theory that it does not.”).

255. Cf. *id.* at 168 (“Of course the question of just which values and ends are being affirmed in any act or choice depends for its answer on the resolution of difficult problems of interpretation.”).

256. Anonymous, *One Man’s Struggle*, V NARTH BULL. 22, 22 (Apr. 1997) (reprinted from ANCHOR: A MESSAGE OF HOPE FOR NON-GAY HOMOSEXUALS) (on file with author).

257. *Id.*

258. *Id.* at 23

259. *Id.*

260. *Id.*

261. Garet, *supra* note 21, at 127. The original passage referred to choices of one’s gender.

“fact”<sup>262</sup> in a way that might suggest that his faith, like that of many Christians, itself is something that he “didn’t initiate.” From this given condition then flows a set of restrictions, “a certain code of conduct” within which he “must live.”<sup>263</sup> There is no indication that the author has specifically adopted these religious beliefs, which contrast with those tenets of Christians who believe that same-sex relationships need not be offensive to God.<sup>264</sup> Perhaps then, he is in the grip of indoctrinated anti-gay beliefs, here of a religious nature, in a way that may be difficult to distinguish from someone who has internalized the secular anti-gay messages that modern U.S. society repeatedly sends.

Yet one simply cannot know. One ought not be confident, for example, in the accuracy of the assertion of a man who, believing that he was once a homosexual in anguish, *now*, after undergoing reorientation efforts, states, “my depression was not a byproduct of societal homophobia.”<sup>265</sup> This uncertainty is especially reinforced when the man who makes such claims currently depends on the pro-change group Exodus International and the resolutely anti-gay organization Focus on the Family for his living.<sup>266</sup>

Moreover, part of the difficulty in trying to evaluate the voluntariness of conversion efforts stems from the fact that most of the available self-accounts of the motivations of those who seek reorientation have been composed only subsequent to a course of “treatment” with psycho-professionals or conversionist religious organizations. To the extent that these technicians and their interventions can influence the beliefs of the patient, one should put less confidence in the probity of these retrospective self-analyses. If one’s desires can be influenced as one undergoes psycho-

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262. Cf. Maggie Gallagher, *How We Should Treat Homosexuality*, Address at the American Public Philosophy Institute Conference on Homosexuality and American Public Life, Wash., D.C. (June 19, 1997) (contending that “[w]e know that homosexuality is not a simple fact because we know that sex is not a simple fact”).

263. Anonymous, *supra* note 256, at 23.

264. See generally, e.g., GARY DAVID COMSTOCK, *GAY THEOLOGY WITHOUT APOLOGY* (1993); JOHN J. MCNEILL, *THE CHURCH AND THE HOMOSEXUAL* (3d ed. 1988); ROBERT WILLIAMS, *JUST AS I AM: A PRACTICAL GUIDE TO BEING OUT, PROUD AND CHRISTIAN* (1992); NANCY WILSON, *OUR TRIBE: QUEER FOLKS, GOD, JESUS, AND THE BIBLE* (1995).

265. Paulk, *supra* note 84.

266. John Paulk is board chair of Exodus International, see Kim Painter, *Once Gay, Now They’re a Family*, USA TODAY, Aug. 3, 1998, and is the “homosexuality and gender analyst” for Focus on the Family, see Andrew Shulman, “Anti-Gay” Group Hires Two Ex-Homosexuals, WASH. TIMES, Aug. 4, 1998. A self-avowed “ex-gay,” Paulk reports entering a conversion ministry some time after hearing God speak to him from a mirrored ball in a disco. See JOHN PAULK WITH TONY MARCO, NOT AFRAID TO CHANGE: THE REMARKABLE STORY OF HOW ONE MAN OVERCAME HOMOSEXUALITY 124-25, 164-65 (1998).

therapy—and there is reason to believe this is so<sup>267</sup>—then it is not clear that ex post declarations of the freeness by which one sought reorientation are accurate assessments of ex ante voluntariness.<sup>268</sup>

Moreover, while the pressures of compulsory heterosexuality described in sub-section III.A.2 above might not be so great as to vitiate all *possibility* of consent, they are certainly great enough to destroy *confidence* in pronouncements of voluntariness of or lack of oppression behind decisions to attempt conversion. Perhaps some self-declared ex-gays are correct that their decisions to pursue sexual orientation conversion were not motivated by homophobia, if that concept is limited by semantic cognate to a profoundly irrational fear of homosexuality. But even if someone were to *say* that she or he did not care that the law had singled out some of their forms of lovemaking for criminal penalty; even if she or he were to *state* that fear of violence played no role in the decision to try to leave her or his former life as a lesbian, gay man, or bisexual person; even if an ostensibly “former” lesbian or gay man were to *assert* that the inability to marry any person to whom she or he was deeply attracted did not make attaining heterosexuality more important to her or him; even if she or he *insisted* that social opprobrium, religious condemnation, and at least the prospect of sexual orientation discrimination in any of a variety of aspects of one’s life played no role in her or his individual decision to engage a conversionist—none of these pronouncements, even if seriously believed by the person uttering them, could be confidently credited. Each may perhaps be within the realm of possibility. But none of the forces mentioned is so impotent that it is likely to have played *no* role, not even on a subconscious level, in the decision of an unhappy les/bi/gay person to attempt sexual reorientation.

Simply because one cannot be certain of the voluntariness of ostensible “consent” to sexual orientation conversion efforts does not, however, mean that they should be prohibited. Nor would confidence in the “impossibility” of consent under current conditions necessarily make prohibition the appropriate response. One should first consider the types of harms these efforts might cause, which this Article does below in Part IV, as well as other regulatory solutions.

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267. See, e.g., Jack Drescher, *Psychoanalytic Subjectivity and Male Homosexuality*, in TEXTBOOK OF HOMOSEXUALITY AND MENTAL HEALTH 173 (R. Cabaj & T. Stein eds., 1996).

268. Cf. Garet, *supra* note 21, at 177 n.118 (“We may wonder whether Agatha’s [a particular transsexual woman’s] description of herself in terms of ‘tension,’ ‘conflict,’ and levels of ‘comfort’ echoes her therapist’s idiom, and, if so, whether this description is her best, most honest attempt to convey what draws her to femaleness.”).

## C. PROPHYLAXIS: TREATING UNHAPPINESS FIRST

To the extent the concern is that people are probably not making truly free choices to pursue sexual orientation conversion, the issue might be addressed by various means that fall short of governmental prohibition.<sup>269</sup> One possible approach is to require psy-professionals to first attempt to help a person adapt to their same-sex sexual orientation, and only upon unsuccessfully engaging in such efforts for a minimum period of time (for example, two years) consider trying to change the person's sexual orientation. Such a requirement, whether adopted by professional organizations or legislatures (or both), would offer several related benefits.

In light of the impossibility of ever being confident in a particular case that someone's apparent consent to conversion efforts is truly freely given,<sup>270</sup> requiring psy-professionals to treat unhappiness first would reduce instances when a psy-professional might engage in conversion efforts with a person who would not choose reorientation under (hypothetical) circumstances conducive to free, autonomous choice. Taking the existence of consent as an effect that might be either incorrectly presumed or incorrectly denied, this limitation will tend to reduce action on the basis of type-1 errors (false conclusions that an effect is present when one is not) perhaps without great chance of ultimately precluding action because of type-2 errors (false conclusions there is no effect when one is present).<sup>271</sup>

The requirement of treating unhappiness first will tend to reduce action on the basis of type-1 errors (basically, false conclusions of consent to conversion) by assisting people who would "choose" to accept their homosexuality or bisexuality in the absence of compulsion to heterosexuality, to change their minds about pursuing sexual reorientation. To some extent, non-conversion therapies are successful in helping les/bi/gay people be happy despite the social forces of compulsory heterosexuality. Thus, the requirement of treating unhappiness first would reduce the effect of those forces, hence presumably allowing more les/bi/gay people who would choose to remain les/bi/gay absent such coercion to do so even in this hetero-coercive society. These are people whose "consent" to reorientation is not free, so the "treat unhappiness first" requirement would protect them from non-consensual conversion efforts.

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269. This potentially might still allow professional organizations to censor the practice as unethical and expel members who perform it, provided the practice should not, by virtue of the interaction of professional organization membership rules and state licensing rules, be wholly proscribed.

270. See *supra* Parts III.A and B.

271. I am grateful to Eric Talley for suggesting this way of looking at the issue, although the arguments and conclusions here are mine and not necessarily endorsed by him.

In addition, the requirement of treating unhappiness first might not greatly increase the ultimate incidence of actions precluded by type-2 errors (basically, refusals to sell conversion efforts to les/bi/gay people whose consent to them might be genuinely free). Such a situation would only occur where a les/bi/gay person who would try to become heterosexual even in a world without compulsory heterosexuality was precluded from pursuing conversion. Yet this would only happen in a way properly chargeable to the “treat unhappiness first” requirement if she or he ended up becoming happy with her or his les/bi/gay orientation. It would seem the rare individual who would in a world without sexual orientation coercion prefer to be heterosexual but in this world with tremendous forces demanding heterosexuality would find those forces outweighed by non-conversion therapies.<sup>272</sup>

#### IV. HARMS OF SEXUAL ORIENTATION CONVERSION EFFORTS

Although the requirement that psy-professionals treat unhappiness first does address concerns about whether consent to sexual orientation conversion efforts can be meaningfully voluntary, given current circumstances, it might fall short of the optimal regulatory response. Depending on the likelihood and magnitude of any harm that sexual reorientation attempts may cause their subjects, uncertainty about consent might, on paternalistic grounds, support a ban on conversion. Moreover, even absent any doubt about consent, a prohibition on sexual orientation conversion efforts might be justified if they cause sufficient negative externalities, harms to third parties not involved in the conversionist-client relationship and not easily compensable under a tort regime.

Section A below discusses harms to the client, concluding that while they are real and warrant detailed informed consent requirements, they do not merit complete prohibition of conversion attempts. Section B then con-

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272. The requirement of treating unhappiness first for a given period is less objectionable than the admittedly much briefer waiting periods imposed in some jurisdictions on women seeking abortions. Sexual orientation conversion efforts are not a one-time process. Thus, would-be converts do not face the detrimental consequences that abortion waiting periods impose on some women, such as those who must travel far to a clinic and cannot stay overnight or cannot conceal two clinic visits from a significant other who might be hostile to her decision to abort.

The “treat unhappiness first” requirement is, rather, more like the requirement that a person seeking genital reconstruction surgery must live for one or two years as a member of the sex to which she or he plans to convert. That requirement may undesirably delay genital reconstruction for some transsexual persons, but it might also lead to the patient’s discovering that she or he does not need what she or he had thought and can be happy without undergoing a course of conduct that may reinforce majoritarian prejudices about the gendered way embodied persons must be.

siders various harms to third-parties, some of which might lend support to regulation but probably are best dealt with by informed consent disclosure requirements.

#### A. HARMS TO THE CLIENT

According to the Public Affairs Office of the APIA, “[d]ata that *conclusively* indicate harmfulness of conversion therapy do not exist . . . .”<sup>273</sup> Sexual orientation conversion attempts nonetheless pose *risks* of various harms to clients, some of them quite serious. These include generic harms that can result from psychotherapy as well as harms particular to sexual orientation conversion techniques. These harms, however, are for the most part not so clearly atrocious as to warrant paternalistic prohibition, rather than strong informed consent obligations (discussed in Part V *infra*) or, perhaps, a suit for infliction of emotional distress (as also briefly discussed below in Part V).

In general, psychotherapy’s “primary risk is simply that it may not work, and if it does not work, that it may cause harm.”<sup>274</sup> Certainly there is adequate evidence of failures of sexual orientation conversion efforts to render failure-to-change a serious prospect facing a person contemplating attempting reorientation.<sup>275</sup> And when this happens, the APIA has recognized on the basis of “extensive clinical experience,” a “client’s issues of poor self-esteem, shame, and guilt” are “particularly” likely to be exacerbated.<sup>276</sup>

“Another major risk of psychotherapy is that even if it works, the patient can go through extremely difficult intermediate mental states before reaching his [sic] optimal mental state.”<sup>277</sup> Indeed, “the transference phenomenon<sup>278</sup> [in psychoanalytic approaches, which many secular conversion efforts incorporate,] itself is risky, since the patient is encouraged to de-

273. American Psychol. Ass’n, Public Affairs Office, *Resolution on Treatments to Alter Sexual Orientation: Questions & Answers*, Aug. 14, 1997, at 2 (visited on Apr. 1, 1999) <<http://www.hrc.org/feature2/apaqa.html>> (emphasis added).

274. Steven Horowitz, *The Doctrine of Informed Consent Applied to Psychotherapy*, 72 GEO. L.J. 1637, 1646 (1984).

275. See *infra* Part V.D.1.

276. American Psychol. Ass’n, *supra* note 273, at 2.

277. Horowitz, *supra* note 274, at 1647.

278. Transference is

[t]he process whereby the patient displaces on to [sic] the therapist feelings, attitudes, and attributes which properly belong to a significant attachment figure of the past, usually a parent, and responds to the therapist accordingly. Transference also refers to everything that is experienced in relation to the treatment arising from the unconscious fantasies that develop within the patient-therapist relationship.

SUE WALROND-SKINNER, A DICTIONARY OF PSYCHOTHERAPY 364 (1986).

velop a transitory form of neurosis that, once unleashed, may be impossible for the therapist to control.”<sup>279</sup> In addition, there are risks stemming from the counter-transference phenomenon:

If the psychotherapist improperly handles his counter-transference feelings, he may reinforce the patient’s pathology. For example, the harm to a patient that might result from a psychotherapist unconsciously expressing hostility toward him is similar to the harm that would result from a parent being hostile to his or her child when the child requests help.<sup>280</sup>

Sexual orientation conversion efforts also present particular risks of harm to their subjects. One possible result is damaged self-esteem or clinical depression from “not trying hard enough.” One former “ex-gay” man reports that, some time into his “treatment,” “[t]he [LDS conversionist] psychiatrist was getting frustrated at me at this point, saying I was not doing enough.”<sup>281</sup> “Having been misled into thinking that being gay is a mental disorder and something that can be changed if they’ll only try hard enough, many people feel doubly flawed when a ‘cure’ eludes them. ‘Frequently, they become very, very depressed’ . . . .”<sup>282</sup> This is true not only of ostensibly secular conversion attempts<sup>283</sup> but of conversion ministries’ efforts as well.<sup>284</sup> Thus, another former “ex-gay” man recounts his experience in a religious conversion group: “I’d set an unrealistic goal, then work toward it until I felt exhausted, then feel like a failure because there were no results.”<sup>285</sup> “Leaving the group, completely in despair, made me feel like I had failed God.”<sup>286</sup>

This kind of psychic damage can lead to self-destructive behavior by the subject of conversion efforts.<sup>287</sup> One person who “unsuccessfully” un-

279. Horowitz, *supra* note 274, at 1648.

280. *Id.*

281. Anonymous, *supra* note 256, at 1.

282. Deb Price, *Psychologist Says Efforts to “Cure” Homosexuality Can Cause Lasting Damage*, THE DETROIT NEWS, Sept. 26, 1997, at E2 (quoting psychologist Ariel Shidlo, who is studying the harms that conversion efforts can cause). See also Horowitz, *supra* note 274, at 1649 (discussing how withdrawal by therapist during treatment can “produc[e] suicidal depression in some patients”).

283. See, e.g., APTA, *supra* note 18 (noting that “therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient”).

284. See, e.g., Mark Schoofs, *Straight to Hell*, VILLAGE VOICE (New York), Aug. 11, 1998, at 57 (Once a les/bi/gay person accepts that “there is no way to be gay and remain in God’s grace, . . . shame, guilt, and self-hate follow.”); John Bush, *John’s Story: No Longer a Puppet*, at 2 (visited Apr. 1, 1999) <[http://members.aol.com/\\_ht\\_a/exexgay/John.html](http://members.aol.com/_ht_a/exexgay/John.html)> (“[T]here are people that come out of these groups feeling guilty and depressed . . .”).

