

JACOB M. VICTOR

Regulating Sexual Orientation Change Efforts: The California Approach, Its Limitations, and Potential Alternatives

ABSTRACT. California recently became the first state to ban licensed psychotherapists from engaging in “sexual orientation change efforts” (SOCE)—also known as conversion therapy—with a minor. This Note argues that, despite the legislation’s laudable goals, California’s regulatory strategy may not necessarily offer the best model for other states seeking to limit SOCE. California’s approach is troubling for several reasons: it reinforces an essentializing conception of sexual identity; it is particularly amenable to First Amendment challenges; and it has the potential to generate political backlash by feeding into historically pervasive anti-gay narratives. I suggest that an alternative approach would curtail SOCE therapists’ influence using existing state laws that forbid medical professionals from making deceptive promises about the effectiveness of their services. As SOCE is widely considered to be ineffective, challenging SOCE practitioners using state anti-deception law could potentially achieve results similar to those of a full SOCE ban.

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INTRODUCTION

In September 2012, the California legislature passed Senate Bill 1172 (SB 1172), which prohibits licensed psychotherapists from engaging in “sexual orientation change efforts” (SOCE) with minor patients.¹ This unprecedented statute aims to prevent any mental health professional from using techniques—commonly known as “conversion therapy” or “reparative therapy”—that attempt to eliminate homosexual attraction or foster heterosexual attraction when treating a minor patient.²

The passage of SB 1172 adds a new dimension to mainstream psychotherapy’s complicated relationship with sexual orientation. As many scholars have pointed out, the majority of psychiatrists and psychologists once believed that same-sex attraction could be “cured” through psychotherapeutic intervention.³ However, since homosexuality was removed from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973,⁴ the mainstream mental health establishment⁵ has come to view homosexuality and bisexuality as benign, encouraging therapists to engage in practices that “affirm” a patient’s sexual orientation.⁶

At the same time, several groups⁷ have continued to insist that sexual orientation can be changed through therapy.⁸ These “ex-gay” organizations,

1. S.B. 1172, 2011-12 S., Reg. Sess. (Cal. 2012) (codified at CAL. BUS. & PROF. CODE § 865-865.2 (West 2013)).

2. *Id.*

3. See, e.g., KENJI YOSHINO, COVERING: THE HIDDEN ASSAULT ON OUR CIVIL RIGHTS 31-49 (2006); David B. Cruz, *Controlling Desires: Sexual Orientation Conversion and the Limits of Knowledge and Law*, 72 S. CAL. L. REV. 1297, 1303-11 (1999).

4. YOSHINO, *supra* note 3, at 41.

5. I use this term to refer to the viewpoints of mainstream psychological, psychiatric, and social work organizations such as the American Psychological Association.

6. See, e.g., *Practice Guidelines for LGB Clients*, AM. PSYCHOL. ASS’N, <http://www.apa.org/pi/lgbt/resources/guidelines.aspx> (last visited Oct. 24, 2013).

7. The National Association for Research & Therapy of Homosexuality (NARTH) and Jews Offering New Alternatives for Healing (JONAH, formerly known as Jews Offering New Alternatives for Homosexuality), are two of the most well-known organizations that espouse SOCE practices and offer SOCE services. For a list of known SOCE-sponsoring organizations, see “*Ex-Gay*” *Industry Snapshot*, TRUTH WINS OUT, <http://www.truthwinsout.org/ex-gay-industry-snapshot> (last visited Oct. 24, 2013).

8. See, e.g., Floyd Godfrey, *Common Questions About SSA*, JONAH, <http://www.jonahweb.org/sections.php?seclD=204> (last visited Oct 24, 2013) (“There are many individuals who have experienced permanent change in sexual orientation. Change is possible. . . . We have

and therapists affiliated with them, continue to provide SOCE therapy and often market these services to minors from religious communities.⁹ In the last several years, the mental health establishment has become increasingly concerned with these practices and has issued reports concluding that SOCE is ineffective and potentially harmful.¹⁰ Lesbian, gay, and bisexual (LGB¹¹) rights organizations have also begun publicly documenting the stories of individual patients subjected to SOCE practices, many of whom describe their treatments as emotionally or sexually abusive.¹²

The California legislature adopted SB 1172 in response to these new reports of SOCE's potential harmfulness, pointing to the state's "compelling interest in protecting the physical and psychological well-being of minors . . . and in protecting its minors against exposure to serious harms caused by sexual orientation change efforts."¹³ The legislation establishes that using SOCE therapy on a minor is "unprofessional conduct,"¹⁴ which provides grounds for a therapist to lose his license.¹⁵ LGB rights groups, especially Equality California, were instrumental in galvanizing the state to act, and also framed the legislation as part of a broader effort to "protect and empower" LGB

not seen anyone who cannot change"); Joseph Nicolosi, THOMAS AQUINAS PSYCHOL. CLINIC, <http://josephnicolosi.com> (last visited Oct. 24, 2013) (advertising psychological services that promise to "[d]iminish your unwanted homosexuality").

9. See, e.g., *Ethics Faith and Family Division*, NARTH, <http://www.narth.com/join-narth#!family-faith-ethics2/c11bg> (last visited Nov. 16, 2013) (linking to anti-LGB articles and videos sponsored by Protestant and Catholic organizations); *Religious Commentary*, JONAH, <http://www.jonahweb.org/sections.php?secId=14> (last visited Nov. 16, 2013) (providing "religious commentary" from various rabbis on why SOCE therapy is worthwhile).
10. See *infra* Sections I.A-B.
11. This Note generally uses the term "LGB," rather than the more common term "LGBT," since the legislation in question deals only with therapies used to "convert" lesbian, gay, and bisexual individuals, not transgender people.
12. See, e.g., *Conversion Therapy*, S. POVERTY L. CENTER, <http://www.splcenter.org/conversion-therapy> (last visited Oct. 24, 2013) (inviting former SOCE patients to share their stories); *Tell Your Story*, TRUTH WINS OUT, <http://www.truthwinsout.org/tell-your-story> (last visited Oct. 24, 2013) (publicizing the stories of former SOCE patients).
13. S.B. 1172 § 1(n), 2011-12 S., Reg. Sess. (Cal. 2012).
14. *Id.* § 2(b)(2) (codified at CAL. BUS. & PROF. CODE § 865 (West 2013)).
15. CAL. BUS. & PROF. CODE § 2960 ("The board may refuse to issue any registration or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee if the applicant, registrant, or licensee has been guilty of unprofessional conduct.").

youth.¹⁶ This strategy of seeking legislation that bans the use of SOCE therapy on minors has now become appealing to LGB rights groups nationwide. In response to lobbying efforts, legislators in New York, Pennsylvania, and Massachusetts have proposed legislation that bans the use of SOCE on minors.¹⁷ And New Jersey recently passed a ban modeled directly after SB 1172.¹⁸

But activists and lawmakers should exercise caution before rushing to copy California's legislation. This Note argues that even those opposed to the use of SOCE should recognize the limitations of employing targeted legislation to ban the use of any SOCE practice on minors.¹⁹ While California's willingness to intervene on behalf of LGB youth is commendable, the regulatory strategy employed in SB 1172 carries a range of presumably unintended consequences: it reinforces an essentializing conception of sexual identity; it is particularly amenable to First Amendment challenges since it treads on ill-defined areas of First Amendment law; and it has the potential to generate political backlash by feeding into historically pervasive anti-gay narratives.

Furthermore, the SB 1172 approach is not the only way for activists and legislators to successfully curtail SOCE. This Note proposes an alternative

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16. *EQCA Advances Bill to Limit Sexual Orientation Conversion Treatment by Mental Health Care Providers*, EQUALITY CAL. (Apr. 23, 2012), <http://www.eqca.org/site/apps/nlnet/content2.aspx?c=kuLRJ9MRKrH&b=7942579&ct=11722145>.
 17. Michelle Garcia, *Massachusetts Considers Ex-Gay Therapy Ban*, ADVOCATE (July 17, 2013, 12:40 PM), <http://www.advocate.com/politics/2013/07/17/massachusetts-considers-ex-gay-therapy-ban>; Jillian Rayfield, *New York Renews Push for Gay Conversion Therapy Ban*, SALON (Aug. 22, 2013, 10:06 AM), http://www.salon.com/2013/08/22/new_york_renews_push_for_gay_conversion_therapy_ban; Lila Shapiro, *Conversion Therapy Ban in Pennsylvania Gaining Support*, HUFFINGTON POST (Sept. 18, 2013, 1:46 PM), http://www.huffingtonpost.com/2013/09/18/conversion-therapy-pennsylvania_n_3948815.html.
 18. Kate Zernike, *Christie Signs Bill Outlawing a Gay 'Cure,'* N.Y. TIMES, Aug. 19, 2013, <http://www.nytimes.com/2013/08/20/nyregion/christie-signs-bill-banning-gay-conversion-therapy.html> (describing the New Jersey ban). For the text of the recently passed legislation, see An Act Concerning the Protection of Minors from Attempts to Change Sexual Orientation and Supplementing Title 45 of the Revised Statutes, Assemb. 3371, 215th Leg., Reg. Sess. (N.J. 2013), http://www.njleg.state.nj.us/2012/Bills/A3500/3371_11.htm.
 19. This Note operates on the assumption that variability in human sexual orientation is an entirely benign phenomenon and that there are no morally or scientifically compelling reasons to attempt to change sexual orientation, especially considering the potential harmful effects of some forms of SOCE, *see infra* Section I.A, and the ineffectiveness of all forms of SOCE, *see infra* Section III.A. While this is, of course, not a universally accepted position, exploration of the religious and moral debate surrounding homosexuality is outside the scope of this Note.

strategy that might bring about the same goal as SB 1172—namely, preventing SOCE practitioners’ access to LGB youth—using another area of law: anti-deception statutes of general applicability. Since the mental health establishment has concluded that SOCE is ineffective in changing sexual orientation, SOCE therapists’ activities could be actionable under state laws that prohibit licensed professionals from engaging in deceptive or misleading practices. California, which the Note uses as a case study, has long prohibited mental health professionals from making deceptive claims, and the regulatory system that implements these requirements could potentially be used to challenge SOCE practitioners. An anti-deception approach to curtailing SOCE could represent a promising alternative or supplement to the SB 1172 approach in all states, but especially in states whose legislatures are unwilling to pass full bans.

This Note proceeds in three Parts. Part I provides background on SB 1172 and explores the understandings of SOCE’s harmfulness that seem to underlie the legislation. This Part argues that SB 1172’s conception of SOCE’s harmfulness is partially grounded in the mental health establishment’s conclusions, derived from clinical studies, but also stems from a more ideologically driven understanding of LGB identity. Part II raises three separate but interrelated problems with the legislation’s broad view of the state’s interest in regulating SOCE. First, SB 1172 rests on assumptions about LGB identity that do not necessarily capture the full range of individuals’ conceptions of their sexual orientations. By imposing these assumptions on patient-therapist relationships, SB 1172 could potentially interfere with some benign, non-SOCE therapeutic practices and, more generally, could feed the persistent marginalization of groups who fall outside the mainstream discourse on sexual orientation. Second, the legislation implicates an ill-defined and controversial area of First Amendment doctrine: the scope of protection for “professional speech.” Though the Ninth Circuit recently affirmed the constitutionality of SB 1172, this result rested on some precarious assumptions about SOCE. There are no guarantees that other courts will follow suit when addressing similar bans.²⁰ And third, SB 1172 risks fostering political backlash

20. New Jersey’s ban has already been challenged on First Amendment grounds in the District of New Jersey. It was recently upheld as constitutional by one district court judge, *see King v. Christie*, CV 13-5038, 2013 WL 5970343 (D.N.J. Nov. 8, 2013), but has also been challenged by other plaintiffs, *see Complaint for Declaratory and Injunctive Relief and Damages, Doe v. Christie*, No. 3:13-cv-06629 (D.N.J. Nov. 1, 2013), http://www.lc.org/media/9980/attachments/pr_complaint_change_therapy_district_camden_nj_1013.pdf.

by playing into a persistent and politically powerful narrative that frames LGB rights in opposition to “parental rights.”

Part III examines potential alternative strategies for limiting SOCE practitioners’ access to patients that focus on the deceptive promises made by most SOCE practitioners regarding the effectiveness of psychotherapeutic intervention in changing sexual orientation. Despite the fact that SOCE is widely considered ineffective, most SOCE practitioners misleadingly hold themselves out as being able to “convert” patients from LGB to heterosexual. These practices could fall under a broader—and, at least in California, already existent—regime that defines deceptive promises made by therapists as unprofessional conduct. Regulating SOCE through such a regime engenders fewer normative or political-strategic concerns and could bring about results similar to those of a targeted ban like SB 1172.

I. SB 1172’S ASSUMPTIONS ABOUT THE HARMFULNESS OF SEXUAL ORIENTATION CHANGE EFFORTS

In passing SB 1172, the California legislature explicitly stated that its goal was “protecting . . . minors against exposure to serious harms caused by sexual orientation change efforts.”²¹ A report issued by the California Senate Rules Committee during the negotiations surrounding SB 1172 clarified this rationale: “[T]he intent of this bill is to limit deceptive therapies that are harmful to minors by mental health providers. This bill seeks to provide awareness of the alternatives to and the potential harmful effects of sexual orientation change therapies while also protecting children from these treatments.”²² According to the legislation, the state’s “compelling interest” in protecting children from these harms warranted a full ban on any attempt to use SOCE practices on minor patients.²³

While California framed its interest in regulating SOCE as preventing “harm” to minors, understanding the precise nature of this harm requires further analysis. This Part analyzes the legislation and its history to identify the types of harm that seemed to be of concern to the California legislature. This Part also examines the degree to which the mental health establishment’s

21. S.B. 1172 § 1(n), 2011-12 S., Reg. Sess. (Cal. 2012).

22. S. RULES COMM., OFFICE OF S. FLOOR ANALYSES, S.B. 1172: THIRD READING, 2d Sess., at 4 (Cal. May 25, 2012).

23. S.B. 1172 § 1(n).

clinical studies, as well as other academic literature, support the conclusion that SOCE is harmful in the ways identified in the legislation.

The types of harm recognized by SB 1172 can be broken down into two categories. First, SOCE causes or exacerbates *clinically demonstrable* psychological disorders, such as anxiety, depression, and suicidal behavior—what the mental health professionals might call “iatrogenic effects” of SOCE treatments.²⁴ Second, SOCE represents an inherently homophobic attack against an LGB patient that leads to internalization of stigma and impedes development of a positive LGB identity. The recognition of this second effect as a harm is more explicitly premised on a set of ideological assumptions about same-sex attraction, rather than clinically demonstrable scientific evidence. These two types of harm are not explicitly identified as separate categories in the text of SB 1172, nor are they mutually exclusive. But recognizing these harms as distinct from one another is necessary to understanding the state’s potential role in regulating SOCE, as well as the problems with SB 1172’s approach, which are explored in the next Part.