285. Rix, *supra* note 253, at 2.

286. *Id.*

287. See APTA, *supra* note 18 (“The potential risks of ‘reparative therapy’ are great, including depression, anxiety and self-destructive behavior . . .”).



derwent conversion efforts tells of the extreme toll that conversion efforts can take:

Sadly, a friend who was in the same [LDS-recommended] exgay program committed suicide after 2 years of electroshock. He had burns on his arms where they would shock him for showing sexual response to pictures. They even had him get married and have children to prove his straightness. Instead, he was visiting parks and alleys for sex. He injected himself with drugs and left behind two beautiful young daughters.<sup>288</sup>

In addition, although not necessarily as permanent, “[r]eparative therapy not only encourages self-hatred but often sours family relationships by spreading the myth that homosexuality results from poor parenting.”<sup>289</sup> Since conversionist ministries often invoke the theories of secular conversionists, they are similarly problematic. As Doug Upchurch has recounted:

The basic premise of the teachings of the group was that being gay was just the tip of a very large psychological iceberg. According to their teaching, my homosexuality [sic] was a result of some emotional and psychological wounds I received as a child from my parents or someone close to me. At first I remember thinking that this was pretty crazy, I mean really, my parents made me gay! However, I unfortunately accepted it as fact and began to alienate myself from my family.<sup>290</sup>

Moreover, “a great many [subjects of sexual orientation conversion efforts] temporarily lose their capacity for real human intimacy. Repressing desire creates a void, not a true heterosexual, [psychologist Ariel] Shidlo finds.”<sup>291</sup> Like many others who have been through conversion attempts, Brandon Bauer “says [that] conversion therapy scarred him in ways that make it hard for him to maintain relationships.”<sup>292</sup> Again, religion-based conversion efforts can cause this harm as well. Anthony Scott, for example, reports of his experiences in Frank Worthen’s New Hope Ministries in California: “I learned how to be nonsexual but not necessarily not gay. For a while I didn’t have any attractions toward anybody.”<sup>293</sup>

288. Anonymous, *supra* note 256, at 1.

289. Price, *supra* note 282, at E2.

290. Doug Upchurch, *Doug’s Story*, at 1 (visited Nov. 23, 1998) <[http://members.aol.com/\\_ht\\_a/exexgay/doug.htm](http://members.aol.com/_ht_a/exexgay/doug.htm)>. (Although this web page does not list Doug’s last name, he has been interviewed in print both before and since the recent conversion ad campaign and has confirmed that “Doug’s Story” is his autobiographical account of his conversion attempt experience. Personal communication to author, Sept. 29, 1998.)

291. Price, *supra* note 282, at E2.

292. Schoofs, *supra* note 284, at 57.

293. Elaine Herscher, *Controversial Conversions: Amid the National Uproar Is One Man’s Quiet Attempt to “Heal” Gays*, S.F. CHRON., Aug. 19, 1998, at A17 (quoting Scott).

All of these harms are real and serious. However, there is a significant lack of information about their incidence. Psychologists Ariel Shidlo and Michael Schroeder are currently conducting research with people who have attempted sexual orientation conversion, but have yet to publish any results.<sup>294</sup> Given the lack of systematic information about the frequency of these harms, and since they are not *necessary* consequences of sexual reorientation efforts, they do not justify a prophylactic prohibition of all sexual orientation conversion efforts, but should be addressed through other means such as informed consent requirements.<sup>295</sup>

#### B. THIRD-PARTY HARMS: PERPETUATION OF STIGMA AND SUBORDINATION

In addition to the clients of sexual orientation conversion, such efforts may cause harms to third parties, which further justify informed consent disclosure requirements for these practices. This Section considers ways in which sexual orientation conversion efforts may perpetuate stigmatization and subordination of les/bi/gay people, suggesting that these concerns are real but are best addressed by informed consent mechanisms.

Those who accept that homosexuality is not a mental illness and oppose reorientation technologies need not simply rest their arguments on conversionists' failure to establish that homosexuality is psychopathological coupled with the fact of historical abuses of les/bi/gay people at the hands of psy-professionals. There is also an argument about the social effects of these conversion efforts. Essentially, the availability of these "treatments" wrongly and wrongfully implies that homosexuality is a mental disorder that may, or perhaps *should*, be treated, perpetuating the stigmatization and subordination of les/bi/gay persons.

The availability of sexual orientation conversion efforts is said to erroneously imply that homosexuality is a mental illness because psy-professionals tend not to research, develop, and/or administer treatments for conditions that are not disorders. Unless homosexuality were a mental illness, "why else would we be spending so much time working on the [conversion] techniques?" asks former Association for the Advancement of

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294. Personal communication to author, Jan. 12, 1998. *Cf. also* Schoofs, *supra* note 284, at 56 (describing Shidlo and Schroeder as "two New York psychologists *who are studying* the effects of conversion therapies") (emphasis added); Jim Green, *There Is No Such Condition as "Ex-Gay"*, CHARLOTTE OBSERVER (N.C.), Feb. 1, 1999 (visited Feb. 1, 1999) <<http://www.charlotte.com/observer/opinion/view/pub/057931.htm>>.

295. *See infra* Part V.C (discussing informed consent disclosure of risks of reorientation efforts).

Behavior Therapy president Gerald Davison.<sup>296</sup> By expending these energies, he argues, conversionists “strengthen[] the prejudice that homosexuality is a ‘problem behavior,’ since treatment may be offered for it. As a consequence of this therapeutic stance, as well as a wider system of social and attitudinal pressures, homosexuals tend to seek treatment *for being homosexuals*.”<sup>297</sup> That result, in turn, is said to inappropriately lend the imprimatur of medical authority to the false position that homosexuality is an established mental disorder.<sup>298</sup> Hence, in Davison’s view, psy-professionals should not attempt sexual reorientation.

In its broadest form, this objection fails to be wholly persuasive. People seek medical assistance in a variety of circumstances without necessarily being disordered. “If therapists believed they should only treat conditions that were abnormal,” writes one conversionist, “they would refuse to terminate the pregnancy of women who request an abortion . . . .”<sup>299</sup> In many cases, the pregnancy is a source of distress in conjunction with the woman’s social situation, rather than an illness.<sup>300</sup> The expectant mother is seeking to gain control over her body and her life course with the assistance of a medical professional.<sup>301</sup> The would-be sexual orientation convert similarly seeks assistance in alleviating distress and gaining control over his or her psyche or sexuality. Certainly, proponents of sexual orientation conversion in the U.S. today *are* encouraging people to seek treatment for being les/bi/gay, but this is not *necessarily* the same as seeking treatment for homosexuality *as* a supposed mental illness.

Indeed, given the spectrum of conditions for which people can and do seek help from contemporary psy-professionals, it is—probably—incorrect that the availability of a treatment for homosexuality would *necessarily* imply that it is a mental illness. To this effect author Patricia Nell Warren has argued:

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296. Gerald C. Davison, *Homosexuality, the Ethical Challenge*, 2 J. HOMOSEXUALITY 195, 200 (1977).

297. *Id.* (quoting D.A. Begelman, *Ethical and Legal Issues of Behavior Modification*, in PROGRESS IN BEHAVIOR MODIFICATION 180 (M. Hersen et al., eds. 1975)) (internal quotation marks omitted).

298. *See supra* Part II (discussing failure to establish psychopathology of homosexuality).

299. Nathaniel McConaghy, *Behavioral Intervention in Homosexuality*, 2 J. HOMOSEXUALITY 221, 225 (1977).

300. It may present a threat to a woman’s health, though even then it would be unusual to describe the pregnancy itself as an illness or ailment.

301. *But see* Diane Curtis, *Doctored Rights: Menstrual Extraction, Self-Help Gynecological Care, and the Law*, 20 N.Y.U. REV. L. & SOC. CHANGE 427 (1994) (examining one abortion technique commonly performed without the assistance of a physician).

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Today people seek therapy to redirect their lives in many ways—to be more assertive, to be less assertive, to get rid of anger, to find more anger, to take control, to give up control, to be more spiritually sensitive, to come down out of the ether and get more grounded. Therapy operates in all kinds of areas that are not traditionally regarded as “bad” or “sick.” Why shouldn’t it be the same for sexual orientation?<sup>302</sup>

I agree that the historical, social, and political, contexts in which “treatments” are offered for a “condition” matter to the social meaning of such techniques. The decisions of some Asian American women in the contemporary U.S. to undergo surgery to produce eyelids or noses that appear more Caucasian cannot be understood without taking into account the existence of a booming cosmetic surgery industry, a long and violent history of ongoing racism, the valorization of white feminine beauty, and the concomitant devaluation of the appearances of non-white women. The availability and use of cosmetic surgery in this context should not be understood to imply that stereotypically Asian eyelids or noses are diseased or disordered. In the U.S. people often undergo surgery to refashion their faces and bodies absent illness or injury. Even though cosmetic surgery is commonly used to “repair” or ameliorate unwanted changes to one’s appearance caused by accidents, silicon implants are not necessarily regarded as addressing defective or diseased breasts. Thus, it is a short (though racially fraught) step to viewing the anglicization of eyes or noses as “simply” a cosmetic choice.

But standards and practices of beauty are never so simple. A woman’s choice to undergo breast augmentation surgery cannot be fully understood without accounting for a standard of feminine beauty that specifies some women’s breasts as, not merely “small,” but “too small.”<sup>303</sup> Such breasts may not be viewed as disordered, but they are too widely regarded as undesirable. Similar social devaluation of eyes without an epicanthic crease or noses without a prominent bridge has prompted some Asian American women to attempt to change their bodies, or, more specifically, their faces, to more highly valued configurations.

Now, it is true that in the U.S. there is significant psychotherapeutic intervention directed at personality traits “that are not traditionally regarded

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302. Warren, *supra* note 1.

303. See, e.g., Julie M. Spanbauer, *Breast Implants as Beauty Ritual: Woman’s Sceptre and Prison*, 9 *YALE J.L. & FEMINISM* 157, 184 (1997) (“These same books [written by plastic surgeons for plastic surgery patients] stress that a woman can achieve ‘normal’ breasts through augmentation surgery, once again sending the message to women with small breasts that there is something wrong with their bodies . . .”).

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as ‘bad’ or ‘sick.’”<sup>304</sup> This is loosely akin to the practice of cosmetic surgery for purposes other than reconstruction. Yet it is not clear, at least to me, that the use of noncurative psychotherapies is so widespread or widely recognized that it would defuse any tendency of people to regard “treatment” of homosexuality as signaling homosexuality’s disordered nature.<sup>305</sup>

Consider in this regard the examples given by Warren quoted above.<sup>306</sup> Note that the therapeutic goals enumerated by Warren are not ones widely believed to be desirable or appropriate for all people. For example, I think it doubtful that many of the American public would think being more assertive uniformly desirable, nor would many think being *less* assertive uniformly desirable. There is, I believe, widespread recognition that some people might benefit from increased assertiveness and others from reduced assertiveness. The same is true of Warren’s examples concerning anger, control, and groundedness.

Such symmetry, which helps to negate any inference that the psychotherapy at issue is “treating” some kind of disordered condition, does not exist within the psy-professions in the same degree with respect to sexual orientation. That is, few people have ever thought heterosexuality to be a mental illness. Hardly any heterosexually identified persons seek to become gay or lesbian, and almost no psy-professional offers or has even explored techniques designed to effectuate such a change. Unlike cases of people seeking to change their assertiveness, where one cannot say that over-assertiveness or under-assertiveness is the disfavored object, in virtually all cases of sought sexual orientation change, the disfavored option is homosexuality.<sup>307</sup> So it should not be surprising if knowledge of the availability of techniques for trying to make les/bi/gay people heterosexual would imply to many that homosexuality and bisexuality are mental illnesses. This is not a *necessary* consequence of the availability of sexual orientation conversion techniques. If the world changes so that sexual orientation is less fraught with moral or other value significance,<sup>308</sup> it will be a less likely consequence. It is, however, a somewhat plausible consequence today given the history and present treatment of les/bi/gay people and ho-

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304. Warren, *supra* note 1.

305. This stems in a large measure from the long history of viewing homosexuality as a mental illness together with the slowness of people both within and without the psy-professions to accept the judgment that homosexuality is not a mental illness.

306. See *supra* text accompanying note 302.

307. See *supra* text accompanying note 220 (discussing asymmetry between efforts to make gay and lesbian people straight and (dearth of) attempts to make heterosexual people gay or lesbian).

308. Cf. Leslie Green, *Sexuality, Authenticity, and Modernity*, 8 CANADIAN J.L. & JURISPRUDENCE 67, 79 (1995) (“[I]f we came to see sexualities . . . as matters of brute taste and devoid of deeper significance, would we not be better and more humane people?”).

mosexuality and bisexuality. Since the reason for exploring this line of inquiry is to contemplate regulation of psy-professional interventions, and attendant possible restriction of access to certain techniques, it is important to repeat that the very existence of attempts to convert someone's sexual orientation from homosexuality to heterosexuality and the fact that some people will pursue conversion *need not* imply that les/bi/gay persons are mentally ill.

*Some* sexual orientation conversion efforts, however, do imply that homosexuality is a disorder.<sup>309</sup> Certain practitioners explicitly hold and promote such a view, and prominent among the secular side of this camp are the members of the National Association for the Research and Therapy of Homosexuality, dyseuphoniouly acronymed NARTH. Thus we see, for example, NARTH President Charles Socarides declaring on the editorial pages of the Wall Street Journal that homosexuality is a "disorder . . . characterized by a constellation of symptoms."<sup>310</sup>

The prominent, public repetition of such discredited views, particularly by ostensible medical professionals, has harmful consequences for les/bi/gay persons, as Frederick Suppe has detailed.<sup>311</sup> Labeling or social reaction theory in sociology would imply that "[t]he labeling of homosexuals as mentally ill causes people to accept these labels as stereotypical reality and to treat persons so diagnosed according to the expectations of those labels."<sup>312</sup> Suppe sees evidence of this proposition in data showing not only that significant numbers of therapists in the U.S. believed homosexuality to be a curable mental illness despite the official pronouncements to the contrary, but also that many Americans believed homosexuals should be excluded from various authority positions where mental illness would be undesirable even though homosexuality per se is irrelevant to the work required.<sup>313</sup> Further support is found in the place of les/bi/gay rights advocacy in the campaign to get the APtA to declassify homosexuality as a mental illness and the ensuing reduction in anti-les/bi/gay discrimination.<sup>314</sup> Suppe concludes that "[t]he offering of programs to cure homosexuality typically involves the labeling of homosexuality as a mental dis-

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309. Cf. APtA, *supra* note 18 ("oppos[ing] any psychiatric treatment, such as 'reparative' or 'conversion' therapy[,] which is based upon the assumption that homosexuality per se is a mental disorder").

310. Socarides et al., *supra* note 11.

311. See Suppe, *supra* note 224, at 408-14.

312. *Id.* at 409.

313. See *id.*

314. See *id.* at 412-13.

order or otherwise inferior. Such labeling causes an increase in the incidences of social prejudice and discrimination toward homosexuals.”<sup>315</sup>

Moreover, because medical professionals wield tremendous influence in U.S. culture,<sup>316</sup> the role of medical authority in pronouncements of homosexuality’s pathology exacerbates the stigmatizing effects of treating homosexuality as a mental illness. This observation’s relevance is more apparent through reexamination of a somewhat analogous case.

Consider again Asian American women who seek cosmetic surgery to create more Caucasian-looking eyelids or noses.<sup>317</sup> Eugenia Kaw has argued that such choices are “attempt[s] to escape persisting racial prejudice that correlates their stereotyped genetic physical features . . . with negative behavioral characteristics . . . .”<sup>318</sup> Kaw further maintains that “[w]ith the authority of scientific rationality and technological efficiency, medicine is effective in perpetuating these racist notions.”<sup>319</sup> “The doctors’ scientific discourse is made more convincing by the seemingly objective manner in which they behave and present themselves in front of their patients in the clinical setting.”<sup>320</sup> Thus, “medicine effectively ‘normalizes’ not only the negative feelings of Asian American women about their features but also their ultimate decision to undergo cosmetic surgery.”<sup>321</sup>

Similarly, sexual orientation conversion efforts not only reflect but reinforce heterosexism.<sup>322</sup> Conversionists trained as mental health professionals wield great scientific authority in their interaction with patients and the lay public. Indeed, observations about the tremendous influence of the clinician over patients are common in professional literature. Even conversionists recognize that psychoanalysis is not an algorithmic procedure producing uniform results but rather “is a dynamic process heavily influenced, regulated, and shaped by the interactions between the patient and the analyst.”<sup>323</sup> Law has at times ceded great authority to medical professionals as

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315. *Id.* at 413.

316. *See, e.g.*, Jonas Robitscher, *The Limits of Psychiatric Authority*, 1 INT’L J.L. & PSYCHIATRY 183, 186 (1978) (“An anxious patient submits to psychiatric authority because he sees the psychiatrist as an expert and a source of help; the psychiatrist then has the power to intervene into the ‘personal life-space’ of that individual.”).

317. *See generally* Kaw, *supra* note 136.

318. *Id.* at 75.

319. *Id.*

320. *Id.* at 83.

321. *Id.*

322. *Cf.* Ruth Hubbard, *Abortion and Disability: Who Should and Who Should Not Inhabit the World?*, in THE DISABILITY STUDIES READER 199 (Lennard J. Davis ed., 1997) (“To the extent that prenatal interventions implement social prejudices against people with disabilities they do not expand our reproductive rights. They constrict them.”).

323. Theo L. Dorpat, *Foreword* to SIEGEL, *supra* note 146, at *xix*.

well. To take but one example, in this instance from the U.K., the permissibility of abortion in England has been largely yielded to the domain of medicine. Sally Sheldon has detailed the ways in which English courts have interpreted governing law in a fashion vesting physicians with sole discretion as to whether a woman may obtain an abortion.<sup>324</sup>

Even in the landmark U.S. case *Roe v. Wade*, the Supreme Court conceived of the abortion right as one subject to medical supervision and control.<sup>325</sup> In summarizing its holding, the Court stated: "For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."<sup>326</sup>

Moreover, this consolidation of legal and medical authority has worked to the particular detriment of les/bi/gay persons in the United States. For example, the U.S. excluded les/bi/gay people from immigrating to the U.S. for decades pursuant to a provision in the immigration laws excluding non-citizens "afflicted with psychopathic personality."<sup>327</sup> In light of the belief that homosexual people were mentally ill, the U.S. Supreme Court held that this provision included gay men in *Boutilier v. INS*,<sup>328</sup> and Congress did not repeal the exclusion until 1990.<sup>329</sup>

But from this perspective, the root problem becomes one with labeling; one of names, information, and medical prestige, and not one about the availability of conversion efforts *vel non*. Thus, it might be addressed by other means short of prohibition such as detailed informed consent disclosures, one possibility explored in Part V below.