Before addressing these two types of harm, it is important to settle on a definition of what types of “therapies” can be classified as SOCE to begin with. While noting that SOCE may include a range of different psychological tools, including “aversive treatments such as electric shock or nausea inducing drugs administered simultaneously with the presentation of homoerotic stimuli . . . [or] visualization, social skills training, psychoanalytic therapy, and spiritual interventions,”²⁵ the California legislature ultimately chose to ban “*any* practices by mental health providers that seek to change an individual’s sexual orientation.”²⁶ This definition would include both physical interventions, like electroshock therapy, and pure “talk therapy,” like psychoanalysis. This broad definition of SOCE is generally in keeping with the approach of organizations like the American Psychological Association (APA), which has treated SOCE as a cohesive category that encompasses any attempt by a mental health professional to change sexual orientation.²⁷ However, as explained further below, the distinction between practices like aversion therapy and exclusively

24. See *infra* note 30 for discussion of this term.

25. S. JUDICIARY COMM., S.B. 1172 (LIEU), 2d Sess., at 2 (Cal. 2012).

26. S.B. 1172 § 2(b)(1) (codified at CAL BUS. & PROF. CODE § 865 (West 2013)) (emphasis added).

27. See *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, AM. PSYCHOL. ASS’N 22-25 (2009), <http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf> [hereinafter *APA Report*].

verbal methods (like psychoanalysis) is significant in exploring the degree to which SOCE's harmfulness is supported by clinical evidence.

A. Causing or Exacerbating Diagnosable Psychological Harm

Section 1 of SB 1172 lists the harmful psychological effects of SOCE treatment that, according to recent research, provide a compelling case for the ban. It states that recent reports have clearly established that SOCE's therapies pose "critical health risks to lesbian, gay, and bisexual people."²⁸ These health risks include the development of diagnosable psychological disorders such as "depression" and "anxiety" as well as "suicidality, substance abuse, . . . sexual dysfunction," and more.²⁹ But the claim that SOCE therapy can cause or exacerbate diagnosable psychological disorders like general anxiety disorder or clinical depression—the "iatrogenic effects" of psychotherapeutic interventions³⁰—is only partially supported by recent reports from the mental health establishment.

As the legislation explains, several types of therapy sometimes used by SOCE practitioners are physically invasive, including electroshock therapy, psychosurgery, use of psychotropic drugs or hormones, or general aversion techniques (such as using painful electric currents or nausea-inducing drugs on a patient while he is exposed to homoerotic images).³¹ The harmfulness of these physically invasive forms of SOCE is well documented. For example, the 2009 APA report, which surveyed all existing peer-reviewed, clinical-study-based literature on SOCE, pointed to compelling clinical evidence³² that aversive techniques "cause inadvertent and harmful mental health effects such

28. S.B. 1172 § 1(b).

29. *Id.* § 1(b), (d).

30. Iatrogenic effects occur when a medical or psychological intervention to treat a specific problem causes or exacerbates other diagnosable problems. See *APA Report, supra* note 27, at 26; Corinne Rees, *Iatrogenic Psychological Harm*, 97 *ARCHIVES DISEASE CHILDHOOD* 440 (2011).

31. Cruz, *supra* note 3, at 1304-07; Sean Young, Note, *Does "Reparative" Therapy Really Constitute Child Abuse?: A Closer Look*, 6 *YALE J. HEALTH POL'Y, L. & ETHICS* 163, 167-68 (2006).

32. *APA Report, supra* note 27, at 41-42 (citing John Bancroft, *Aversion Therapy of Homosexuality: A Pilot Study of 10 Cases*, 115 *BRIT. J. PSYCHIATRY* 1417 (1969)).

as increased anxiety, depression, suicidality, and loss of sexual functioning.”³³ These conclusions are also reflected in the numerous anecdotes, many now available online, that describe SOCE patients’ experiences with aversion therapy. One former patient describes becoming suicidal after going through therapy in which ice, hot coils, and electric currents were placed on his skin while he watched homoerotic images.³⁴ Even some courts and legislatures have begun to recognize the harmfulness of physically invasive forms of SOCE therapy. For example, the Ninth Circuit once described a SOCE treatment that prescribed the use of sedative drugs as akin to torture.³⁵ And many states now regulate the use of treatments like psychosurgery on minors across the board.³⁶

However, the risks of SOCE methods that exclusively involve “talk therapy”—including therapies grounded in psychoanalysis or in religious traditions, which are by far the most common types of SOCE therapies used today³⁷—are less clearly documented in the psychological literature. In recent years, the mental health establishment has explored the potential dangers of *all* forms of SOCE, including talk therapy, but come to mixed conclusions. Most significantly, the 2009 APA report concluded that while there is some, primarily anecdotal, evidence that any form of SOCE has iatrogenic effects, “[e]arly and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation.”³⁸ While some anecdotal evidence

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33. *Id.* at 67; cf. J. Thorpe et al., *Aversion-Relief Therapy: A New Method for General Application*, 2 BEHAV. RES. & THERAPY 71 (1964) (cautiously endorsing aversion therapy but noting the occurrence of mental health problems in patients).
 34. Nathan Manske, *True LGBTQ Stories: Gay Conversion Therapy Victim Says He Was Electrocuted*, HUFFINGTON POST (Oct. 6, 2011, 12:06 PM), http://www.huffingtonpost.com/nathan-manske/gay-conversion-therapy_b_997330.html.
 35. *Pitcherskaia v. INS*, 118 F.3d 641, 648 (9th Cir. 1997) (reviewing an asylum application by a Russian woman and finding that her torturous experiences in a Russian SOCE program contributed to a compelling fear of persecution).
 36. See, e.g., CAL. WELF. & INST. CODE § 5326.6(d) (West 2013) (“Under no circumstances shall psychosurgery be performed on a minor.”); LA. CHILD. CODE ANN. art. 1409 (2013) (“Prefrontal lobotomy shall be prohibited as a treatment solely for medical or emotional illness of a minor patient.”).
 37. See Cruz, *supra* note 3, at 1307-10; Kenji Yoshino, *Covering*, 111 YALE L.J. 769, 789 (2002) (“Even mental health professionals who currently advocate psychoanalytic therapy for homosexuals deride such physical interventions as ‘quackeries.’” (quoting CHARLES W. SOCARIDES, *HOMOSEXUALITY: A FREEDOM TOO FAR* 103 (1995))).
 38. *APA Report*, *supra* note 27, at 41-43.

demonstrates that even SOCE talk therapy can lead to psychological harm,³⁹ the APA report states that, due to the absence of rigorous clinical evidence, “we cannot conclude how likely it is that harm will occur from SOCE.”⁴⁰

Thus, the evidence makes a compelling case for the state’s interest in regulating physically invasive forms of SOCE (such as aversion therapy), which have been demonstrated to lead to marked psychological harm. However, the dearth of evidence that all forms of SOCE therapy (including talk therapy) cause or exacerbate diagnosable psychological conditions makes it difficult to rationalize a ban on *any* attempt by a therapist to change a minor patient’s sexual orientation on grounds of psychological harm alone. Perhaps for that reason, the proponents of SB 1172 relied on a more expansive understanding of “harm”—beyond scientifically demonstrable iatrogenic effects—in justifying the legislation. The next Section explores this broader conception of the harm inflicted by SOCE.