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324. See generally Sally Sheldon, *Subject Only to the Attitude of the Surgeon Concerned: The Judicial Protection of Medical Discretion*, 5 SOC. & LEGAL STUD. 95 (1995).

325. 410 U.S. 113, 153 (1973) (concluding, in paragraph stating that constitutional right of privacy encompasses right to abortion, that "the woman and her responsible physician necessarily will consider in consultation" various factors bearing on exercise of choice to abort); *id.* at 156 (referring to decisions protecting "the reasons for which a physician and his pregnant patient might decide that she should have an abortion in the early stages of pregnancy"); *id.* at 163 (arguably holding that "prior to [viability], the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated").

326. *Id.* at 164.

327. Immigration and Nationality Act of 1952 § 212(a)(4), 8 U.S.C. § 1182(a)(4) (1952).

328. 387 U.S. 118 (1967). It is not apparent from the court's decision whether Clive Boutilier would better have been understood as a bisexual man. See generally WILLIAM N. ESKRIDGE, JR., & NAN D. HUNTER, *SEXUALITY, GENDER, AND THE LAW* (1997) (discussing whether statute should extend to bisexual persons, as Boutilier arguably was).

329. Immigration Act of 1990 § 601, Pub. L. No. 101-649, 104 Stat. 4978, 5067.



## V. THE POSSIBILITY OF INFORMED CONSENT?

If society cares about all its members, then it should attack the root causes of the suffering experienced by les/bi/gay persons, enacting laws that protect people in our daily lives and opening civil institutions without regard to sexual orientation. The importance of that task does not mean that there are no avenues for addressing the harms that clients of conversionists may suffer from sexual reorientation attempts. One remote possibility would be to bring a tort suit for intentional infliction of emotional distress. Of course, this is an intentional tort and thus might only constitute “unauthorized psychotherapy,” that is, psychotherapy attempted “without proper consent.”<sup>330</sup> While Part III argued that one cannot know whether consent is possible or has been given in a particular case, and that the best regulatory response to this uncertainty would be to impose a requirement of treating unhappiness first, there may still be circumstances in which it is possible to conclude that proper consent was in fact *not* obtained: where the conversionist fails to provide the potential client with adequate information for *informed* consent (assuming consent is possible at all). Accordingly, this Part of the Article takes up issues of informed consent.

In an August, 1998 Resolution, the APIA affirmed the principles that “psychologists respect the rights of individuals to . . . self-determination and autonomy” and “that psychologists obtain appropriate informed consent to therapy or related procedures which generally implies that the client or patient (1) has the capacity to consent, (2) has been informed of significant information concerning the procedure, (3) has freely and without undue influence expressed consent, and (4) consent has been appropriately documented.”<sup>331</sup> Even NARTH “agree[s] with the AP[I]A on the importance of ‘informed consent’—i.e., that the client be informed about treatment techniques, expected outcomes, and alternatives to the treatments . . . .”<sup>332</sup> NARTH also believes, as one would hope it must, “that all such statement [sic] should be ‘true and non-deceptive.’”<sup>333</sup>

A typical standard of informed consent, albeit one articulated in a more traditional medical context, holds that “a physician has a fiduciary

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330. Horowitz, *supra* note 274, at 1656 n.125. See also *infra* text accompanying notes 495-99.

331. American Psychol. Ass’n, *Resolution on Appropriate Therapeutic Responses to Sexual Orientation* (adopted by the American Psychological Association Council of Representatives, Aug. 14, 1997) (visited Apr. 1, 1999) <<http://www.hrc.org/feature2/apares.html>> (on file with author). See also American Psychol. Ass’n, *APA Council of Representatives Passes Resolution on Appropriate Therapeutic Responses to Sexual Orientation: Resolution Reaffirms Psychology’s Opposition to Homophobia and Client’s Rights to Unbiased Treatment*, Aug. 14, 1997 (on file with author).

332. NARTH, *supra* note 86, at 3.

333. *Id.*

duty to disclose all information material to the patient's decision."<sup>334</sup> In particular, one California appellate court explained:

"The scope of a physician's duty to disclose is measured by the amount of knowledge a patient needs in order to make an informed choice. All information relevant to the patient's decision should be given. Material information is that which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure."<sup>335</sup>

Thus, to obtain "informed consent" to a recommended therapy, the physician must provide a reasonable explanation of the procedure, its likelihood of success, and the risks involved in accepting or rejecting the therapy."<sup>336</sup> In short, "[a] client has the right to know any and all relevant facts that may substantially influence the decision to obtain services from a professional."<sup>337</sup>

Professional organizations and governments should make explicit mandatory disclosures designed to enhance the autonomy of (prospective) psychotherapeutic patients by assuring meaningful informed consent,<sup>338</sup> though the potential efficacy of such disclosures remains questionable. Comprehending the import of such disclosures would require a certain amount of sophistication, and thus they would likely be of greater value to psychoanalytic patients than other consumers of conversion efforts. "Psychoanalysis is of course an expensive and time-consuming process, generally available only to a small sector of the population."<sup>339</sup> Not surprisingly, "psychoanalytic patients are notoriously atypical in that they are often better educated, more intelligent, and of higher socioeconomic status" than the general U.S. population.<sup>340</sup>

Nevertheless, given that existing informed consent norms do dictate certain disclosures, and that these might help some prospective clients make an informed decision whether to pursue sexual orientation conversion, this Part explicates the disclosures that should be adhered to. Because

334. *Mathis v. Morrisey*, 13 Cal. Rptr. 2d 819, 822 (Ct. App. 1992) (quoting *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479 (Cal. 1990)).

335. *Id.* at 823 (quoting *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980)).

336. *Id.* (citing *Cobbs v. Grant*, 502 P.2d 1, 10-11 (Cal. 1972)).

337. Bruce W. Ebert, *Informed Consent*, BOARD OF PSYCHOL. UPDATE 3, 3 (Jan. 1997).

338. NARTH would seem to demand an unrealistic lack of detail in insisting that "if [the APIA's] current general [informed consent] guidelines are insufficient to protect the client from unscrupulous practitioners, then these standards should be revised across the board . . ." NARTH, *supra* note 86, at 3.

339. LEVAY, *supra* note 14, at 79.

340. Gonsiorek, *supra* note 131, at 121.

it is based on existing informed consent law, any novelty in the proposals lies primarily in the application of the doctrine to this particular factual setting, which is quite rich. To the extent that non-conversionist professionals fail to live up to the dictates of informed consent,<sup>341</sup> they too may be subject to criticisms like those below, as applicable to their particular treatment method. Section A explains what conversionists should tell prospective clients about their procedures and premises, while Section B addresses what should and should not be said to prospective clients about alternatives to conversion efforts, in particular arguing that AIDS is not a risk attributable to non-conversion therapies. Section C briefly discusses the risks of pursuing sexual reorientation, which conversionists are required to disclose to clients considering this route rather than one of the non-conversion alternatives. Section D then examines the complicated issues surrounding what clients should be told about the efficacy of ostensible conversion techniques, concluding that no definitive success rates can be given due to inability to ascertain the truth of claims of heterosexuality in contemporary U.S. society. Finally, Section E presents means of enforcing these informed consent norms (such as law suits, license revocation proceedings, or professional organization ejection), along with key limitations thereto, in particular U.S. law's significant inability to regulate religious individuals' and organizations' practices.

#### A. PROCEDURES AND PREMISES

One of the first requirements of informed consent is a reasonable explanation of the procedure including all significant information concerning it. In the case of sexual orientation conversion efforts, this should include a detailed explanation of the practitioners' contested premises—clients presumably will be better able to exercise autonomy if they are aware not only of the therapists' views but also that those views will likely color the conceptualization of the problem—and of the possibility that the particular application of the techniques should be considered experimental. Moreover, all of this information should be provided in writing to the prospective client.

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342. Empirical evidence suggests that this may be the case. *See generally* CHARLES W. LIDZ, ALAN MEISEL, EVIATAR ZERUBAVEL, MARY CARTER, REGINA M. SESTAK & LOREN H. ROTH, INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY 8 (1984) (reporting lax adherence to informed consent norms found in four-year study in various settings within one hospital). *See also infra* text accompanying note 401.

### 1. *The Premises of the Procedures*

Some psy-professionals apparently target homosexuality for eradication from the beginning by viewing conversion as a goal to be sought wherever feasible rather than a possibility that might arise.<sup>342</sup> NARTH, for example, “maintains that it is ethically acceptable for a psychologist to . . . enter a client-therapist relationship focused on the diminishing of unwanted homosexual symptoms and the enhancement of heterosexual responsiveness . . . .”<sup>343</sup> Conversionist mental health professionals and organizations often do not try to ascertain whether they can help an individual “handle” homosexuality responsibly but instead view the proper goal from the outset as merely determining whether the patient is amenable to overcoming homosexuality. Thus, Nicolosi writes:

[The patient] will usually know immediately whether or not he is in accord with [the therapy’s] *premises* . . . . If the first session lapses into a debate about the merits of reparative therapy or the ethical implications of the gay life-style alternative [sic], this is an indication that the client is not *ready* for this therapy.<sup>344</sup>

Any mismatch between the patient and the therapy is attributed not to the theoretical commitments of the therapy but merely to the maturity of the patient.

Conversionists may be entitled to hold such beliefs—although they do not seem the hallmarks of a scientifically open mind—but such a position should be explained to patients up front. If, as is common among conversionists, they believe that homosexuality is caused either by poor or non-existent relations with one’s same-sex parent,<sup>345</sup> by sexual abuse,<sup>346</sup> or by poor hand-eye coordination (in males),<sup>347</sup> they should disclose this at the outset regardless of how ridiculous it might sound to a person who has yet

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342. Cf. APTA, *supra* note 18 (“oppos[ing] any psychiatric treatment, such as ‘reparative’ or ‘conversion’ therapy[,] which is . . . based upon the a priori assumption that the patient should change his/her homosexual orientation”).

343. NARTH, *supra* note 86, at 1 (emphasis added).

344. NICOLOSI, *supra* note 16, at 219-20 (emphases added).

345. See, e.g., BIEBER ET AL., *supra* note 61.

346. See, e.g., Anthony A. Falzarano, *As a Former Homosexual, I Can No Longer Be Silent*, FAIRFAX J. (Va.) (visited Sept. 17, 1998) <<http://www.jrnl.com/news/98/Sep/jrn24170998.html>> (asserting, with no attempt whatsoever to support his claim, that “75 percent of homosexuals have been molested and/or raped in their youth”). Falzarano “is the national director of Parents & Friends of Ex-gays (P-FOX) in Washington, D.C., and runs Transformation Christian Ministries, the Washington affiliate of Exodus International.” *Id.*

347. See, e.g., Richard Fitzgibbons, *The Origins and Therapy of Same-Sex Attraction Disorder*, in *HOMOSEXUALITY AND AMERICAN PUBLIC LIFE* 85, 88 (Christopher Wolfe ed., 1999) (claiming that “the major cause” of male homosexuality is “[w]eak masculine identity,” which supposedly “can be an outgrowth of weak-eye hand coordination which results in an inability to play sports well”).

to spend months or years having her or his life interpreted by a trusted conversionist through the lens of the conversionist's preferred theories of homosexual etiology. If the conversionist believes that homosexuality is a mental illness, a "sexual disorder" as stated for example in NARTH's mission statement,<sup>348</sup> she or he should disclose this to the prospective patient as well.

Disclosure of any of the above beliefs about homosexuality's supposed pathology is, however, not enough. Delivering such pronouncements from a position of psy-professional authority without more would improperly exacerbate a distressed patient's concerns about being gay. Conversionists who view homosexuality as a mental disorder should thus also inform any prospective patient that they disagree with the major psy-professional associations in the U.S.<sup>349</sup> The American Psychological Association, the American Psychiatric Association, and the American Psychoanalytic Association have all rejected the position that homosexuality is a mental disorder, the simplistic causal story about "weak" fathers and "smothering" mothers abandoned long ago. If conversionists are going to insist that their contrary beliefs are "informed, professional opinion[s],"<sup>350</sup> and thereby attempt to stake out a significant measure of credibility for their procedures, then the fact that the major organizations of their professions have reached contrary views vitiates the conversionists' appeal to professional authority, and thus is relevant to an informed decision by the patient whether to pursue sexual orientation conversion.<sup>351</sup>

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348. See NARTH, *Statement of Policy* (visited Nov. 23, 1998) <<http://www.narth.com/statement.html>> ("Of the whole range of sexual disorders, homosexuality is probably the most misunderstood."). See also CHARLES W. SOCARIDES, *HOMOSEXUALITY: A FREEDOM TOO FAR: A PSYCHOANALYST ANSWERS 100 QUESTIONS ABOUT CAUSES AND CURE AND THE IMPACT OF THE GAY RIGHTS MOVEMENT ON AMERICAN SOCIETY* 8 (1995) (referring to homosexuality as, in part, "one of the many psychological disorders that walk into my office almost every day").

349. Formally such a requirement would most likely be drafted neutrally so as to apply to all therapists, both anti-conversion and "pro-choice." An ostensibly more substantively neutral disclosure requirement might require all therapists to inform patients of both the majority view and the dissenting "illness" view of homosexuality. While such a requirement might promote a population more skeptical of the professions' claims to privileged authority, which might be desirable, it would deviate significantly from current medical practice (which does not, for example, require physicians to inform patients of the beliefs of Christian Scientists about illness), would pose difficult questions of degree about the size of dissenting groups and the bases of their beliefs sufficient to warrant such instruction, and could be contraindicated if sexual reorientation efforts wreak significant harm, see discussion Part IV.A. *supra*.

350. NARTH, *supra* note 86, at 1.

351. Cf. CAL. WELF. & INST. CODE § 5326.2(e) (West 1998) (requiring for "voluntary informed consent" that patients be told "[t]hat there exists a division of opinion as to the efficacy of the proposed treatment"). I discuss disclosure about efficacy *infra* Part V.D.

Similarly, conversionists who hold uniformly negative views of the minds and lives of les/bi/gay persons should disclose those beliefs, along with the fact that many people dispute the universality of such stereotypes.<sup>352</sup> Joseph Nicolosi, for example, boldly asserts that “[g]ay couples are *characteristically* brief and very volatile, with much fighting, arguing, making-up again, and continual disappointments” and professes that he “do[es] not believe that the gay life-style [sic] can ever be completely healthy.”<sup>353</sup> This latter statement falsely implies that there is one way of living life that constitutes “*the* gay lifestyle,”<sup>354</sup> and thus reflects deep prejudice. But conversionists such as Nicolosi should disclose these views to their prospective clients, as well as the fact many psy-professional organizations and countless people, les/bi/gay and otherwise, believe this position to be false. This kind of distorted information disseminated by unscrupulous or misguided conversionists dramatically impairs people’s ability to make informed choices about whether to attempt sexual reorientation.<sup>355</sup>

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352. See, e.g., APTA, *supra* note 18 (“Many patients who have undergone ‘reparative therapy’ relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction.”).

353. NICOLOSI, *supra* note 16, at 110 (emphasis added); *id.* at 13. In his view, no “man can ever be truly at peace in living out a homosexual orientation.” *Id.* at 149.

354. *Id.* at 134 (taking as fact “[t]he characteristic promiscuity of the gay life-style”). See also Marc Fajer, *Can Two Real Men Eat Quiche Together? Storytelling, Gender-Role Stereotypes, and Legal Protection for Lesbians and Gay Men*, 46 U. MIAMI L. REV. 511, 537-46 (1992) (discussing “sex-as-lifestyle” assumption).

355. Similarly, many would-be converts have interpreted conviviality as insincere posturing in conformity with conversionists’ negative pronouncements about les/bi/gay persons’ lives. See, e.g., Bernard Coleman, *Hope for the Future* (visited Nov. 23, 1998) <<http://www.anotherway.com/pages/bernardc.html>> (“Lights in the bar were dim, like the faces surrounding me. I loathed looking into those faces because they mirrored my own. Those sad, lonely faces with sighing eyes searched the bar that night just as I did, longing for someone to fill their emptiness.”); J Rebecca Ann Johnston, *Crying Behind the Mask* (visited Nov. 23, 1998) <<http://www.leaderu.com/stonewall/pages/rebeccaj.html>> (“As I looked around, God showed me the unhappiness under all the smiling masks around me.”); Bill Hernandez, *An End to the Loneliness* (visited Nov. 23, 1998) <[http://www.leaderu.com/stonewall/pages/bill\\_h.html](http://www.leaderu.com/stonewall/pages/bill_h.html)> (“I became a bartender at the White Horse Bar in Oakland, Calif., a position that made me popular and available. I knew many people at that bar; we were like one big family. Most of the customers were alcoholics and sex addicts looking for a temporary lover.”); Sinclair “Sy” Rogers, *Man in the Mirror* (visited Nov. 23, 1998) <[http://www.anotherway.com/pages/sy\\_r.html](http://www.anotherway.com/pages/sy_r.html)> (“Stationed in Hawaii, I totally immersed myself in Honolulu’s gay scene. But behind the façade of acceptance and the promise of love, I saw many unhappy, cynical, and desperate people in the gay lifestyle.”). Many of these narratives’ authors are confident that their fellow patrons’ happiness was not genuine but rather a veneer over a core of despair more consonant with the teachings of the authors’ established faith communities about the ostensible realities of les/bi/gay lives. Cf. Schoofs, *supra* note 284, at 2 (recounting Brandon Bauer’s having been “told that homosexuality would mean ‘a life of promiscuity and drug use and really sleazy bars that would be horribly lonely’”).