B. Reinforcing Stigma and Impeding Personal Development

The text of SB 1172 demonstrates that the California legislature also understood SOCE as implicating a second, more ambiguous type of harm: impeding the full individual self-realization of LGB patients by reinforcing stigma and self-hatred. The legislation is predicated on the assumption that “[b]eing lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming;”⁴¹ that is, that being LGB is entirely benign and not worthy of psychological intervention. Any attempts to “treat” a non-heterosexual orientation through therapy would then seem to be an illegitimate—perhaps even animus-driven—attempt to stigmatize homosexuality. According to the text of SB 1172, exposing patients to such stigma in the context of a patient-therapist relationship is antithetical to a therapist’s true role in “promot[ing] self-acceptance”⁴² and stifles the development of a patient’s authentic self. The legislation explains that effects such as “decreased self-esteem and authenticity to others, increased self-hatred, . . . feelings of anger and betrayal, . . . [and] a

39. See discussion *infra* note 134 (describing allegations of abuse made by plaintiffs in a lawsuit against a SOCE practitioner).

40. *APA Report*, *supra* note 27, at 42.

41. S.B. 1172 § 1(a), 2011-12 S., Reg. Sess. (Cal. 2012).

42. *Id.* § 1(e) (quoting *Position Statement: The Professional School Counselor and LGBTQ Youth*, AM. SCH. COUNS. ASS’N, <http://www.safeschoolscoalition.org/RG-PositionStatement-asca.html> (last updated June 15, 2011)).

feeling of being dehumanized and untrue to self” can all emerge from SOCE therapy.⁴³ The legislation even explicitly clarifies that its restrictions are based on the assumption that a therapist’s primary task should be positively affirming a patient’s LGB identity, explaining that, under the legislation’s definitions, SOCE “does not include psychotherapies that . . . provide acceptance, support, and understanding of clients[’ LGB orientation or] . . . identity exploration and development.”⁴⁴

While SOCE’s iatrogenic harms, described above, are (or at least could be) grounded in clinical studies, conceiving of SOCE therapy as *per se* harmful because of its role in stigmatizing LGB people requires a more subjective set of assumptions. Indeed, this type of harm may not necessarily be demonstrable through clinical studies at all. Psychologists often speak of “minority stress” or “internalized homophobia” as phenomena that are worthy of psychological attention, but the literature generally treats these phenomena as significant only to the extent they lead to *diagnosable* mental health effects, such as depression, anxiety, or sexual dysfunction.⁴⁵ The APA report, for example, comments on the problem of “stigmatization” in the lives of LGB people (and the potential role of SOCE in furthering this stigma),⁴⁶ but mainly points to instances in which stigmatization leads to measurable “negative mental health consequences.”⁴⁷ In more general terms, assessment of “harm” in the course of psychological treatment is often tied to “symptom worsening [or] the appearance of new symptoms,”⁴⁸ presumably because such iatrogenic effects can be observed in the course of clinical studies and potentially reproduced in further studies. The notion that stigmatization in the course of therapy is *per se harmful*, regardless of the development of iatrogenic effects—which is the position that SB 1172 seems to take—would therefore seem difficult to prove solely on the basis of clinical evidence.

43. *Id.* § 1(b).

44. *Id.* § 2(b)(2) (codified at CAL. BUS. & PROF. CODE § 865 (West 2013)).

45. See, e.g., Joanne DiPlacido, *Minority Stress Among Lesbians, Gay Men, and Bisexuals: A Consequence of Heterosexism, Homophobia, and Stigmatization*, in *STIGMA AND SEXUAL ORIENTATION: UNDERSTANDING PREJUDICE AGAINST LESBIANS, GAY MEN, AND BISEXUALS* 138, 139-41 (Gregory M. Herek ed., 1998); Ilan H. Meyer & Laura Dean, *Internalized Homophobia, Intimacy, and Sexual Behavior Among Gay and Bisexual Men*, in *STIGMA AND SEXUAL ORIENTATION*, *supra*, at 160, 160-66.

46. *APA Report*, *supra* note 27, at 15-17.

47. *Id.* at 55.

48. Scott O. Lilienfeld, *Psychological Treatments That Cause Harm*, 2 *PERSP. ON PSYCHOL. SCI.* 53, 56 (2007).

This is not to say that there are no compelling arguments that SOCE contributes to the stigmatization of LGB people and is problematic for this reason alone. These arguments, however, generally operate in normative, rather than scientific, terms. For example, Laura Gans has argued that victims of SOCE therapies should have a cause of action under the tort of “intentional infliction of emotional distress” under the theory that SOCE therapy can be considered harmful because of the very “outrageousness” of the claim that non-heterosexual orientations should be “eradicate[d].”⁴⁹ For a therapist to impose this problematic outlook on his patient, in a context in which a therapist should be looking out for the patient’s wellbeing, is itself a “homophobic attack” on the patient “under the shameless guise of beneficence.”⁵⁰

David Cruz provides a more subtle account of the normative problems posed by a therapist who attempts to change a patient’s sexual orientation. Though Cruz does not claim that such acts are harmful enough to warrant a full ban⁵¹ (contrary to the proponents of SB 1172), he does point to the “role of medical authority in pronouncements of homosexuality’s pathology” and the “stigmatizing effects” that such authority can have.⁵² On this account, for a therapist to question a patient’s LGB sexual orientation is inevitably to impose an anti-gay ideological conception of homosexuality on a patient (even if the therapist frames her role as simply providing the patient with a choice between homosexuality and heterosexuality). This is especially problematic because it lends the appearance of objective authority to homophobia. An LGB person may be able to recognize a homophobic attack as ideologically driven when it comes from a peer, but when it comes from an “ostensible medical professional[]” it carries greater potential to define the LGB person’s sense of self-worth.⁵³ Cruz analogizes to the work of Eugenia Kaw, who has studied Asian women who seek cosmetic surgery to make their eyelids look more like those of Caucasian women. Kaw argues that such surgeries are inherently harmful because they “normalize[]” . . . the negative feelings of Asian

49. Laura Gans, *Inverts, Perverts, and Converts: Sexual Orientation Conversion Therapy and Liability*, 8 B.U. PUB. INT. L.J. 219, 245-46 (1999).

50. *Id.* at 249.

51. Cruz, *supra* note 3, at 1350-51, 1354 (speculating that the “harms” of SOCE might warrant greater regulation of these practices, but adding the caveat that there is not yet sufficient evidence that the harms of SOCE are significant enough to warrant a complete ban).

52. *Id.* at 1359.

53. *Id.* at 1352-53, 1358-59.

American women about their features” and, in so doing, reinforce self-hatred.⁵⁴ So too in the case of SOCE, the very act of trying to change an LGB person’s sexual orientation would seem to normalize society’s disapproval of homosexuality, reinforcing self-hatred and impeding the patient’s development of a positive LGB identity.

While these arguments may indeed make a compelling case against SOCE, the fact that this stigmatization-based conception of harm is predicated on a set of clearly normative assumptions makes its role in demonstrating California’s “compelling interest in protecting the physical and psychological well-being of minors”⁵⁵ potentially problematic. While the first type of harm described above—SOCE’s iatrogenic effects—is demonstrable through clinical scientific study,⁵⁶ all forms of SOCE can only be understood as per se harmful under this second conception of harm if we embrace a set of ideological assumptions about homosexuality, especially its fixedness, its benignity, its easy categorizability, and its status as constitutive of a person’s identity.⁵⁷ The next Part unpacks some of these assumptions to explore some of the potential drawbacks of SB 1172’s approach.

* * *

In sum, California’s argument for a full ban rests on an amalgam of both clinical evidence of SOCE’s harmfulness and a more ideological conception of a therapist’s proper role in affirming a patient’s sexual orientation in order to avoid stigmatization and allow the patient to develop a fully realized sense of self. Accounting only for clinical evidence of SOCE’s harmfulness could, at

54. *Id.* at 1359 (quoting Eugenia Kaw, *Medicalization of Racial Features: Asian-American Women and Cosmetic Surgery*, 7 *MED. ANTHROPOLOGY Q.* 74, 83 (1993)).

55. S.B. 1172 § 1(n), 2011-12 S., Reg. Sess. (Cal. 2012).

56. One might object that every discourse, including the clinical/scientific psychological discourse described above, is norm-driven. See generally 1 MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY: AN INTRODUCTION* 51-73 (Robert Hurley trans., 1990) (uncovering the norms that underlie the “scientific” study of sexuality). Understanding scientific/clinical evidence of psychological harm as more “objectively true” than discussions of SOCE’s potential stigmatizing effects may strike some—especially those sympathetic to post-structuralism—as a false dichotomy. However, this Note is predicated on the assumption that such a dichotomy is legally significant—that clinically reproducible evidence can provide sufficient authority to rationalize a regulatory regime that inevitably quashes opposing viewpoints (as SB 1172 does), whereas predominantly normative or ideological arguments may not be able to carry this burden.

57. See *infra* Section II.A for further discussion of these assumptions.

least at this point, rationalize only a ban on physical interventions like aversion therapy, since the psychological establishment has not yet reached a consensus on whether talk-therapy forms of SOCE are per se harmful. However, by also relying on the stigma-based conception of SOCE's harmfulness, California could rationalize the need for a ban on "any practices by mental health providers that seek to change an individual's sexual orientation."⁵⁸ The next Part explains why some of the normative assumptions that inform this second conception of SOCE's harmfulness might nonetheless pose problems for a regulatory regime like SB 1172—both from the standpoint of LGB people who may not share the conception of LGB identity that underlies the regime, and from the perspective of the First Amendment.

II. PROBLEMS WITH THE SB 1172 APPROACH

This Part explores why the strategy that animates SB 1172—using legislation to completely prohibit *any* attempt by a mental health provider to change a minor patient's sexual orientation—might be problematic, even from the standpoint of those opposed to SOCE. These concerns are offered from several different but interrelated perspectives. From a purely normative perspective, SB 1172 is problematic because it is predicated on a categorizing and essentializing account of sexual orientation and imposes this conception using the power of the state. From a legal perspective, SB 1172 is especially amenable to First Amendment challenges because it prohibits a type of speech on partially ideological grounds. Finally, from a political-strategic perspective, SB 1172 is inexpedient and could easily foment backlash because it may feed popular conceptions of LGB people as "anti-family" by appearing to take away "parental rights." While these three criticisms operate from different vantage points, they seize on two specific aspects of the strategy at play in SB 1172: treating *any* questioning of a patient's sexual orientation by a therapist as per se harmful,⁵⁹ and singling out SOCE for special regulation in the first place. The essentialism and First Amendment critiques focus primarily on the first aspect, and the political backlash critique focuses on the second.

58. S.B. 1172 § 2(b)(1) (codified at CAL. BUS. & PROF. CODE § 865 (West 2013)) (emphasis added).

59. See *supra* Section I.B.

A. *SB 1172 Assumes and Normalizes an Essentializing Conception of Sexual Orientation*

As discussed in Part I, SB 1172 imposes a blanket ban on *any* attempt by a licensed therapist to alter a minor patient’s sexual orientation. Formulating this ban required the legislature to identify “homosexual,” “bisexual,” and “heterosexual” as concrete markers of identity—as things that a person must either “be” or not “be.”⁶⁰ When dealing with a patient, a therapist seemingly must identify the patient as belonging to one of these categories and work only to promote “identity exploration and development,”⁶¹ while taking care to avoid forcing a patient into a category to which she does not belong. But this highly categorized and identity-driven conception of sexual orientation may be at odds with many people’s personal experiences of sexual orientation.⁶² As this Section argues, SB 1172’s assumptions about the easy categorizability of sexual orientation, and its broad prohibition of “any practices by mental health providers that seek to change an individual’s sexual orientation,”⁶³ are problematic for two reasons. First, the ban may have collateral effects outside its immediate goal of banning SOCE by constraining even a non-SOCE-practicing therapist’s ability to fully engage with patients who do not conceive of their sexual orientation in conventional terms. Second, the ban may reinforce a categorized and identity-driven conception of sexual orientation in the contemporary discourse on sexuality, thereby minimizing the experiences of those who fall outside of mainstream definitions of sexual orientation.

While the majority of same-sex-attracted individuals understand their orientation to be a fixed and essential aspect of their personhood, many others do not.⁶⁴ The fact that SB 1172 is predicated on the existence of concrete and

60. S.B. 1172 § 1(a) (“Being lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming.”).

61. *Id.* § 2(b)(2) (codified at CAL. BUS. & PROF. CODE § 865).

62. This is, of course, not a problem unique to SB 1172. Eve Kosofsky Sedgwick has famously distinguished between a “minoritizing” view of sexuality, which focuses on homosexual identity, and a “universalizing” view, focused on the implications of LGB-rights questions for all “people across the spectrum of sexualities.” Sedgwick has demonstrated that these two discourses are deeply intertwined in contemporary discussion of sexuality. EVE KOSOFSKY SEDGWICK, *EPISTEMOLOGY OF THE CLOSET* 1, 40-44 (1990).

63. S.B. 1172 § 2(b)(1) (codified at CAL. BUS. & PROF. CODE § 865).

64. See Gregory M. Herek et al., *Demographic, Psychological, and Social Characteristics of Self-Identified Lesbian, Gay, and Bisexual Adults in a U.S. Probability Sample*, 7 *SEXUALITY RES. & SOC. POL’Y* 176, 186 (2010).

easily identifiable categories of sexual identity would seem to privilege especially the experiences of gay men over those of lesbians and bisexuals. Recent research has shown that “variability in the emergence and expression of female same-sex desire during the life course” is in fact quite common and that many lesbian-identified women experience their sexuality in more fluid terms than gay men.⁶⁵ The persistent understanding of sexuality as easily definable and fixed may be a consequence of treating the experiences of men as paradigmatic and imposing this conception on women.⁶⁶ Bisexual experience has been even more marginalized within mainstream discourse on sexuality, a phenomenon often labeled “bisexual erasure.” Kenji Yoshino has explored the persistence of bisexual erasure in the law, explaining that even a legal regime that claims to recognize the existence of the category of “bisexual” can still be guilty of bisexual erasure if the regime implicitly operates on the assumption that a person must be *either* attracted to people of the same gender or people of the opposite gender.⁶⁷ SB 1172 seems to provide an example of this