To further understand why, consider the situation of some women deciding whether to abort a fetus when they have learned that their child would have a disability. Many people simply do not know what the lives of people with given disabilities are like<sup>356</sup> and may, in their ignorance, believe (perhaps based on media depictions, or rumors or lore, or unguided speculation) that those lives are worse than they are, or even that such people would rather not have been born (even if they would not go so far as to take their own life). This lack of knowledge of the actual lives of persons living with disabilities, it has been argued, is one reason “that in many of these situations parents have only the most tenuous basis for making their decisions.”<sup>357</sup>

Yet, many wonderful people live fulfilling lives even with severe disabilities.<sup>358</sup> If more women knew this firsthand, then assuming a reasonable measure of rational calculation underlies their decision, some may be less likely to abort a fetus when faced with a diagnosis of disability, for the prospect facing their potential child would rightfully appear less grim to them. In the absence of such information, their decisionmaking might not be considered adequately informed.

Similarly, while homosexuality is not a disability or mental disorder,<sup>359</sup> to the extent that persons contemplating sexual orientation conversion make their decisions under a cloud of misinformation about the possibilities of les/bi/gay life, their assessments will as a result be systematically and wrongfully skewed toward attempting reorientation. And conversionists have been reported to sow inaccuracies or untruths about les/bi/gay persons.<sup>360</sup>

One “former member” and one-time “chapter leader” of Homosexuals Anonymous (HA) reports being falsely taught by HA “that there is no such thing as long-term gay/lesbian relationships.”<sup>361</sup> Another gay man who formerly attended HA and other similar groups to try to convert to heterosexuality reported that each group taught “that [his] homosexual feelings

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356. See, e.g., Lennard J. Davis, *Introduction* to THE DISABILITY STUDIES READER, *supra* note 322, at 2 (“My experience is that while most ‘normals’ think they understand the issue of disability, they in fact do not.”).

357. Hubbard, *supra* note 322, at 198.

358. Cf. *id.* at 187-88 (“Many of us know people with a disease or disability whom we value highly . . .”).

359. See *supra* Part II.

360. Cf. Pillard, *supra* note 252, at 416 (contending that “some therapists . . . discourage patients from learning about homosexual life”).

361. “Kurt,” *Kurt’s Story* (visited Nov. 23, 1998) <<http://members.aol.com/exexgay/page5.html>>. (This web site keeps “personal information” such as one’s “real name” confidential unless otherwise requested. See <<http://members.aol.com/exexgay/page3.html>>.)

were a result of a poor/nonexistent relationship with [his] father or an overbearing mother or sexual abuse as a child.”<sup>362</sup> Why did he have difficulty accepting this dogma? He “grew up in a loving family ([his] mom and dad have been together for 35 years), [his] father was always there for [him], [his] mother was not smothering, and [he] was not sexually abused as a child.”<sup>363</sup>

Requiring disclosure of such skewed perspectives on homosexuality held by conversionists would diminish the aura of authority surrounding the conversionist’s professional position that might otherwise lend to a misleading and potentially harmful representation. The client then would be less likely to seek conversion out of a mistaken belief that the entire psy-profession believes a les/bi/gay person’s only hope for health is to “get het,” as it were.

Furthermore, conversionists should disclose to the patient the probable duration of the proposed course of “therapy.”<sup>364</sup> It appears increasingly common for conversionists to maintain that change to heterosexuality is possible but may well take years or even a lifetime of intensive “treatment.”<sup>365</sup> (Claims to the contrary<sup>366</sup> strain credulity, particularly since many who seek sexual orientation conversion have unsuccessfully struggled for years to extinguish their same-sex attractions and desires.) Patients have a right not to be misled into thinking a quick change is likely, and disclosure of the expected duration of “therapy” will allow them to see how valuable they would be to the conversionist as paying customers for years and years to come. While it is not unusual for (generally expensive) psychotherapeutic processes to take years, the fact that the psy-professionals of NARTH assertedly believe they are treating a mental illness not recognized as such by the major psy-professional organizations renders their financial self-interest more suspect.

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362. John Bush, *John’s Story: No Longer a Puppet* (visited Apr. 1, 1999) <<http://members.aol.com/exexgay/page6.html>>.

363. *Id.*

364. *Cf.* CAL. WELF. & INST. CODE § 5326.2(b) (West 1998) (requiring for “voluntary informed consent” that patients be told “[t]he nature of the procedure to be used in the proposed treatment, including its probable frequency and duration”).

365. *See, e.g.*, NICOLOSI, *supra* note 16, at 22 (“Freud concluded that analysis is essentially a lifetime process. This is true in the treatment of homosexuality . . .”); *id.* at 156 (“Reparative therapy views change as a long-term process, and one that is in fact most probably lifelong.”).

366. *See, e.g.*, WILLIAM H. MASTERS & VIRGINIA E. JOHNSON, *HOMOSEXUALITY IN PERSPECTIVE* (1979).



## 2. *Experimental "Treatments"*

Part of the problem with relying on conversionists to disclose and explain their premises is they seem not to realize or to accept that, as discussed in Part II above, they lack a scientific basis for their belief that homosexuality is a mental disorder. It is, therefore, difficult to imagine them actually telling potential paying clients that their "treatment" program is based not on scientific findings, but on faith in a particular moral framework that prescribes "healthy" desires according to one's biological sex. That would be a difficult, though not impossible, position for anyone with a stake in considering her- or himself a "behavioral *scientist*" to maintain.<sup>367</sup> All of this is *not* to concede that secular conversionists are *not* obligated to tell clients of the weakness of their claimed "science"; it is only to suggest that this obligation is, as a descriptive matter, likely to be observed most frequently in the breach.

An additional possibility, then, would be to require conversionists to describe their techniques to potential clients as "investigative" or "experimental."<sup>368</sup> One definition of "investigative treatment" is a "treatment performed when the service, procedure, drug or treatment has limited human application but has not achieved general acceptance in medicine."<sup>369</sup> Similarly, one definition of "experimental treatment" is one that is "not uniformly and professionally endorsed by the general medical community as standard medical care."<sup>370</sup> Translated to the psy-professional context, it is clear, particularly in light of their lack of established efficacy,<sup>371</sup> that sexual orientation conversion techniques have "not achieved general acceptance in"<sup>372</sup> the psy-professions and are not regarded as standard psychotherapeutic care for les/bi/gay persons.

Such a disclosure of experimental or investigative status would at least warn the potential client that the conversionist would be operating out of the psychotherapeutic mainstream. It may not (nor ought it necessarily)

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367. NARTH, *NARTH Home Page* (visited Nov. 23, 1998) <<http://www.narth.com>> (explaining that NARTH "is composed of psychoanalysts, psychoanalytically-informed psychologists, certified social workers, and other behavioral scientists, as well as laymen in fields such as law, religion, and education") (emphasis added).

368. Cf. Jack Drescher, "What Needs Changing?" *Some Questions Raised by Reparative Therapy Practices*, NEWSLETTER OF THE N.Y. STATE PSYCHIATRIC ASS'N 8, 10 (1997) (comparing conversionist techniques to a hypothetical "experimental surgical procedure that promises only a 35% cure rate, or a possible worsening of the patient's physical condition in the other 65%").

369. *Hendricks v. Central Reserve Life Ins.*, 39 F.3d 507, 511 (4th Cir. 1994).

370. *Exbom v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 900 F.2d 1138, 1139 (7th Cir. 1990).

371. See *infra* Part V.D.

372. *Hendricks*, 39 F.3d at 511.

dissuade the truly desperate from subjecting themselves to conversion efforts, but it may at least signal to those whose minds are not irrevocably set on sexual orientation conversion that the conversionist lacks a solid scientific basis for her or his interventions that guarantee no benefits<sup>373</sup> and risk significant harms.

### 3. *Written Disclosures*

It has been advocated that a therapist should be required to disclose in writing the information that the client needs to make an informed consent to treatment.<sup>374</sup> Some state laws already require written documentation that informed consent was obtained for medical treatments,<sup>375</sup> and “adequate documentation . . . is required by the 1992 AP[1]A Ethical Principles of Psychologists and Code of Conduct.”<sup>376</sup> Providing informed consent information in writing will promote patient understanding by affording a potential client the opportunity to revisit points that she or he might decide on further reflection were not wholly clear when initially explained by the professional. It will also foster some measure of accountability, making compliance with the dictates of informed consent more likely by facilitating monitoring and enforcement.

## B. ALTERNATIVES TO CONVERSION

Informed consent also generally requires that the subject be informed of alternatives to the proposed course of treatment. In addition, the client should be advised of the risk that those alternatives may pose. But the client should not be misinformed as to situations unfairly attributable to those treatments by conversionists.

### 1. *Non-Conversion Therapy*

It is not enough simply to say to a client concerned about being gay or lesbian “that if he was [gay], he could choose Gay Affirmative Therapy [sic], or he could seek to grow out of homosexuality.”<sup>377</sup> Beyond refrain-

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373. See *infra* Part V.D.

374. See, e.g., Judith Gleysteen McEntyre, *Responsibility in Mental Health Care*, 23 VT. B.J. & L. DIG. 38 (1997).

375. See, e.g., CAL. WELF. & INST. CODE § 5326.4 (West 1998) (“Supplemented written consent form; oral explanation by physician; entry on record”). Cf. TEX. HEALTH & SAFETY CODE ANN. § 462.009 (West 1994) (requiring signed consent form or “a statement of the treating physician that documents that consent was given by the appropriate person and the circumstances under which the consent was obtained”).

376. Ebert, *supra* note 337, at 3.

377. NICOLosi, *supra* note 16, at 4.

ing from seeking to steer the client into paying for conversion attempts by evoking a hetero-biased dualism that almost explicitly contrasts approaches that help people reach psychic maturity with non-conversion approaches,<sup>378</sup> a conversionist should explain that many unhappy les/bi/gay persons have been assisted by psy-professionals who do not feel that attempting to change their sexual orientation is feasible.<sup>379</sup> A range of non-conversion therapies—including psychoanalysis, depth psychology,<sup>380</sup> cognitive therapy,<sup>381</sup> humanistic psychotherapy,<sup>382</sup> and client-centered therapy,<sup>383</sup> to name just a few—might be selected by the client, all of which would focus on helping her or him with mental or emotional problems without targeting homosexuality itself as a mental illness or problem.

## 2. *The Risks of Alternatives to Sexual Orientation Conversion Efforts?*

Informed consent requires as well that a psy-professional inform a prospective client not only of treatment alternatives but also of the risks that those present. In the case of non-conversion therapy, besides the obvious consequence of likely remaining les/bi/gay, patients might face the prospect that their unhappiness might remain significantly undiminished. Contrary to some pro-conversion suggestions, however, AIDS should not be considered one of the risks attributable to non-conversion therapy.

By definition, non-conversion therapies do not seek to effectuate a change in a les/bi/gay client's sexual orientation. Thus, in having explained to a prospective client that non-conversion therapy is an alternative, a conversionist will also necessarily have informed the person that her or his sexual orientation likely would remain intact. To the extent that a given person might consider this a less than optimal outcome, the conversionist will have already articulated that "risk."

A conversionist should, however, explain that the prospective client's unhappiness or distress might not diminish significantly from non-conversion therapy. Lack of improvement despite the money, time, and hope or expectations invested by the patient is a risk with virtually any

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378. Cf. Warren J. Blumenfeld, *History/Hysteria: Parallel Representations of Jews and Gays, Lesbians, and Bisexuals*, in *QUEER STUDIES: A LESBIAN, GAY, BISEXUAL, & TRANSGENDER ANTHOLOGY* 146, 152 (Brett Beemyn & Mickey Eliason eds., 1996).

379. Cf. APTA, *supra* note 18 ("The possibility that the person [undergoing 'reparative therapy'] might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.").

380. See WALROND-SKINNER, *supra* note 278, at 93-94.

381. See *id.* at 57-58.

382. See *id.* at 172-73.

383. See *id.* at 53-54.

psy-professional technique. Certainly it is a risk with conversion attempts, as the discussion in Part IV.A above illustrates. But especially because many of those who present for sexual reorientation efforts presumably do so, at least in part, because of pressure to “change” from friends, family, and co-religionists, choosing instead to undertake a course of therapy designed to address psychic problems but not one’s sexual orientation may leave the patient facing undiminished or exacerbated hostility from anti-gay factions. Even though this possibility is external to the patient, the therapist, and the treatment relationship, it is a serious consideration. Thus, while the moral responsibility for such demonstrated animus would rest with the scorning or shunning individuals or communities, an unhappy les/bi/gay person contemplating psy-professional assistance should know this could happen. Ignorance of this prospect seems unlikely to be a problem, for persons initially seeking sexual orientation conversion will generally be all too aware of this threat, and conversionists are utterly likely to ensure that it is not overlooked.

However, not everything a conversionist might be inclined to attribute to non-conversion therapy should be considered a risk of such therapy. AIDS is a prime example of a condition that should not be “disclosed” because it is not a risk attributable to non-conversion therapies. Yet in transparent attempts to panic people into heterosexuality, to scare them straight, as it were, some conversionists have been arguing that AIDS is such a risk.<sup>384</sup> *That practice should stop, now.*

One example of this linkage sullied the editorial pages of the *Wall Street Journal*. In a piece compassionately entitled “Don’t Forsake Homosexuals Who Want Help,” a number of prominent conversionists including Charles Socarides and Joseph Nicolosi argue that it is the despair of being informed (wrongly, in the authors’ view) they will always be gay that leads to “reckless and life-threatening actions” such as “unprotected sex with strangers.”<sup>385</sup> The authors explicitly blame deaths from AIDS on depressed young men’s having thought non-conversion therapies their only option:

As we grieve for all those lives so abruptly ended by AIDS, we would do well to reflect that many of the young men who have died of AIDS have [sic] sought treatment for their homosexuality and were denied knowledge and hope. Many of them would be alive today if they had only been told where to find [the] help they sought.<sup>386</sup>

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384. Andrew Gans has suggested that this kind of faulty reasoning would support the jarring conclusion that unintended pregnancy must be disclosed as a risk of conversion efforts. Personal communication with author, Sept. 25, 1998.

385. Socarides et al., *supra* note 11.

386. *Id.*

The fourth in the controversial “truth in love” ad series sponsored by far right political and religious groups<sup>387</sup> provides another particularly disgraceful example.<sup>388</sup> Beneath a photo of a three-year-old-boy blowing out the candles on his birthday cake, the 72-point typeface caption announces ominously, “From innocence to AIDS.” The ad next announces that it contains “[o]ne mother’s plea to the parents of homosexuals.”<sup>389</sup> The text that follows tells the story of HIV-positive Michael Johnston and delivers the message, although not quite in so many words, that homosexuality leads to AIDS.

One technique the ad uses to establish this linkage is to erase any role for love or emotion in non-heterosexual sexual orientations and to reduce them to debauchery. Thus, the ad refers to “homosexuality,” “active homosexual men and women,” “your child’s homosexual behavior,” “dangerous behavior,” “this lifestyle,” and “lifestyle choices.”<sup>390</sup> The ad tells the reader—by telling what Michael’s parents<sup>391</sup> had told him—that homosexuality [is] sin and that he needed to turn from it.” In a paragraph captioned “If you’re sold on homosexuality, read no further[.]” the ad continues by discussing the wages of sin: “the physical and spiritual consequences of sin.” Invoking the objective authority of unspecified “statistics,” the ad cautions that “[o]ne unguarded moment can mean a lifetime of suffering with a sexually transmitted disease or, with AIDS, no lifetime at all.” And just so there is no doubt that the Johnstons’ is a cautionary tale, the ad queries rhetorically, “what loving parent wouldn’t want to protect their child by warning them [sic] of the dangers?”<sup>392</sup>

And lest an unsympathetic reader worry that the ad’s sponsors or Michael’s parents are blaming the victim here, Michael adds his voice to the chorus in one key paragraph. Below the contemporary family picture of the three of them (a small image of “AIDS” to counter the much larger, bathetic image of “innocence” that opens the ad?), a first-person quote (ex-

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387. See Human Rights Campaign, *Politicians Behind the Lies* (visited June 29, 1999) <<http://www.hrc.org/ray/behind.html>> (describing campaign and characterizing the sponsors).