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65. Lisa M. Diamond & Ritch C. Savin-Williams, *Explaining Diversity in the Development of Same-Sex Sexuality Among Young Women*, 56 J. SOC. ISSUES 297, 298, 301-07 (2000); see also Lisa M. Diamond, *Sexual Identity, Attractions, and Behavior Among Young Sexual-Minority Women Over a 2-Year Period*, 36 DEVELOPMENTAL PSYCHOL. 241 (2000) (finding high fluidity in the sexual identities and behaviors of a sample of adolescent sexual-minority women); Robin West, *Sex, Reason, and a Taste for the Absurd*, 81 GEO. L.J. 2413, 2432 (1993) (reviewing RICHARD A. POSNER, *SEX AND REASON* (1992)) (“Many women, for example, have felt themselves to be heterosexual only to later discover a much richer, truer, somehow more authentic identity as a ‘woman-identified-woman.’ Similarly, a significant number of gay men and women find themselves at some point in their lives ‘inexplicably’ attracted to a man or woman of the opposite sex, and suddenly embroiled in an unexpected heterosexual relationship.”).
66. See LISA M. DIAMOND, *SEXUAL FLUIDITY: UNDERSTANDING WOMEN’S LOVE AND DESIRE* (2009) (making this argument); Adrienne Rich, *Compulsory Heterosexuality and Lesbian Experience*, in POWERS OF DESIRE: THE POLITICS OF SEXUALITY 177, 193 (Ann Snitow et al. eds., 1983) (“Lesbians have historically been deprived of a political existence through ‘inclusion’ as female versions of male homosexuality. To equate lesbian existence with male homosexuality . . . is to deny and erase female reality . . .”).
67. See Kenji Yoshino, *The Epistemic Contract of Bisexual Erasure*, 52 STAN. L. REV. 353, 446-54 (2000). Yoshino cites the “horseplay exemption” in same-sex sexual harassment claims, under which a court interprets an alleged act of harassment as an example of “homosocial” horseplay rather than as a sexually-charged “homoerotic” act of harassment. Courts will frequently accept evidence of a defendant’s opposite-sex relationships as proof that the alleged act of harassment could not have possibly been sexual in nature. Such arguments implicitly deny bisexuality’s existence by positing that if a defendant manifests opposite-sex attraction, an alleged act of harassment against someone of the same sex cannot possibly be motivated by same-sex desire. *Id.*

phenomenon: while bisexuals are identified for protection in the legislation, along with gays and lesbians, the scheme is still predicated on the assumption that a therapist can easily identify the category to which a person's sexual attraction belongs and thus take steps to affirm (rather than seek to change) the patient's sexual identity. The ambiguity presented by many bisexuals—whose same-sex attraction may be far more context-specific and may ebb and flow over time—would seem to present a quandary for therapists under the regime. Similarly, the regime fails to acknowledge that many—especially younger people—now eschew labels such “gay” or “bisexual” altogether, instead using the umbrella term “queer” to describe anyone who falls outside mainstream expectations of sexuality or gender performance.⁶⁸

In practice, SB 1172 seems to require that a therapist operate under the assumption that *every* patient can be easily identified under the conventional definitions of lesbian, gay, bisexual, or straight, regardless of whether those categorizations are consistent with the patient's behavior or sense of self. This requirement could impact the ability of even non-SOCE-espousing therapists to fully engage with patients with ambiguous or non-traditional sexual identities. As a hypothetical example, it seems unclear how a therapist, under SB 1172's regime, should react when confronted with a patient who self-identifies as a lesbian but speaks of growing attraction to men and seeks to make sense of these feelings. Attempts by the therapist to encourage this patient's exploration of her heterosexual attraction, despite her avowed lesbian identity, could potentially run afoul of SB 1172's prohibition of “any practices by mental health providers that seek to change an individual's sexual orientation.”⁶⁹ While SOCE practitioners often employ specific psychotherapeutic techniques in the service of an explicit attempt to change a patient's sexual orientation,⁷⁰ “seek to change” is left open-ended in the legislation, and seemingly does not require any specific anti-LGB animus on the part of the therapist. SB 1172's prohibitions thus could potentially cover any statements by a therapist—even innocuous ones—that might lead a patient to change from self-conceiving as one category of sexual orientation to another. Thus, a therapist who said to the questioning lesbian-identified patient described above, “I think you are straight,” (or even “I think you are bisexual”)

68. A Definition of “Queer,” PARENTS, FAMILIES & FRIENDS OF LESBIANS & GAYS, INC., <http://community.pflag.org/page.aspx?pid=952> (last visited Dec. 4, 2013).

69. S.B. 1172 § 2(b)(1), 2011-12 S., Reg. Sess. (Cal. 2012) (codified at CAL. BUS. & PROF. CODE § 865 (West 2013)).

70. See discussion *supra* Part I; *infra* notes 154-155 and accompanying text.

could potentially be guilty of unprofessional conduct under the SB 1172 regime.⁷¹

Generally, we might understand this dilemma as a kind of collateral effect of the state's attempt to regulate the specific (and genuine) harms presented by SOCE. Targeting SOCE through a wide-ranging regime that implicitly requires a therapist to clearly identify a person as belonging to a specific category of sexual orientation, and then to work only to affirm that category, might constrain even a non-SOCE-espousing therapist from grappling with the full range of her patients' experiences of sexual identity. The California legislature presumably did not intend to restrict this kind of benign therapeutic intervention. But its decision to predicate the legislation on the existence of fixed categories of sexual identity that correlate to specific forms of behavior, its assumption that these categories are easily identifiable by a therapist, and its assumption that these categories form an essential part of a patient's identity,⁷² seem to have spawned a regime with potentially far more wide-ranging effects.⁷³

While instances in which non-SOCE therapists are constrained by SB 1172 (such as the hypothetical scenario described above) are likely to be rare, SB

71. One might counter that SB 1172's caveat that "[s]exual orientation change efforts' does not include psychotherapies that . . . provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development," S.B. 1172 § 2(b)(2) (codified at CAL. BUS. & PROF. CODE § 865), might immunize these more innocuous statements from sanction. However, the line between a statement that "seeks to change" sexual orientation and one that seeks to promote "identity exploration and development" is not easy to draw, especially when it comes to assessing a therapist's intent. After all, even avowed SOCE practitioners often think of themselves as seeking to unearth an LGB patient's authentic heterosexual self. See, e.g., Joseph Nicolosi, *The Meaning of Same-Sex Attraction*, NARTH, <http://www.narth.org/docs/niconew.html> (last visited Dec. 4, 2013) ("For my clients, homosexual enactment does not represent their personal intentions, will or self-identity, and it is in violation of their aspirations and life goals. Gay life is unsatisfying to them, so they enter therapy in the hope of reducing their unwanted attractions and developing their heterosexual potential.").

72. See *supra* Section I.B.

73. It is important to note that these concerns over the legislation's scope (especially the ambiguity of the phrase "seek to change") is likely insufficient to support a vagueness challenge. As the Ninth Circuit noted in recent litigation on SB 1172's constitutionality, "uncertainty at a statute's margins will not warrant facial invalidation if it is clear what the statute proscribes in the vast majority of its intended applications." *Pickup v. Brown*, No. 12-17681, slip op. at 47 (9th Cir. Jan. 29, 2014), *amending and denying reh'g*, 728 F.3d 1042 (9th Cir. 2013) (quoting *Cal. Teacher's Ass'n v. State Bd. of Educ.*, 271 F.3d 1141, 1151 (9th Cir. 2001)).