388. See Alliance for Traditional Marriage—Hawaii et al., *Towards a New Hope for Healing*, WALL ST. J., Aug. 10, 1998, at A5 (advertisement) [hereinafter Alliance].

389. *Id.*

390. *Id.*

391. Although the ad primarily speaks in the first person for Frances and Jerry Johnston, repeatedly telling how “we” felt or what “we” did, there is an occasional unspecified “I.” For example: “We told Michael that we could never stop loving him. But *I* also told him we would never accept his homosexuality.” (emphases added). Perhaps this is a subtle invocation of the “mother” who offered a “plea” in the ad’s captioning. The ad does not reveal whether Michael’s father also prayed for him, or why he does not plead along with his wife.

392. Alliance, *supra* note 388, at A5.

plicitly attributed to Michael) declares his tremendous gratitude to his parents “for loving me enough to tell me the truth.” Apparently Michael left home when he was 16 (“to meet the world on his own terms”), as the ad announces under the paragraph heading “The heartbreak of homosexuality[,]” not because his parents did a poor job in making him feel that they could and would support him no matter what,<sup>393</sup> but rather “just so I [i.e., Michael] could pursue my own *selfish desires*.”<sup>394</sup>

In these depictions, then, “homosexuality” does not involve *loving* and being loved by a person of one’s own sex, as many lesbian and gay people might have thought. It is not even the “empty affection” the ad says that “love without truth” constitutes.<sup>395</sup> It is, merely, a “selfish desire[]” to engage in a “lifestyle” of “dangerous behavior[s],” “sin” with “physical consequences.”<sup>396</sup>

The problems with arguments such as these are manifold. Being les/bi/gay does not necessarily imply getting AIDS. One is not at risk for AIDS just because the people to whom one is attracted include members of one’s own sex. Nor does being les/bi/gay necessarily imply engaging in high-risk sexual behavior.

Indeed, according to “statistics,”<sup>397</sup> woman-to-woman transmission of HIV is tremendously rare. If risk of AIDS were a persuasive argument for men to consider switching from homosexuality to heterosexuality, it should also be a persuasive reason for more women to consider exiting heterosexuality for a passionate life among women. No wonder the pro-conversion forces scrupulously avoid discussing women when they are trying to frighten les/bi/gay people or their families into a quest for heterosexuality.

Moreover, being heterosexually identified does not shield one from AIDS, either in the U.S. or abroad. Indeed, the majority of HIV infection/AIDS in the world is from heterosexual transmission—not needles or

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393. *Id.* Author Paul Varnell “read[s] between the lines” of the ad to hypothesize that Michael “was so eager to get away from home that he dropped out of high school” and that “he had serious conflicts with his strict, perhaps unloving, parents”). Paul Varnell, ‘Ex-Gays’ on the Couch, WINDY CITY TIMES: CHICAGO’S GAY & LESBIAN ONLINE NEWSWEEKLY, Aug. 13, 1998, (visited Apr. 1, 1999) <[http://www.wctimes.com/html/8\\_13\\_observer\\_s\\_notebook.html](http://www.wctimes.com/html/8_13_observer_s_notebook.html)>.

394. Alliance, *supra* note 388, at A5 (emphasis added).

395. *Id.* (emphasis omitted).

396. *Id.*

397. See, e.g., Mary Becker, *Women, Morality, and Sexual Orientation*, 8 UCLA WOMEN’S L.J. 165, 175 & n.33 (1993); Cicchino, *supra* note 159, at 152 & n.55. *But cf.* *Women and HIV: Breaking the Silence*, 9 BERKELEY WOMEN’S L.J. 144, 146 (1994) (discussing higher HIV seroprevalence among lesbian- and bisexual-identified women in San Francisco than among all San Francisco women, without comparing male seroprevalence rates).

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male/male sex. Again, the sex- or gender-direction of one's desires does not determine one's vulnerability to HIV infection. It is the specific sexual and needle-sharing behaviors that put one at risk. And heterosexually identified people have sex without protection other than birth control pills (which do *not* prevent HIV transmission) and contract sexually transmitted diseases *including* AIDS. In addition, being a "lapsing" heterosexual (or should that be homosexual?), who may present a straight face at church and to one's family but who "may engage in 'more than occasional' homosexual encounters,"<sup>398</sup> is not necessarily conducive to avoiding disease and may, depending on the furtiveness of the circumstances in which one "slips," actually exacerbate one's risk of contracting something nasty or potentially life-threatening.

For all the foregoing reasons, in addition to the simple lack of data to support the claim, AIDS should not be considered a risk attributable to non-conversion therapies. Should it ever come to light that conversionists are intimidating prospective clients into pursuing sexual orientation conversion by invoking the specter of AIDS in their informed consent disclosure discussions of alternatives to their own practices, professional organizations should not hesitate to discipline them for unprofessional conduct. The fact that such alarming behavior is unlikely to come to the attention of professional boards merely underscores the limited utility of professional discipline as a means of protecting client autonomy.

### C. EXPLAINING THE RISKS OF CONVERSION EFFORTS

While AIDS is not a risk of non-conversion therapeutic alternatives that would need to be explained to a client considering attempting sexual reorientation, conversion techniques themselves threaten their subjects with risks of various harms, described above in Part IV.A. A psy-professional must explain the risk of these harms in order to allow the possibility of informed consent. This obligation, however, is unlikely to afford much protection because, even assuming good faith on the part of conversionists, in operation it may require a mindset radically different from a conversionist's own in order for meaningful disclosure to be possible.

There is no great reason to think that conversionists would be any more prone than other psy-professionals to fail to disclose generic risks of their techniques. For example, conversionists and non-conversionist psy-

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398. Douglas C. Haldeman, *Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination*, in GONSIORREK & WEINRICH, *supra* note 36, at 149, 151 [hereinafter *Conversion Therapy*].

choanalysts might seem equally likely or equally unlikely to fulfill their obligation to tell prospective clients that “even if it works, the patient can go through extremely difficult intermediate mental states before reaching [her or] his optimal mental state.”<sup>399</sup> Similarly, improper handling of counter-transference reactions (wherein the analyst develops emotional reactions from her or his relationship with the analysand)<sup>400</sup> is always some risk in analysis, though one unlikely to be explained to the client by any analyst, conversionist or non-conversionist.<sup>401</sup>

When it comes to explaining risks peculiar to conversion efforts, however, psy-professionals are likely to be unwilling or unable to satisfy their informed consent obligations. It would be difficult if not impossible for a conversionist who sincerely believes that homosexuality is a mental disorder and client motivation a key, if not the primary, factor in “successful” reorientation<sup>402</sup> to explain effectively to a client that the psy-professional’s conversion efforts may cause depression and harms to the client’s self-esteem by the psy-professional’s blaming the client for not trying hard enough should conversion prove elusive. While “resistances” to analysis, for example, are not uncommonly invoked by analysts as the source of difficulty with clients who are not improving or meeting their goals,<sup>403</sup> conversionists seem more likely to attribute non-correction of what they believe to be a mental disorder to a resistance than to consider that they may be trying to help “cure” a non-illness. For those conversionists who are convinced that, at their core, all people are really heterosexual, it may be inconceivable that lack of success at recovering or removing impedances to the client’s heterosexuality might be due to the absence of any such “authentic” core to be restored or unblocked. Or, a conversionist who is certain that pathologic family dynamics such as over-dependence on the mother caused a male client’s homosexuality may find herself or himself

399. Horowitz, *supra* note 274, at 1647.

400. See WALROND-SKINNER, *supra* note 278, at 82 (discussing two views of counter-transference: “the effects of the analyst’s own unconscious needs and conflicts on his understanding or technique,” and a broader view, “the whole of the therapist’s feelings and his *conscious* and *unconscious* reactions to the patient”) (internal quotation marks omitted).

401. Interview with Professor Elyn Saks, University of Southern California Law School (Sept. 29, 1998).

402. Cf. BIEBER ET AL., *supra* note 61, at 319 (“[I]n our judgment a heterosexual shift is a possibility for all homosexuals who are strongly motivated to change.”).

403. Cf. Pillard, *supra* note 252, at 417-18 (somewhat polemically recounting some conversionists’ view that “[i]f homosexuality is not disappearing, it is not the treatment but the patient who is worthless. He refuses to want what the doctor thinks is good for him and therefore he cannot be ‘helped’”). “Resistance,” defined as “[t]he patient’s efforts to obstruct the aims and process of treatment,” is “a fundamental concept in psychoanalysis.” WALROND-SKINNER, *supra* note 278, at 298 (emphasis omitted).



unable to convey to the (prospective) client that one risk of harm he faces from conversion efforts is a deterioration of family relationships; after all, the conversionist believes that the client-mother relationship is already affirmatively bad, and that it would be healthier for the client to withdraw (at least to some extent) from that relationship. So how could the professional consider that a harm? It is, of course, possible for conversionists to say something like, “if you—or the government or the APIA or APtA—would consider it to be a harm if you were to give less weight to your mother’s utterances and generally have a less close relationship with her because of a new skepticism of her authority, even though I would not think it a harm in your case [*optional*: because she has a smothering relationship with you that is trapping you in a homosexual problem], then that would be a risk of pursuing heterosexuality.” But the more convoluted the Janus-like “disclosure” gets, and the more it attempts to steer the client into conversion efforts by minimizing their risks, the less likely it can effectively communicate to the client what informed consent requires the professional to disclose.

#### D. EXPLAINING EFFICACY OF CONVERSION EFFORTS

In addition to explaining the risks of the procedure at issue, a professional who wishes to obtain genuine informed consent must provide a prospective client with information about the likely effect of the procedure at issue, which requires some discussion of its efficacy in general. This is one area where conversionists have not been hesitant to offer information. Unfortunately, their assertions of demonstrated efficacy are profoundly unreliable, although in ways that are likely not easily explained to prospective clients.

Subsection 1 below takes some studies of conversion efforts at face value and reviews the evidence of failures of conversion. In the significant majority of cases they concede failure to produce heterosexuality in their subjects. Next, subsection 2 discusses the “content” of “homosexuality,” what the concept might or should mean, which is necessary to critically evaluate claims of “change” in the context of sexual reorientation efforts. It suggests that no one conception of homosexuality is adequate both to reflect the realities of people’s social, emotional, and erotic lives and to serve the social (including legal and constitutional) purposes into which our definitions are pressed. For evaluating claims of effective sexual orientation conversion, however, a conception focusing on fantasies, arousal, and attraction should be used. With that caveat and working conception in place, this subsection then revisits efficacy studies with a more skeptical eye,

concluding that their failure to address possible components of sexual orientation carefully in many cases eliminates their potential reliability as evidence of even limited effectiveness at sexual orientation conversion. Finally, subsection 3 investigates difficulties in ascertaining both a person's sexual orientation and whether conversion efforts have truly been effective, concluding that it remains impossible for observers to know to what extent, if any, sexual reorientation techniques are effective. This highlights some of the limits of human ability to attain knowledge and, as a result, of law's ability to protect against the dangers of sexual orientation conversion efforts by insisting on disclosure of efficacy rates.

### 1. *Taking Studies on Their Own Terms: Evidence of Failures*

Proponents of sexual orientation conversion efforts maintain, sometimes vociferously, that they work. They may concede that "none of these approaches *guarantees* results, and most require[] a long period of treatment."<sup>404</sup> But they insist that people "have a right to know that prevention and *effective* treatment are available . . . . A variety of studies," some conversionists claim, "have *shown* that between 25% and 50% of those seeking treatment experienced significant improvement."<sup>405</sup>

Some who are concerned about conversion attempts view the evidence of efficacy differently, finding it at best "less than compelling."<sup>406</sup> They maintain that a number of studies suffer from "inadequacies in the selection criteria and the classification of subjects and poorly designed and administered outcome measures."<sup>407</sup> Even the APIA, which has not to date taken a substantive position on the efficacy of the treatments, has concluded that "[w]ell-designed scientific studies to test [the belief that reparative or conversion therapy is effective and beneficial] have not been done."<sup>408</sup>

There is, however, considerable evidence of failures of conversion efforts. This is not to say definitively that no conversions have ever been ef-

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404. Socarides et al., *supra* note 11 (emphasis added).

405. *Id.* (emphasis added). The authors do not, however, define "significant improvement," which typically means something like "significant improvement in the client's mental health," which need not include "improvement" in his or her sexual orientation.

406. Haldeman, *supra* note 61, at 223.

407. *Id.* at 224.

408. American Psychol. Ass'n, *supra* note 273, at 1. Still others believe the efficacy question irrelevant to whether sexual orientation conversion should be attempted by psy-professionals. Davison, for example, believes that the one possible "sense in which efficacy relates to the ethical issue" is if harms to patients result from *ineffective* sexual reorientation efforts, exacerbating their situations. Davison, *supra* note 296, at 199-200. On that question, too, the APIA believes there is a lack of evidence to date. See American Psychological Association, *supra* note 273, at 1. But see *supra* Part IV.A (discussing harms of sexual orientation conversion efforts).

fective, but that the clear majority of recorded attempts have been admittedly unsuccessful. In part this is a matter of perspective, akin to viewing the proverbial glass as half-empty or half-full. But again, given the grim history of reorientation efforts recounted in Part I of this Article and the history of these efforts' failures, the "pessimistic" perspective seems somewhat more appropriate than the "optimistic" one, though a more nuanced position than either might be optimal.

Certainly documented physical and religious attempts to change sexual orientation have not proven productive of exclusive heterosexuality, particularly in exclusively homosexual subjects. On the physical side, lobotomies were not effective at changing people's sexual orientation or sexual behavior. For example, one patient lobotomized in 1941 suffered a progressive mental decline apparently caused by the operation, progressing through psychosis to dementia.<sup>409</sup> Another man, who endured a frontal lobotomy in 1951, subsequently "participated in all types of homoerotic and autoerotic manifestations—kissing, fondling other patients, engaging in active and passive fellatio."<sup>410</sup> The researchers examining that case, after studying the cases of a number of patients who had been lobotomized for various reasons, concluded that "[l]obotomy, in the majority of cases, does not change the pattern of sexual behavior which existed prior to operation."<sup>411</sup>

Testicular tissue transplants<sup>412</sup> have not been successful.<sup>413</sup> Neither have other surgical and chemical technologies, including hormonal interventions. One study of chemical aversive conditioning by Kurt Freund, published in 1960, claimed some success, but the results were short-lived: by five years after treatment *all* of the patients were experiencing same-sex attractions or desires again, and eighty-seven percent of them were engaging in same-sex sexual behavior.<sup>414</sup> The apparent "success" reported by one practitioner who used the drug Metrazol to induce grand mal seizures<sup>415</sup> was not replicated.<sup>416</sup> No hormonal intervention has seemed able

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409. See KATZ, *supra* note 11, at 175, 181 (reprinting Joseph Friedlander & Ralph S. Banay, *Psychosis Following Lobotomy in a Case of Sexual Psychopathology: Report of a Case*, 59 ARCHIVES OF NEUROLOGY & PSYCHIATRY 302 (1948)).

410. *Id.* at 192 (reprinting Moses Zlotow & Albert E. Paganini, *Autoerotic and Homoerotic Manifestations in Hospitalized Male Postlobotomy Patients*, 33 PSYCHIATRIC Q. 490 (1959)).

411. *Id.* at 193.

412. See *supra* text accompanying note 38.

413. See Silverstein, *supra* note 36, at 107.

414. See LEVAY, *supra* note 14, at 92 (citing Kurt Freund, *Some Problems in the Treatment of Homosexuality*, in BEHAVIOR THERAPY AND THE NEUROSES 312-26 (H. Eysenck ed., 1960)).

415. See *supra* note 47 and accompanying text.

to change men's sexual orientations, the gender *direction* of desires, as opposed to influencing *degrees* of sexual desire or drive.<sup>417</sup> In addition, perhaps the most commonly cited study of "spiritual" conversion efforts resulted in three of eleven subjects (selected by unspecified criteria from a pool of *three hundred* "dissatisfied" homosexuals) "report[ing] no current homosexual desires, fantasies, or impulses," though even "one of the three [was] listed as still being 'incidentally homosexual.'"<sup>418</sup>

Psychotherapeutic approaches also demonstrate substantial failure rates. All methodological problems aside (and there are many), Bieber's (in)famous study<sup>419</sup> itself reported only a "27% success rate in heterosexual shift after long-term therapy. Of these [successful cases], however, only 18% were exclusively homosexual in the first place . . ." <sup>420</sup> A different study published three years later stated "that half of 19 subjects reported exclusive heterosexual behavior four and a half years after treatment. However, as in Bieber's study, those subjects reporting such change were bisexual to begin with; exclusively homosexual subjects reported little change."<sup>421</sup>

On the higher side, one conversionist has "claim[ed] that overall, 38% of his patients achieved 'solid heterosexual shifts' . . ." <sup>422</sup> Comparably, another study of thirty-two patients undergoing group therapies aimed at changing sexual orientation "report[ed] a 37% shift to heterosexual-

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416. See KATZ, *supra* note 11, at 167 (citing George N. Thompson, *Electroshock and Other Therapeutic Considerations in Sexual Psychotherapy*, 109 J. NERVOUS & MENTAL DISEASES 531 (1949)).