1172's problematic collateral effects might extend beyond specific patient-therapist relationships into the broader contemporary discourse on sexual orientation. As several scholars have argued, systems of classification and categorization, especially those imposed using the coercive power of the regulatory state, have profound power to "shap[e] reality"; namely, to define what characteristics become normatively or politically salient in dividing people from one another.⁷⁴ Indeed, such arguments have animated some critiques of recognizing LGB people as a protected class for equal protection purposes, especially in light of the tendency of courts to reinforce the importance of certain supposedly "immutable" traits when identifying a group as a protected class.⁷⁵ As much as identifying LGB people as a suspect class based on the "immutability" of homosexuality might signal the state's role in protecting LGB people, it might also reinforce the notion that sexual orientation is a fundamental, identity-defining characteristic, thereby marginalizing the experiences of those who do not conceive of their sexuality along these lines.⁷⁶

Similarly, SB 1172, by assuming a conception of sexual orientation that focuses on rigid categories⁷⁷ and takes for granted that sexual preference

74. Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 744-50 (2008) (explaining how the government's system of classifying gender reifies the definitions of gender upon which this system is based). See generally GEOFFREY C. BOWKER & SUSAN LEIGH STAR, *SORTING THINGS OUT: CLASSIFICATION AND ITS CONSEQUENCES* (1999) (theorizing the normative consequences of systems of classification).
75. Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 795 (2011) (highlighting the argument "that when the courts protect a trait as part of a group's identity, they strengthen . . . stereotypes").
76. See Lisa Bower, *Queer Problems/Straight Solutions: The Limits of a Politics of "Official Recognition,"* in *PLAYING WITH FIRE: QUEER POLITICS, QUEER THEORIES* 267 (Shane Phelan ed., 1997); Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503, 567 (1994) ("When pro-gay advocates use the argument from immutability before a court on behalf of gay men, lesbians, and bisexuals, they misrepresent us."); Darren Lenard Hutchinson, "Gay Rights" for "Gay Whites"?: *Race, Sexual Identity, and Equal Protection Discourse*, 85 CORNELL L. REV. 1358, 1380 (2000) ("[A] doctrinal requirement [in the equal protection context] of immutability compels homogeneity. Rather than questioning the legitimacy or value of discriminatory practices, it demands that oppressed people 'change' to fit within a presumably 'valid' social structure that, in reality, embraces oppressive hierarchies."); see also Sonia Katyal, *Exporting Identity*, 14 YALE J.L. & FEMINISM 97, 110-15 (2002) (describing the importance of an identity-based conception of sexual orientation in equal protection cases like *Romer v. Evans*, but pointing out that imposing this model on "individuals who may engage in same-sex sexual behavior, but who do not fit a substitutive paradigm between identity and conduct, can be unduly confining, exclusionary, and inappropriate").
77. See *supra* discussion accompanying notes 60-62.

invariably forms an essential aspect of a person's identity,⁷⁸ normalizes this understanding within the contemporary discourse on sexuality. In practice, this could reinforce broader attempts to delegitimize the experiences of some lesbian-defined women and many bisexuals or queer-identified people whose experiences differ from mainstream expectations regarding sexuality, as explained above.⁷⁹ It also might impede greater acceptance of non-Western conceptions of sexuality in Western debates about sexual orientation. Scholars such as Sonia Katyal have explored the problems that a categorized, "identity-based" conception of sexual orientation can pose for non-Western communities. The notion that sexual orientation constitutes an essential aspect of a person's identity can "often collide with . . . preexisting social meanings of same-sex sexual activity,"⁸⁰ posing particular problems for immigrant communities.⁸¹ In this respect, legislation crafted around an identity-based framework, like SB 1172, may also marginalize the experiences of members of non-Western cultures who conceive of same-sex sexual activity in ways different from, or incompatible with, an identity-oriented conception.

These criticisms are not meant to deny the very real concerns, discussed above, that SB 1172 seeks to address: that certain forms of SOCE lead to concrete psychological damage and that any form of SOCE is inherently harmful because it lends medical authority to attempts to stigmatize and further self-hatred among LGB people. However, as Part III argues, there may be alternative strategies for preventing these harms that would not require the state to espouse a settled definition of sexual orientation and directly regulate the practices of therapists in service of this definition.

B. SB 1172 Is Particularly Vulnerable to First Amendment Challenges

As recent litigation in California demonstrates,⁸² SB 1172 also treads on a

78. See *supra* Section I.B.

79. See *supra* discussion accompanying notes 64-68.

80. Katyal, *supra* note 76, at 100.

81. See *id.* at 108-68 (describing the rise of the identity-oriented "substitutive model" of gay identity in the United States and documenting examples in which it has clashed with non-Western conceptions of sexuality).

82. While the trajectory of this litigation is explored in detail below, a brief overview is in order. *Welch v. Brown*, 907 F. Supp. 2d 1102 (E.D. Cal. 2012), enjoined implementation of SB 1172 on First Amendment grounds, whereas *Pickup v. Brown*, No. 2:12-CV-02497-KJM-EFB, 2012 WL 6021465 (E.D. Cal. Dec. 4, 2012), denied a motion for preliminary injunction. The cases were consolidated before the Ninth Circuit, which also entered a preliminary

particularly controversial and ill-defined area of First Amendment law: the regulation of professional-client speech. After its passage, SB 1172 was immediately challenged by practitioners and patients seeking a preliminary injunction preventing California from implementing the new law. The challengers argued that SB 1172 violates the First Amendment by prohibiting therapists from engaging in protected speech. Two federal district courts considered separate motions for a preliminary injunction and came to opposite conclusions. In *Welch v. Brown*, Judge William Shubb enjoined implementation of SB 1172, holding that the statute regulates protected speech and lacks content and viewpoint neutrality.⁸³ In *Pickup v. Brown*, however, Judge Kimberly Mueller rejected the plaintiffs' motion, holding that because "SOCE therapy is subject to the state's legitimate control over the professions, SB 1172's restrictions on therapy do not implicate fundamental [First Amendment] rights."⁸⁴ The Ninth Circuit granted a preliminary injunction pending appeal⁸⁵ and, after consolidating the two cases, ultimately upheld SB 1172's constitutionality.⁸⁶ The court also denied the plaintiffs' petition for rehearing en banc⁸⁷ but recently stayed its mandate for at least ninety days to allow the plaintiffs to file a petition for writ of certiorari.

The primary question posed by the *Pickup* case was whether banning SOCE therapy for minors involves regulation of psychotherapists' professional conduct,⁸⁸ or whether SB 1172 in fact prohibits protected speech.⁸⁹ The Ninth

injunction in *Pickup v. Brown*, No. 12-17681, 2012 WL 6869637 (9th Cir. Dec. 21, 2012), but later held the statute constitutional, *Pickup v. Brown*, No. 12-17681 (9th Cir. Jan. 29, 2014), *amending and denying reh'g*, 728 F.3d 1042 (9th Cir. 2013)

83. 907 F. Supp. 2d at 1113-17.

84. 2012 WL 6021465, at *12.

85. *Pickup*, 2012 WL 6869637.

86. *Pickup*, No. 12-17681.

87. Order Denying Petition for Panel Rehearing and Rehearing En Banc, *Pickup*, No. 12-17681.

88. *Pickup*, No. 12-17681, slip op. at 30 (claiming that "[t]he first step in our analysis is to determine whether SB 1172 is a regulation of conduct or speech" and holding that it is a regulation of conduct); see also *Pickup*, 2012 WL 6021465, at *9 (holding that SB 1172 is a regulation of conduct); Erwin Chemerinsky, 'Gay Conversion' Therapy Is Not Protected Free Speech, ATLANTIC (Dec. 10, 2012, 2:41 PM), <http://www.theatlantic.com/national/archive/2012/12/gay-conversion-therapy-is-not-protected-free-speech/266102> ("The fact that conversion therapy is done primarily through words does not mean that it is automatically protected as speech under the First Amendment. Never have the courts treated the First Amendment as an absolute protection for speech, and indeed they have upheld many laws that restrict speech by professionals, such as doctors and lawyers.").