417. See Murphy, *supra* note 17, at 511-12.

418. *Conversion Therapy*, *supra* note 398, at 158 (citing and quoting E. Mansell Pattison & Myrna Pattison, *Ex-Gays: Religiously-Mediated Change in Homosexuals*, 137 AM. J. PSYCHIATRY 1553 (1980)).

419. See *supra* note 61 and *supra* text accompanying note 109.

420. *Conversion Therapy*, *supra* note 398, at 151.

421. *Id.* Houston MacIntosh is reported as claiming a 23% aggregate rate of change to "comfortable heterosexuality" in over 1200 patients seen by 285 psychoanalysts in the U.S. See Joseph Berger, *A Critique of the Writings of Richard Isay* (visited Nov. 23, 1998) <<http://www.narth.com/docs/1996papers/berger.html>> (discussing Houston MacIntosh, *Attitudes and Experiences of Psychoanalysts in Analyzing Homosexual Patients*, 42 J. AM. PSYCHOANALYTIC ASS'N 1183 (1994)). NARTH even misleadingly stated that this study involved "a survey of 1275 patients." NARTH, *supra* note 86 (emphasis added). MacIntosh himself, however, subsequently characterized his results more modestly (and more accurately), as "psychoanalysts' opinions regarding whether a homosexual patient in analysis, for whatever reason, can . . . change to heterosexuality." Houston MacIntosh, *Factors Associated with the Outcome of Psychoanalysis of Homosexual Patients* (visited July 1, 1999) <<http://www.narth.com/docs/1996papers/macintosh.html>> (emphasis added).

422. *Conversion Therapy*, *supra* note 398, at 151.

ity . . . .”<sup>423</sup> The reliability of these figures is another matter, and will be discussed below.

More typical of claimed successes, however, even one of the most ardent advocates of reorientation concedes that “[h]istorically, the cure rate in the treatment of homosexuality has been low. In those few studies that do claim success, the percentage of clients converted to heterosexuality runs from 15 to 30 percent, and there is question whether ‘cure’ was maintained on long-term follow-up.”<sup>424</sup>

Indeed, according to a fact sheet on reparative therapy issued by the APIA a few years ago, “[n]o scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change sexual orientation.”<sup>425</sup> The next sub-section addresses some reasons for the state of the record.

## 2. *Conceptual Confusion: Defining “Homosexuality,” “Heterosexuality,” and “Change”*

*“Even if one limits oneself to standard variations, there are literally hundreds of different sexual identities and sexual orientations.”*<sup>426</sup>

One problem with many conversionists’ contentions, and some of the anti-conversionists’ as well, stems from inadequate conceptualization of the “homosexuality” that is also the subject of debate. In addition to the definitional difficulties, there are profound epistemological problems that must be confronted.

Douglas Haldeman is mainly correct in stating that a definition of sexual orientation should precede any putative description of how sexual orientation may be changed.<sup>427</sup> Sexual orientation can mean different things to different people at different times, and it is not always clear that those who argue about contemporary efforts to convert people to heterosexuality are fighting on common ground. It is difficult if not impossible to evaluate

423. *Id.* (citing S. Hadden, *Treatment of Male Homosexuals in Groups*, 16 INT’L. J. GROUP PSYCHOTHERAPY 13 (1966)).

424. NICOLSI, *supra* note 16, at 11.

425. *Conversion Therapy*, *supra* note 398, at 160.

426. Frederick Suppe, *Explaining Homosexuality: Who Cares Anyway?*, in SAME SEX: DEBATING THE ETHICS, SCIENCE, AND CULTURE OF HOMOSEXUALITY 167, 170 (John Corvino ed., 1997) [hereinafter *Explaining Homosexuality*]. *Cf.* Koppelman, *supra* note 30, at 263 (“No bright line exists to distinguish the white and black races, while the distinction between male and female is firmly rooted in biology; but there is no clear distinction between ‘homosexuals’ and ‘heterosexuals.’”). I would, however, note that the “natural” male/female dichotomy is neither as exhaustive nor as mutually exclusive as is commonly believed. *See generally supra* note 154.

427. *See Haldeman, supra* note 61, at 221.

the success of efforts to change homosexuality without establishing the meaning of “homosexuality” and “heterosexuality.” But agreement on a specific conception may be difficult to attain. This is true even if, like many sexual scientists,<sup>428</sup> one limits notions of sexual orientation to ones focused on the sex (or perhaps gender) of the person at issue and the sex or sexes (or possibly gender or genders) of those to whom she or he is attracted, sometimes referred to as “sex of object choice”—rather than explore other possible dimensions of sexual attraction such as body shape, age, race, class, particular sex acts, and on and on.<sup>429</sup>

This subsection briefly addresses the possible factors that “sexual orientation” might comprise, which extend beyond the obviously behavioral, and argues that fantasies, affection, and arousal provide the best definition in this context. It then revisits some of the studies purporting to establish effective changes in people’s sexual orientations, demonstrating how their failure to use this conception (or even to specify any conception) renders them unreliable as evidence for the supposed efficacy of *sexual orientation* change efforts.

*“Any definition of sexuality based solely on behavior is bound to be deficient and misleading.”*<sup>430</sup>

Some people reserve the term “homosexuality” for acts of sexual behavior. Thus, Charles Socarides tells a lay readership that homosexuality is “[s]ame-sex sex,” that is, “men having sex with other men. Or women having sex with other women.”<sup>431</sup> In a somewhat similar fashion, although not explicitly purporting to offer a definition, Representative William Danemeyer has basically insisted that you cannot take the sex out of the homosexual, or, in the words of Naomi Mezey, that “[y]ou can tell the homosexuals by what they do.”<sup>432</sup> His incredulous indignation at the denial of this conduct-claim blares forth from the pages of the *Congressional Record*: “They are actually asking Americans to believe that a man can be a

428. See, e.g., MURPHY, *supra* note 27, at 70 (“I have had to restrict my discussion to erotic interests based on sex traits when it is clear that sexual orientation includes a great deal of other erotic interests involving, for example, hair color, race, age, and preferred contexts for intercourse.”).

429. See, e.g., EVE KOSOFSKY SEDGWICK, *EPISTEMOLOGY OF THE CLOSET* 25 (1990) (noting various ways in which an individual’s sexual attractions may vary); Deborah C. Stearns, *Gendered Sexuality: The Privileging of Sex and Gender in Sexual Orientation*, 7 NAT’L WOMEN’S STUD. ASS’N J. 8, 16, 18-20 (1995) (arguing that sexuality outstrips the category of “gender”).

430. Haldeman, *supra* note 61, at 221.

431. SOCARIDES, *supra* note 348, at 15.

432. Mezey, *supra* note 23, at 114.

homosexual without ever committing sodomy or any other intimate physical act with the same sex.”<sup>433</sup>

Few if any mental health professionals, however, regard sexual orientation so narrowly. Reviewing the literature, Frederick Suppe found five broadly recognized components of sexual orientation: sexual behavior, interpersonal affection patterns, erotic fantasy structure, arousal cue-response patterns, and self-labeling.<sup>434</sup> These components may vary fairly independently of one another,<sup>435</sup> and they can be thought to have both direction (toward men, toward women, or toward both) and magnitude (stronger or weaker) with respect to each direction they run. There thus are a variety of more sophisticated notions of “homosexuality” (and, at least implicitly, “heterosexuality” and “bisexuality”) employed by both non-conversion therapists and conversionists.

In the latter camp Nicolosi, in particular, distinguishes between “gay” and “homosexual” persons. In his view, “[g]ay describes a contemporary sociopolitical identity and life-style.”<sup>436</sup> But based on his experience with his clients, Nicolosi has concluded that

[t]here are homosexual men who reject the label of “gay” along with all of the implications that label would bestow upon them. Although “homosexual” may name an undeniable aspect of their psychology, “gay” describes a life-style and values they do not claim. These men experience conflict between their values and their sexual orientation. Experiencing their personal development to be encumbered by homoerotic desires, they seek not to surrender to, but to surmount their homosexual attractions . . . . I call [these men] *non-gay homosexuals*.<sup>437</sup>

Nicolosi admits that these men’s “sexual feelings” are same-sex in orientation, but (in a not atypical slippage) maintains that “[s]exual *behavior* is just one aspect of a man’s identity, an identity that continually deepens, grows—even changes—through his relationship with others.”<sup>438</sup>

Thus, it is reasonably clear that *sexual orientation* (and the related concept *homosexuality*) might plausibly refer to a variety of different attributes, singly or in combination. What is not immediately clear is whether one conception is most suited to all social, legal, and constitutional purposes. For some issues—perhaps evaluating the constitutional persua-

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433. *Id.* (quoting 135 Cong. Rec. H3511 (daily ed. June 29, 1989) (statement of Rep. Danne-meyer)).

434. *See Explaining Homosexuality, supra* note 426, at 169.

435. *See id.*

436. NICOLOSI, *supra* note 16, at 3-4.

437. *Id.* at xv-xvi.

438. *Id.* at 13 (emphasis added).

siveness of the invocation by the U.S. government of sex acts proscribed by the aspirationally named Uniform Code of Military Justice in defense of excluding les/bi/gay persons from military service—a focus on actual sexual behavior, of both heterosexual and les/bi/gay persons, may be the most salient aspect. For many others—such as, perhaps, evaluating the constitutional permissibility of the U.S. government’s invocation of ostensibly heterosexual servicemembers’ antipathy to les/bi/gay persons—sexual orientation identities, both self- and other-ascribed, might prove more salient. No universal, unidimensional conception of “sexual orientation” (or “homosexuality”) seems likely to prove adequate.

For evaluating claims of efficacy of sexual orientation conversion efforts, it is probably most helpful to focus on the sex or gender (to which I earlier referred as the direction) of the subjects of a person’s fantasies, affections, and arousal.<sup>439</sup> These are the elements of one’s psychic/mental/emotional life that correspond most intuitively to an “orientation,” which seems to connote an inner state.<sup>440</sup> They therefore best reflect the most likely understanding of claims that a person’s “sexual orientation” has been changed or “homosexuality” eliminated.<sup>441</sup>

Actual sexual behavior (which Dannemeyer would demand) and self-labeling (which even Nicolosi would not) are less important in this con-

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439. Indeed, many people have taken (uniform) same-sex desire as the defining trait of homosexuality. Philosopher Richard Mohr, for example, takes as a “core” definition of *homosexuality* “the desire for sexual relations with members of one’s own biological sex.” RICHARD D. MOHR, *GAY IDEAS: OUTING AND OTHER CONTROVERSIES* 241 (1992). Similarly, Historian John Boswell argued that one could meaningfully look in different historical eras and contexts for persons “whose erotic interest is predominantly directed toward their own gender (i.e., regardless of how conscious they are of this as a distinguishing characteristic).” John Boswell, *Revolutions, Universals, and Sexual Categories* (1982), reprinted in *HIDDEN FROM HISTORY: RECLAIMING THE GAY AND LESBIAN PAST* 35 (Martin Duberman, Martha Vicinus & George Chauncey, Jr. eds., 1989).

440. John Finnis argues that

[t]he phrase ‘sexual orientation’ is radically equivocal[,] . . . ambiguously assimilat[ing] two things: [I] a psychological or psychosomatic disposition inwardly orienting one *towards* homosexual activity; [II] the deliberate decision so to orient one’s public *behavior* as to express or *manifest* one’s active interest in and endorsement of homosexual *conduct* and/or forms of life which presumptively involve such conduct.

John M. Finnis, *Law, Morality, and “Sexual Orientation,”* 69 NOTRE DAME L. REV. 1049, 1053-54 (1994). I believe this passage is mistaken in arguing that “sexual orientation” is the primary ambiguous culprits, rather than “*discrimination based on sexual orientation*,” on which his subsequent discussion focuses. See *id.* at 1054-55 (emphasis added). Cf. Janet E. Halley, *Romer v. Hardwick*, 68 U. COLO. L. REV. 429, 442 (1997) (discussing use of scare quotes around “orientation”).

441. Cf. American Psychol. Ass’n, *Answers to Your Questions About Sexual Orientation and Homosexuality* (visited Apr. 14, 1999) <<http://www.apa.org/pubinfo/orient.html>> (“Sexual orientation . . . is distinguished by an enduring emotional, romantic, sexual or affectionate attraction to individuals of a particular gender.”).



text.<sup>442</sup> As psychobiologist James Weinrich and anthropologist Walter Williams maintain, “people can be defined as ‘homosexual’ even if they do not perform any homosexual acts, or even if they despise the gay world or their homosexual feelings.”<sup>443</sup> Because most, though not all, conversionist individuals and organizations hold out the promise of a change in orientation (or “homosexuality”), not merely a change in behavior, and because a great many who seek heterosexuality report doing so out of concerns about their feelings toward people of the same-sex—even if they have never engaged in same-sex sexual activity because of those feelings—fantasies, affection, and arousal should be the aspects of sexual orientation used to evaluate claims of sexual orientation conversion efforts’ efficacy.

In trying to assess claims of success made by conversionists in light of the above observations, conceptual difficulties immediately arise, for their studies generally do not adopt conceptions of *sexual orientation* (whether explicitly or implicitly) by which reorientation efforts might be adequately gauged. Writing of one highly touted conversionist study, one scholar queries: “If a ‘solid heterosexual shift’ [can encompass] one in which a ‘happily married’ person may engage in ‘more than occasional’ homosexual encounters, what does a ‘soft’ heterosexual shift look like?”<sup>444</sup>

Some critics have charged that pro-change forces are led by their biases to ignore the conceptual difficulties. “Eager to construe heterosexual competence as orientation change, these researchers ignore the complex question of how sexual orientation is assessed in the first place.”<sup>445</sup> What is promised and what is delivered sometimes do not seem to match well: “While [the studies discussed in one review] claim to change orientation, the outcomes’ [success and failure] are nearly always defined in terms of heterosexual performance.”<sup>446</sup>

In one study of aversive conditioning, “the outcome criteria were defined as suppression of *homosexuality*, and an increased capacity for heterosexual behavior. It is not uncommon for homosexuals who have undergone aversive treatments to notice a temporary sharp decline in their

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442. Not only could self-labeling distinguish between “gay” and “homosexual” as Nicolosi does, it also may or may not vary with behavior, fantasies, affection, and arousal. Some men who have sex with other men, or at least another man, do not conceive of themselves as gay (or “homosexual”); some men who do consider themselves gay may lack one or more of same-sex behavior, fantasies, affection, and arousal.

443. James D. Weinrich & Walter L. Williams, *Strange Customs, Familiar Lives: Homosexualities in Other Cultures*, in GONSIORÉK & WEINRICH, *supra* note 36, at 44, 57-58 (1991).

444. *Conversion Therapy*, *supra* note 398, at 151.

445. *Id.* at 152.

446. *Id.*

homosexual responsiveness.”<sup>447</sup> Another reviewer concluded that “aversive therapies in homosexuality do not alter subjects’ sexual *orientation*, but serve only to reduce sexual arousal”; that is, they do not change the sex or gender of those about whom a person fantasizes or towards whom she or he feels affection and arousal, but only reduce her or his degree of fantasizing, affection, and arousal.<sup>448</sup> “Another study suggest[s] that behavioral conditioning decreases homosexual orientation, but does not elevate heterosexual interest.”<sup>449</sup>

One oft-cited study on religiously-based conversion efforts claimed that eleven male subjects experienced “complete *orientation* reversal” from homosexual to heterosexual.<sup>450</sup> However, the study actually defined successful outcomes as the (self-reported) capacity for peno-vaginal intercourse.<sup>451</sup> Now, it is unlikely that the authors even mistakenly believed that a man who became able to enjoy male-female sex (or so claimed) could not also be genuinely attracted to other men, for only three of their subjects (out of an initial group of three hundred) “reported no current homosexual desires, fantasies, or impulses,” and one of those was reported “as still being ‘incidentally homosexual.’”<sup>452</sup>

The failure to distinguish among various dimensions of sexuality that might be affected by sexual orientation conversion efforts clouds the significance of the studies purporting to show “conversions” or “cures” of “homosexuals.” Just as sexual orientation is a multi-faceted phenomenon no single aspect of which is likely to suffice for all purposes, “change” of sexual orientation also enjoys manifold possibilities, and the failure of conversionists to specify carefully the types of change they claim to produce renders unreliable their sometimes grandiose claims of success in changing people’s sexual orientations. Without using a conception proper for evaluating efficacy of sexual *orientation* change, these studies do not establish the efficacy of conversion efforts.

### 3. *Difficulties of Ascertainment*

Even with a more sophisticated conceptualization of sexual orientations, however, there remain truly daunting epistemological challenges, dif-

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447. *Id.* (emphasis added).

448. *Id.* at 153 (emphasis added) (quoting Nathaniel McConaghy, *Controlled Comparison of Aversive Therapy and Covert Sensitization in Compulsive Homosexuality*, 19 BEHAV. RES. & THERAPY 425 (1981)).

449. *Id.*

450. *Id.* at 158 (emphasis added) (quoting Pattison & Pattison, *supra* note 418).

451. *See id.*

452. *Id.* (citing and quoting Pattison & Pattison, *supra* note 418).

facilities in ascertaining—“measuring” as it were—what sexual orientations people actually have at some given moment. In particular, the claims to privileged authority of mental health professionals and the necessity of reliance on therapist- and self-reports in a heterosupremacist culture renders the empirical evaluative enterprise irreducibly impracticable.

Psychoanalytic conversionists are unlikely to be persuaded by non-psychoanalytic empirical research that homosexuality is not a mental disorder, for their beliefs and theories commonly resist empirical challenge. Thus, conversionists might have rejected the APtA’s 1973 decision to remove homosexuality per se from the DSM in part on the grounds that *lack of distress* “often revealed the depths of pathology.”<sup>453</sup> This is one example of the non-falsifiability of much psychoanalytic theorizing. Another includes the position, however reasonable, held by the family dynamics school of etiology, that what matters in determining a boy’s reaction to his relationship with his father and whether or not the boy will become homosexual is the boy’s subjective reaction to this relationship and not whether observers would characterize it as good or poor on the basis of objective, verifiable criteria.<sup>454</sup>

Thus, Charles Socarides, for example, proclaims that “[o]nly in the consulting room, using the technique of introspective reporting and free association, protected by all the laws of medicine, psychology, and psychiatry, will an individual reveal the hidden (even from himself) meaning and reasons behind his act.”<sup>455</sup> A more candid statement of the conversionist’s investment in his or her position as a psy-professional authority is hard to come by. But it is this supreme confidence in their privileged access to the “truth” about their patients that allows conversionists authoritatively to declare, for example, that homosexual patients’ “social anxiety, *despite ap-*

453. BAYER, *supra* note 31, at 139. Cf. ESKRIDGE & HUNTER, *supra* note 328, at 145 (“[Certain serious sociopathic personality] disturbances combined serious pathology with a lack of concern on the part of the patient. This trick explained how some homosexuals could consider themselves healthy and normal: part of their sickness was they didn’t realize how sick they were!”).

454. See, e.g., Audio tape of Jane Boyer’s address at the Homosexuality and Public Life Conference, Washington, D.C. (June 19, 1997). She said:

The other thing that I want to point out is that there does not necessarily have to be abuse within the family [for someone to become gay]. It can be, what it is, it’s *your* perception of rejection, it’s how *you* perceive it. And with everyone else looking into the family dynamics will [sic] say, “Well, this guy came from the perfect family” . . . But it’s one’s perception.

*Id.* Ms. Boyer leads a conversion ministry.

455. Socarides, *supra* note 126, at 315. Cf. DAVID F. GREENBERG, THE CONSTRUCTION OF HOMOSEXUALITY 431 (1988) (“[Behaviorism’s] applicability to social problems was premised on the existence of a small elite who could use it to manipulate the masses. It was a doctrine for technocrats, not participatory democrats.”) (footnote omitted).

parently rational justification, however, is based largely on a projected form of unconscious guilt.”<sup>456</sup>

Moreover, this very investment is only one factor rendering suspect the conversionist’s reports of change. When the people claiming “successful” change adhere to a scientifically dubious—indeed, discredited—notion that homosexuality is a mental disorder, they raise concerns about whether “the measurement of change due to a treatment [is] unbiased.”<sup>457</sup> In addition, observations or assessments of “treatment” outcomes may be biased because “[m]ost people who claim effectiveness are also providing the treatment.”<sup>458</sup> Furthermore, “because of the nature of the relationship between clients and their therapists”—which in reparative therapy is marked by even more therapist intervention than typical of psychoanalysis<sup>459</sup>—“clients’ wishes to please their therapists” may affect reported results.<sup>460</sup>

Reliance on self-reports for assessments of conversion efforts has widely been viewed as problematic for other reasons, as well. First, there are little reliable systematic data about the sexual orientation conversion efforts attempted in the U.S. today. Pro-change psy-professional Jeffrey Satinover claims that “many groups of substantial size across the country do ‘treat’ homosexuality with remarkable success.”<sup>461</sup> He concedes, however, that “there is little ‘hard’ data—only first-hand experience and reports . . . . Many, though not all, such programs are ministries, and their approach is unabashedly based on faith.”<sup>462</sup> Also contributing to the dearth of data, survey participants may and have declined to answer questions about homosexuality.<sup>463</sup>

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456. Socarides, *supra* note 112 (emphasis added).

457. American Psychol. Ass’n, Public Affairs Office, *supra* note 273, at 1.

458. *Id.* See also *Demise of the Illness Model*, *supra* note 131, at 127 (criticizing BIEBER ET AL., *supra* note 61):

[T]he same group of psychoanalysts developed a theory about homosexuality; developed the questionnaire to test their theory; designed the research study; served as analysts for the patient subjects; served as raters in the research project on their own patients; interpreted the results; and finally concluded that their theory had been verified. There are too many sources of potential researcher bias in this research. In fact, it would be difficult to build more potential for researcher bias into experimental procedures than the Bieber group did.

*Id.*

459. *Supra* text accompanying notes 59-64.

460. American Psychol. Ass’n, Public Affairs Office, *supra* note 273, at 1.

461. SATINOVER, *supra* note 10, at 170.

462. *Id.* (emphasis omitted).

463. See, e.g., John C. Gonsiorek & James D. Weinrich, *The Definition and Scope of Sexual Orientation*, in GONSIOROK & WEINRICH, *supra* note 36, at 8 (discussing 15.4% refusal rate, in Robert E. Fay, Charles E. Turner, Albert D. Klassen & John H. Gagnon, *Prevalence and Patterns of Same-Gender Sexual Contact Among Men*, 243 SCI. 338 (1989)) [hereinafter *Scope of Sexual Orientation*].

Second, such data as exist are, for a number of reasons, of questionable value. For example, even if survey participants do answer, they “must accurately appraise their own degree of same-sex interests,” which may not always occur in individuals who have yet to come out.<sup>464</sup> The “social condemnation of homosexuality”<sup>465</sup> may lead to false denials of same-sex attractions, sexual behavior, identifications, and so on, or false affirmations of heterosexualward change. “Research subjects who have reasons to doubt the confidentiality or anonymity of the data or who are simply frightened of negative repercussions, regardless of guarantees of safety, are likely to underreport same-sex orientation.”<sup>466</sup>

The magnitude of this problem should not be underestimated. Janet Halley has detailed the ways in which in U.S. society (where non-heterosexually-identified persons’ sexual orientation or perceptions thereof often have negative social and legal consequences for our jobs, our families, our safety) can and does render incoherent the search for “true” sexual orientation identities. Professor Halley discusses the case of one man ejected from the Navy under the U.S.’s homo- and bi-phobic exclusion policy, despite his renouncing his lapse in heterosexuality. Halley admits that we are not “entitled to conclude that [his] profession of repugnance [at the same-sex sexual acts in which he had engaged] was merely strategic and cynical,” yet she also notes that “we are not entitled to impute to [him] actual repugnance . . . (and thus a stable or reformed heterosexual identity) because his confession of this emotion might be cynically strategic.”<sup>467</sup> Cynicism aside, it is not difficult to understand how a married man who wishes to remain with his wife for one or more of many possible reasons after she has discovered his homoerotic interests might have powerful incentives to report a successful “cure,” even if that required misrepresentation.

In addition to the shortage and inherent unreliability of first-hand data about change to heterosexuality, there is another potential problem. When a person experiencing conflicts and same-sex desires presents to a psychoanalyst, particularly one who still or newly believes that “homosexuality” itself is a mental illness,<sup>468</sup> the ability to judge her or his claims of “suc-

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464. *Id.*

465. *Id.*

466. *Id.*

467. Janet E. Halley, *The Construction of Heterosexuality*, in *FEAR OF A QUEER PLANET: QUEER POLITICS AND SOCIAL THEORY* 82, 86-87 (Michael Warner ed., 1993).

468. Cf. SIEGEL, *supra* note 146, at *xii*:

To be a liberal and liberated woman and yet to view homosexuality as the result of untoward development seemed at times a betrayal of all I then believed. But viewing my patients through the lens of psychoanalytic thinkers and clinicians [especially Socarides] soon showed

cess” is radically undermined from the outset. This epistemological precariousness is only exacerbated when the glowing “first-hand” testimonials of these patients are articulated in the very jargon and theories of the conversionists who claim that they are only serving the patient’s choices and values, helping him or her to deeper understanding through introspection.<sup>469</sup>

For example, Nicolosi claims that one former client said or wrote the following:

The issue for me is disconnectedness from my masculine identity. I feel like an outsider when I’m with men. I don’t feel accepted by them, and I have difficulty living out or expressing anything that I see as a masculine trait. Risk-taking is a masculine trait, and goal-setting requires a masculine energy that I feel very intimidated by. I’ve always had a tremendous craving for the masculine, whether it’s a male friend or some activity that is masculine, some kind of sports.

Searching for different ways to reach that masculinity I feel detached from, I realize I don’t really want to sexually pursue other men. I see that I’m trying to bond with them so that I can feel a part of them, connected with them, equal to them, and not to feel that I’m less and the other man’s more.<sup>470</sup>

This confession closely tracks the language of Nicolosi’s theory, which holds that male patients “particularly need[] intimate male connectedness.”<sup>471</sup> “[D]isenfranchisement from males,” Nicolosi maintains, “leads to an eroticization of maleness.”<sup>472</sup> “In his fullest masculine identity, [the male] may . . . be aggressive and risk-taking.”<sup>473</sup> Moreover, “[m]ale bonding is an especially important goal through the development of mutuality in nonerotic same-sex friendships.”<sup>474</sup>

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me that allowing myself to be seduced into perceiving female homosexuality as a normal lifestyle would have cemented both my patients and myself into a rigid mode that precluded change of whatever nature.

469. Cf. Jeffery R. Jensen, *Homosexuality: A Psychiatrist’s Response to LDS Social Services* 41 (n.d.) (unpublished manuscript, on file with author) (“Other examples of therapist indoctrination of patients are found in the case examples . . . in which theoretical statements are quoted *verbatim* in the patients’ testimonials.”).

470. NICOLOSI, *supra* note 16, at 158.

471. *Id.* at 20.

472. *Id.* at *xvi*.

473. *Id.* at 155.

474. *Id.* at *xviii*. Or consider the reported words of another of Nicolosi’s clients, one who sounds passingly familiar with Freudian theory or at least terminology:

In threatening to quit, I was going to do to you what I’ve done to every other man . . . trash ‘em. If you were really a faggot . . . you could, I fear, reduce me to all the fuckin’ shit that all the other queers brought me down to, which is zero.

Some parallelism between (quasi-)psychoanalytic theory and patient narratives is to be expected, because analysis is a clinical art involving the interpretation of the analysand's experiences. And these repetitions may, *perhaps*, reflect the patients' interior lives with some accuracy. Yet when from the first intake visit, Nicolosi insists to a patient that "[a] lack of complete identification with masculinity can make a man sexually interested in other males," and "[w]hen you were having a sexual relationships with the boys [when you were in school], I think you were really trying to get close to them emotionally, trying to bond to them[,] . . . short-circuiting your need for male identification and intimacy by having sexual contact";<sup>475</sup> when these are sentiments he repeats in the course of the session;<sup>476</sup> when he insists that thinking about this is important to the patient's therapy; and when he implies that as a therapist Nicolosi can help him<sup>477</sup>—the notion that such patients' narratives unproblematically reveal a pre-intervention "truth" about the client strains credibility and may well give the lie to naive claims that the therapist and therapy are value-neutral.

Much of sexual orientation is mental, and as the foregoing discussion reflects, we simply lack direct, uncomplicated access to others' mental states, either pre- or post-treatment. But before giving up entirely on the prospect of answering the question whether given "treatments" produce changes in sexual orientation or only changes in observable behaviors, it is worth considering an additional assessment technology: plethysmography, or genital blood quantification. By measuring changes in volume of the penis or vaginal blood engorgement,<sup>478</sup> researchers can measure physiological responses to images of naked individuals. These devices (typically consisting of something like, for men, a bell jar with a built-in condom, or, for women, "a small, transparent acrylic probe" with a light source and photocell)<sup>479</sup> allow calibration of subjects' responses to images of bodies "of various ages, appearances, and sexes."<sup>480</sup>

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If I've hated you, it's because I've hated my father. I castrated you as my father castrated me. My father refused to share his manhood with me. He'd reduce me to powerlessness. Will you neglect me like my father?

*Id.* at 174 (omissions in original). Presumably this patient was not literally claiming that he or Nicolosi suffered an orchiectomy, though he is perhaps seeking, in Nicolosi's theoretical words, to "find some of what he missed in the failed father-son bond." *Id.* at 150.

475. *Id.* at 225.

476. *See, e.g., id.* at 228-29.

477. *See id.* at 225, 235.

478. "For women, sometimes measures other than vaginal blood are used." JAMES D. WEINRICH, *SEXUAL LANDSCAPES: WHY WE ARE WHAT WE ARE, WHY WE LOVE WHOM WE LOVE* 161 n.2 (1987).

479. *Id.* at 161, 163.

480. *Scope of Sexual Orientation, supra* note 463, at 1, 6.

The utility of these technologies as assessment tools for the efficacy of sexual orientation conversion efforts is limited. Certainly, they accurately measure vasocongestion, meaning blood pooling.<sup>481</sup> However, “plethysmography does not work well with involuntary subjects. It is therefore impractical to use to determine the incidence of sexual orientations in the population at large.”<sup>482</sup> Moreover, plethysmography shows, perhaps at most, “that there are responses embedded in the nervous system that are related, however imperfectly, to what people term sexual or erotic orientation.”<sup>483</sup>

Indeed, this relation may be quite tenuous. Perhaps genital hemo-engorgement is an accurate measure of sexual arousal to sexed or gendered bodies. Arousal, however, is simply one component of sexual orientation. It is not clear that genital blood flow patterns would have a strong correlation with the sexed or gendered aspects of the subjects of people’s fantasies, affection, and arousal in interpersonal contexts.<sup>484</sup>

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In sum, accurately disclosing the efficacy of sexual orientation conversion efforts to prospective patients is excruciatingly complicated. Few conversionists are likely to be happy with (or with only) the formulation of the APtA:

There is no published scientific evidence supporting the efficacy of ‘reparative therapy’ as a treatment to change one’s sexual orientation . . . .

There are a few reports in the literature of efforts to use psychotherapeutic and counseling techniques to treat persons troubled by their homosexuality who desire to become heterosexual; however, results have not been conclusive, nor have they been replicated. There is no evidence that any treatment can change a homosexual person’s deep seated sexual feelings for others of the same sex.<sup>485</sup>

The human reaction to having to repeat such skeptical positions about one’s own professional practices would be, if not noncompliance, then an elaboration on this statement to show how the picture is more complicated and one’s own practice can be effective. Yet once a psy-professional starts down that road, it would be misleading to omit discussion of the kinds of

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481. See WEINRICH, *supra* note 478, at 169.

482. *Scope of Sexual Orientation*, *supra* note 463, at 6.

483. *Id.*

484. See *supra* text accompanying note 434. See also *Scope of Sexual Orientation*, *supra* note 463, at 6; MARTHA C. NUSSBAUM, SEX AND SOCIAL JUSTICE 265-66 & n.50 (1999).

485. American Psychiatric Ass’n, *American Psychiatric Association Fact Sheet* (Sept. 1994) (visited Apr. 14, 1999) <<http://www.thebody.com/apa/apafacts.html>>.



reasons I have presented for why efficacy rates cannot be known. While the *Southern California Law Review* would almost certainly be happy to make reprints of this Article available at cost to conversionists for helping patients understand the limits of what we can know about the efficacy of sexual orientation conversion efforts, I would not expect many such requests. Length alone makes this discussion unwieldy to present to a prospective client, along with all other necessary information, in a fifty-minute session.

#### E. ENSURING INFORMED CONSENT

Even if informed consent requirements were widely understood to entail the disclosures I have discussed above, however limited in efficacy they might be in the best case, there would remain an issue of enforcement. Some conversionists might be expected to adhere scrupulously to the dictates of informed consent, but others might not. Those who are already convinced that “homosexuality” is a mental disorder and that the mainstream psy-professional organizations are betraying science under the influence of “homosexual activists”—especially ones who see themselves as beleaguered or persecuted<sup>486</sup>—would seem unlikely to rush to embrace any requirement that they provide information to patients that casts any doubt on their preferred but scientifically repudiated theories. Hence, mechanisms for countering such reticence will likely be necessary.

##### 1. *Secular Psy-professionals*

Though likely of limited utility, lawsuits for damages provide one possible means of motivating compliance with the norms of informed consent with respect to sexual orientation conversion efforts. These might be brought against secular psy-professionals under the rubric of malpractice or more specifically as tort actions for failure to obtain informed consent. No such malpractice suits are said to have been brought thus far against psy-professionals engaged in conversion efforts.<sup>487</sup> One prominent conver-

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486. See, e.g., John Berlau, *Who Has the Right to Go Straight?*, WASH. TIMES, Dec. 15, 1997, INSIGHT (Magazine), at 16 (“I think the gay activists within the mental-health profession have been successful in creating a certain tone of intimidation and fear among practitioners.”) (quoting Joseph Nicolosi). Cf. Ellen Goodman, *Sexuality Fight Is Growing—Out of Closet: Different Sides of Issue Are Taking Very Different Sides*, VENTURA COUNTY STAR (Cal.), Aug. 3, 1998, at B8 (“One ad claims that ‘Christians’ are being persecuted: ‘For years Christians have taken a stand in the public square against aggressive homosexual activism. We’ve paid a heavy price with sound-bite labels like “bigot” and “homophobe.””).

487. See Berlau, *supra* note 486. But cf. George Rush & Joanna Molloy, *Gay Man Sues Travolta Over Sect’s Appeal*, N.Y. DAILY NEWS, Aug. 7, 1998, at 14 (reporting lawsuit, derided as “meritless” by John Travolta’s lawyer, claiming “the Church of Scientology deceive[d] a gay member into believ-

sionist maintains that this lack of litigation is because of the alleged efficacious and non-coercive nature of reorientation efforts.<sup>488</sup> However, given the people who have come away from conversionists with psychic damage, it seems plausible to attribute at least part of this disputative dearth as stemming from the obstacles to bringing suit against psy-professionals for breach of informed consent requirements.<sup>489</sup>

One commentator who has surveyed the problem concluded that “problems of proof encountered in a psychotherapy case normally are insurmountable.”<sup>490</sup> It will often be difficult in a negligence suit for someone harmed by a psy-professional<sup>491</sup> to establish a standard of care that was allegedly breached.<sup>492</sup> Proving that a harm, such as depression, was caused by “the psychotherapy, and not another factor, such as rejection by a friend,” is also difficult.<sup>493</sup> In addition, in “an informed consent suit against a psychotherapist[,] . . . damages are mainly psychic,” and courts have been “hesitant to grant compensation for negligently inflicted emotional injuries.”<sup>494</sup>

Laura Gans has suggested that conversionists could be sued for intentional infliction of emotional distress (IIED).<sup>495</sup> *The Restatement of Torts* lists the elements of IIED as “(1) extreme and outrageous conduct (2) that intentionally or recklessly caused (3) severe emotional distress to another.”<sup>496</sup> Given the pervasive heteronormativity of contemporary U.S. society, the widespread acceptance of psychotherapies, and the lack of blanket condemnation of sexual orientation conversion efforts by the major psy-professional organizations,<sup>497</sup> conversion efforts probably do not con-

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ing he could turn straight” and “alleg[ing] that the powerful sect used Travolta as an example of a homosexual ‘cured’ by the church”).

488. See Berlau, *supra* note 486 (quoting Joseph Nicolosi).

489. See also Gans, *supra* note 32 (discussing fears that may deter client suits against psy-professionals).

490. Horowitz, *supra* note 274, at 1638.

491. Horowitz actually confines his discussion of psychotherapy to “the psychoanalytic mode,” as opposed to behavioral modes or “organic therapy, which acts by biological or chemical means on the patient’s body.” *Id.* at 1637 n.1.

492. See *id.* at 1639. See also Gans, *supra* note 32, at 234-35 (amplifying this point).

493. Horowitz, *supra* note 274, at 1661. See also Gans, *supra* note 32, at 235-37 (presenting similar arguments, although perhaps more optimistically).

494. Horowitz, *supra* note 274, at 1658. See also Gans, *supra* note 32, 237-38 (explaining the difficulties involved); *id.* at 238-40 (discussing contributory negligence and other potential obstacles to successful suit).

495. See Gans, *supra* note 32 and *supra* text accompanying notes 169-89.

496. See Gans, *supra* note 32, at 246 (citing RESTATEMENT (SECOND) OF TORTS § 46(1) (1965)).

497. See, e.g., *supra* note 18; *supra* notes 82-84, 331 and accompanying text.

stitute “extreme and outrageous conduct.”<sup>498</sup> Gans’ argument does not confront this point because her extended example involves a woman subjected to conversion efforts despite her express directive to the psy-professional not to attempt conversion.<sup>499</sup>

One alternative to civil suits may lie in license revocation proceedings,<sup>500</sup> but they are not without problems of their own. Because state licensing and revocation thereof both clearly involve state action, constitutional norms would protect conversionist psy-professionals in ways that might constrict the availability of revocation. Certainly, the necessity for the informed consent disclosures discussed above would need to be sufficiently clearly established so that conversionists will have had due notice before the state terminates their ability to engage in their profession. Indeed, if the U.S. Constitution or state constitutions protect either a psy-professional’s “right” to purvey at least verbal reorientation techniques or an abject homosexual’s right to purchase the same, state licensing arguably could not be revoked if state law precludes all unlicensed persons from offering talk therapies.

Professional ejection may present a more viable means of enforcing informed consent requirements with respect to reorientation attempts. In many states one need not be a member of the major psy-professional organizations to be licensed. To the extent that membership in these organizations confers prestige and/or signals competence to prospective clients, conversionists who do belong to them would have incentives to remain. While the APtA and APIA have not (unlike NARTH) excluded psy-professionals from their ranks simply for public disagreement with their institutional position on the pathology *vel non* of homosexuality,<sup>501</sup> knowing failure to obtain informed consent is a serious breach of professional ethics, and the APAs thus might be more willing to oust conversionist members

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498. It is similarly unlikely that those who choose to undergo sexual orientation conversion efforts could show that they were “especially sensitive, susceptible and vulnerable to injury through mental distress at” the conversion efforts, a judicially recognized way of establishing extreme and outrageous conduct. See Gans, *supra* note 32, at 246-47 & n.173 (quoting W. PAGE KEETON, DAN B. DOBBS, ROBERT E. KEETON & DAVID G. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS § 12 (5th ed. 1984)).

499. See Gans, *supra* note 32, at 240, 247-49.

500. Cf. *Olson v. Morris*, Nos. 98-15693, CV-94-02072 RGS, 1999 WL 494023 (9th Cir. July 1, 1999) (rejecting on *res judicata* grounds constitutional challenges to license revocation of licensed psychologist who prayed to the Holy Spirit and performed an exorcism of a boy who had been referred solely for psychological evaluation and treatment).

501. See Drescher, *supra* note 58, at 37-38 (explaining NARTH’s ideologically exclusive membership policies).

who refuse to present people with the information they need to make an informed decision whether to subject themselves to reorientation efforts.

## 2. *Religious Conversionists*

The foregoing discussion of damages suits, license revocation, and professional organization ejection to enforce the strictures of informed consent was explicitly framed in terms of secular psy-professional conversionists. Faith ministries that try to convert people to heterosexuality pose significantly different issues. The religion clause of the U.S. Constitution<sup>502</sup> requires governments to maintain scrupulous neutrality among religious beliefs and a significant measure of equality between religious and non-religious beliefs. At the same time, however, religion is legally recognized and in some respects special; one example is the constitutional ban on governmental establishment of religion, which has no express constitutional counterpart dealing with secular ideologies. In addition, the guarantee of free exercise of religion in conjunction with constitutional free speech principles limit governmental regulation of “activities involving the transmission, through group association and spoken or printed word, of religious belief and doctrine.”<sup>503</sup>

Accordingly, for the sake of religious freedom, government should refrain from imposing detailed informed consent requirements on pastoral care providers or religious support groups that offer talk therapies for “homosexuality”—*provided* that they make clear that their conversion techniques, however much modeled after approaches developed by psy-professionals, are at root faith-based.<sup>504</sup> If religious entities wish to engage in scientific or medical practices and characterize them as such, they may in general be subject to the same rules as secular practitioners of the same techniques.<sup>505</sup> If and only if they make clear that their methods are relig-

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502. U.S. CONST. amend. I (“Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . .”) “By virtue of the fourteenth amendment incorporation doctrine, these provisions protect religious freedom from intrusions by state, as well as federal, government.” Cruz, *supra* note 15, at 1190 (footnote omitted).

503. Cruz, *supra* note 15, at 1192. See also *id.* at 1201-05 (defending this proposition).

504. While the distinction between the secular and the religious is sometimes difficult, it is firmly entrenched in U.S. constitutional law. See generally Laura Underkuffler-Fruend, *The Separation of the Religious and the Secular: A Foundational Challenge to First Amendment Theory*, 36 WM. & MARY L. REV. 837 (1995).

505. As a matter of constitutional doctrine, this arguably follows from *Employment Division, Department of Human Resources v. Smith*, 494 U.S. 872 (1990), which held that neutral laws of general applicability raise no free exercise concerns. See *id.* at 890.

ious may they properly claim immunity from governmental regulation of the sort under consideration here.<sup>506</sup>

This may well leave vulnerable people at risk of emotional damage by religiously-based conversionists. This risk is non-trivial, for it is the conversion ministries that have taken center stage in the recent advertising blitz, and the charge of anti-religious bigotry has been deployed against people raising concerns about these sexual reorientation efforts. I believe the risk to be one of the prices of meaningful freedom of religion in this country. Yet the cost may be mitigated by the secular informed consent requirements (if somewhat effective) and by counter-invocations of this same religious freedom.

Religious belief systems are not hermetically isolated from secular events, institutions, and forces, and taking informed consent seriously for secular psy-professionals may have ripple effects for religious conversionists. If more people realized the lack of scientific foundation for the conversionist position, fewer would be likely to pursue reorientation, which in turn could reduce the perceived credibility of these efforts. If conversionists who refused to provide potential clients with adequate information were ejected from the major psy-professional organizations or perhaps even had their licenses revoked, this too would tarnish the luster of objectivity with which conversionists have tried to gild their “services.” In turn, religious conversionist reliance on the legitimating pronouncements of secular psy-professionals would be undermined. At least at the margins, that may be enough to convince some people not to buy what the “cure” ministries are selling.<sup>507</sup>

In addition, disestablishment in the U.S. means that no one religious position enjoys special legal favor, and all faiths may try to take advantage of constitutional religious freedoms. In particular, the many denominations or subsets thereof that accept les/bi/gay persons as part of the divine order, and fully deserving of respect without reorientation, are free to get out their own message of “hope and healing.”<sup>508</sup> If more people realize that many

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506. See generally Jonathan Weiss, *Privilege, Posture and Protection: “Religion” in the Law*, 73 YALE L.J. 593 (1964) (analyzing the fraud prosecution in *U.S. v. Ballard*, 322 U.S. 78 (1944), *rev’d on other grounds after remand*, 329 U.S. 187 (1946), in the course of explicating the proper treatment of religious claims of, inter alia, healing power).

507. See, e.g., Woody Baird, *90’s Crusade to ‘Convert’ Gays*, CHI. TRIB., Apr. 16, 1999, at N8 (describing “\$950-a-month residential treatment program for ‘recovering’ homosexuals” run by “Love In Action” ministry in Memphis, Tennessee).

508. See Upchurch, *supra* note 290 (recalling asking during his struggles to convert to heterosexuality, “Why were [there] churches that said gays and lesbians could be loved by God when my church said that they couldn’t?”). Cf. Alliance for Traditional Marriage—Hawaii et al., *Toward Hope and*

see no conflict between Christianity or other faiths and homosexuality, some of them are bound to question the vociferous teachings to the contrary of their own faiths. This in turn may lead to conversion of another sort, from a belief system that may deny the joy of sexual love to lesbians and gay men<sup>509</sup> to one that does not treat us as “broken” and in need of cure.<sup>510</sup>

### CONCLUSION

People seek to understand in order to be able to control. In many ways, in many settings, people seek to overcome mystery to reach mastery.<sup>511</sup> So it is with human sexuality, or at least homosexuality. Many people are not content to accept same-sex attractions and love as a given facet of human sexuality, although they take heterosexuality as such. Instead, they quest for knowledge and control, the power to convert what they see as the dross of homosexuality to lustrous heterosexuality—a sexual philosopher’s stone.

As this Article has shown, however, there are limits to knowledge—areas where certainty or even reasonable confidence is, at least today, as elusive as the philosopher’s stone proved for medieval alchemists. Humans cannot know everything. And, this Article has argued, given the history of homosexuality, under current social circumstances where a vast array of social—including legal—forces act in concert to demand fealty to heterosexuality, people cannot know whether voluntary consent to sexual orientation conversion by les/bi/gay people is possible in general, whether any

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*Healing for Homosexuals*, N.Y. TIMES, July 13, 1998, at A11 (advertisement); Human Rights Campaign Foundation, *Toward Hope and Healing for America*, USA TODAY, July 15, 1998 (advertisement).

509. Cf., e.g., Chuck Colbert, *Priest Seeks Help in “Big Battle” with Gays*, 34 NAT’L CATHOLIC REP., Sept. 4, 1998, at 6 (discussing commitment to celibacy of Courage, an organization of gay and lesbian Catholics seeking to follow the church’s teachings on homosexuality, as well as Courage’s more recent endorsement of conversion efforts). See also generally Ertman, *supra* note 201.

510. See, e.g., Eric Adler, *Ministries Heighten Debate on Sexuality: “Conversion” of Gays Becomes a Hot Issue, Thanks to Recent Ads*, KAN. CITY STAR (Mo.), Aug. 15, 1998, at A1 (reporting on Desert Stream ministry, which sees gay and lesbian persons as suffering “sexual brokenness”). Cf. John Leland & Mark Miller, *Can Gays Convert?*, NEWSWEEK, Aug. 17, 1998, at 47 (quoting New Hope Ministries counselor Anita Worthen as stating, “We have to work with people who are broke and ready”); David Kyle Foster, *A Way out for Homosexuals?*, WASH. TIMES, Sept. 14, 1997, at B5 (avowing “the emotional and psychological ‘brokenness’ out of which the homosexual operates,” which he assertedly “know[s] the truth of . . . not only from science, but from my own experience in their culture”).

511. Cf. LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW §§ 15-21, at 1424 n.28 (2d ed. 1988) (“Precisely because the Court deems sex to be ‘a great and mysterious motive force in human life,’ *Roth v. United States*, 354 U.S. 476, 487 (1957), the Court harbors traditional Freudian fears of anti-social consequences unless sex is repressed by society.”) (citing Thomas C. Grey, *Eros, Civilization, and the Burger Court*, 43 LAW & CONTEMP. PROBS. 83, 91 (1980)).

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particular person's decision to pursue heterosexuality is meaningfully voluntary, or even whether any supposed case of effective conversion to heterosexuality is genuine. Inner allegiance to heterosexuality is at least for now necessarily undeterminable.

The limits of knowledge in turn limit the operation of law. It may be that uncertainty about the possibility of consent precludes the adoption of laws that would prohibit sexual orientation conversion, laws that could protect vulnerable les/bi/gay people from coercion to majoritarian preferences about how to love.

Yet the limits of knowledge may also limit society's ability to control in authoritarian or totalitarian ways. So long as people lack the knowledge of how effectually to make a les/bi/gay person heterosexual, it remains difficult for law to insist that people *be* heterosexual. Even the many laws that pressure people to *act* heterosexual come increasingly under attack as unjust to people who love others of their own sex. These laws would be unjust even if it were possible to choose to *be*, and to reliably become, heterosexual, and perhaps in time more people will come to accept that conclusion. Today, however, the inability to know that one can swig some "straight serum" and become a happy heterosexual renders comprehensible to some people the injustice of discriminating against les/bi/gay persons and excluding us from important societal institutions, like marriage or the military.

Perhaps one day society will develop a means of accurately knowing a person's interior thoughts and feelings, and will thereby be able to determine decisively whether a purported sexual orientation conversion technique is efficacious. I doubt it, and I hope not. The human mind is far too powerful and complicated and precious to be fully captured by itself and subjected to the control of human lawgivers.

For now, again, there is space for resisting control, for claiming fragments of autonomy. Even sexual orientation conversion efforts are not always successful at enforcing majoritarian institutional sexual morality. Group "treatments," both secular and run by faith ministries, have often provided sad and isolated les/bi/gay persons a chance to meet others, to talk about their same-sex feelings in a somewhat less threatening situation than offered elsewhere in their lives, and, sometimes, to find love.<sup>512</sup> And *that*

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512. See, e.g., Ronald Lawson, *The Troubled Career of an "Ex-Gay" Healer: Colin Cook, Seventh-day Adventists, and the Christian Right* 12 (n.d.) (unpublished manuscript, on file with author): Eleven of the 14 [interviewed] counselees said the Quest program led them to accept and feel good about their homosexuality. Before they came to Reading they had experienced no meaningful gay friendships—their guilt was typically so great that any sexual activity was anonymous (that is, usually with different partners each time). But at Quest they discussed

opportunity is something that law and society should hesitate before destroying, even while seeking ways to foster less repressive alternatives.

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their homosexual impulses openly, mixed regularly with others like themselves, felt less guilt and shame, formed friendships, were active sexually with these friends, and sometimes, for the first time, fell in love. These new experiences significantly fostered the unintended and unexpected outcome of affirmation and self-acceptance.

*Cf.* Cliff O'Neill, *Forget We Ever Said Those Things: Two Founders of "Ex-Gay" Ministry Now Repudiate Goals of Exodus International*, BAY WINDOWS (Boston), Mar 1-7, 1990, at 1, 11 (recounting meeting of lovers Michael Bussee and Gary Cooper at Melodyland where they organized "the first-ever conference of 'ex-gay' ministries").