Circuit ultimately decided that:

Senate Bill 1172 regulates conduct. It bans a form of treatment for minors . . . Pursuant to its police power, California has authority to regulate licensed mental health providers' administration of therapies that the legislature has deemed harmful [and] . . . the fact that speech may be used to carry out those therapies does not turn the regulation of conduct into a regulation of speech.⁹⁰

The Ninth Circuit thus determined that SB 1172, as a regulation of professional conduct that only regulates speech "incidentally," is outside the scope of the First Amendment protection and simply needed to withstand the rational basis test.⁹¹ The panel held that the statute could easily meet this burden.⁹² In so doing, the court rejected Judge Shubb's argument that SB 1172 regulates speech (and was not content- or viewpoint-neutral) and therefore must withstand strict scrutiny.⁹³

But as the differing district court rulings (and the Ninth Circuit's earlier decision to enter an emergency injunction pending appeal) demonstrate, the Ninth Circuit's ultimate decision affirming SB 1172's constitutionality was by no means inevitable. Indeed, the scope of so-called "professional speech" is particularly ill-defined in First Amendment doctrine.⁹⁴ Robert Post has

89. See *Welch v. Brown*, 907 F. Supp. 2d 1102 (E.D. Cal. 2012) (holding that SB 1172 prohibits protected speech), *rev'd sub nom.* *Pickup v. Brown*, No. 12-17681 (9th Cir. Jan. 29, 2014).

90. *Pickup*, No. 12-17681, slip op. at 38 (citations omitted). Additionally, the Ninth Circuit found that SB 1172 does not infringe patients' and therapists' freedom of association, is not void for vagueness, is not overbroad, and does not infringe parents' rights to control their children. *Id.* at 45-53. But the bulk of the court's analysis was devoted to the free speech question.

91. *Id.* at 42 ("[W]e conclude that any effect [SB 1172] may have on free speech interests is merely incidental. Therefore, we hold that SB 1172 is subject to only rational basis review and must be upheld if it bears a rational relationship to a legitimate state interest.").

92. *Id.* at 43 ("Without a doubt, protecting the well-being of minors is a legitimate state interest.").

93. *Welch*, 907 F. Supp. 2d at 1102.

94. See, e.g., Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 944-45 (highlighting the divided views among courts and scholars regarding the regulation of speech by professionals); see also Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 772 (1999) ("Current First Amendment analysis lacks a coherent view of speech in the professions."); Eugene Volokh, *Little-Discussed Free Speech Question*, VOLOKH CONSPIRACY (May 28, 2004, 3:37 PM), <http://www.volokh.com/archives>

succinctly identified the scope of the debate around professional speech, pointing out that a doctor's speech is clearly regulable as professional conduct, without offending the First Amendment, when the state seeks only to ensure that a doctor's conduct remains consistent with the standards of her profession.⁹⁵ As an obvious example, a doctor has no First Amendment right to deliberately withhold a diagnosis; such a failure to speak can be censured as malpractice without implicating the First Amendment.⁹⁶ At the other extreme, regulation of speech by a doctor that is not related to the professional conduct of her field would arguably receive some First Amendment protection, even if the speech is uttered in a professional context.⁹⁷ But the line between speech that is incidental to professional conduct and protected speech is not easy to parse, considering the underdeveloped case law in this area.⁹⁸

The Ninth Circuit's decision grappled with this issue, but its conclusions remain open to question. The panel acknowledged that a doctor has a First Amendment right to express his opinions in public, but it explained that this protection diminishes when it comes to speech uttered in the confines of a "professional-client relationship" and ultimately ceases when it comes to speech that is uttered in a context exclusively regulated by accepted standards of professional conduct; at that point, the speech is simply speech incidental to

/archive_2004_05_23-2004_05_29.shtml#1085773062 (arguing that the constitutional status of professional speech has not been fully developed by scholars and courts). Scholars have taken radically different positions on whether, normatively, speech incidental to professional conduct should be outside the protections of the First Amendment. Compare Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. REV. 201, 243 (1994) (arguing that doctor-patient speech should be fully protected under the First Amendment), with Katharine McCarthy, Note, *Conant v. Walters: A Misapplication of Free Speech Rights in the Doctor-Patient Relationship*, 56 ME. L. REV. 447, 465 (2004) (arguing that such speech may be properly subject to regulation by the state).

95. Post, *supra* note 94, at 951-53 (pointing out that "we routinely sanction doctors who deviate from professional standards in the course of their professional speech because we believe that in professional practice the safety and health of patients" is paramount).
96. *Id.* at 950-51.
97. *Id.* at 953-60 (arguing at length that a South Dakota law requiring doctors to describe a fetus as a "human being" to a patient before performing an abortion is an example of compelled ideological, rather than professional, speech and thus runs afoul of the First Amendment).
98. See Halberstam, *supra* note 94, at 834 ("[T]he Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional's freedom to speak to a client.").

professional conduct (for example, making or withholding a diagnosis).⁹⁹ The panel concluded that a ban on all forms of SOCE falls squarely in this latter category. But the court reached this result only by deferring to the California legislature's finding that SOCE is per se "harmful" and thus outside the "accepted standard" of the psychological profession.¹⁰⁰

As Part I explained, however, the California legislature's findings that all forms of SOCE are per se harmful may have relied on the mingling of both clinical evidence and more ideological assumptions about the nature of sexual orientation.¹⁰¹ If SB 1172 were tailored exclusively to prevent practices that lead to clinically demonstrable psychological damage, in clear violation of the therapist's basic professional standard of "avoid[ing] harm,"¹⁰² it would be an obvious example of the regulation of professional conduct, outside the scope of the First Amendment. But as explained above, SB 1172 also operates under a more subjective conception of harm, which understands all SOCE as stigmatizing and thus per se harmful to the fostering of a patient's positive LGB identity.¹⁰³ Had the Ninth Circuit questioned the legislature's evidence, it might have concluded that a full SOCE ban could not be justified as a pure regulation of professional conduct, at least until further evidence emerged that all forms of SOCE are in fact harmful and thus clearly outside the norms of the psychological profession. Indeed, the Ninth Circuit even acknowledged that there is some question as to whether all SOCE is per se harmful, but ultimately

99. *Pickup v. Brown*, No. 12-17681, slip op. at 37-38 (9th Cir. Jan. 29, 2014), *amending and denying reh'g*, 728 F.3d 1042 (9th Cir. 2013) ("[T]he First Amendment tolerates a substantial amount of speech regulation within the professional-client relationship that it would not tolerate outside of it. And that toleration makes sense: When professionals, by means of their state-issued licenses, form relationships with clients, the purpose of those relationships is to advance the welfare of the clients, rather than to contribute to public debate. . . . Most, if not all, medical and mental health treatments require speech, but that fact does not give rise to a First Amendment claim when the state bans a particular treatment. When a drug is banned, for example, a doctor who treats patients with that drug does not have a First Amendment right to speak the words necessary to provide or administer the banned drug.").

100. *Id.* at 35-39, 42-44.

101. See discussion *supra* Section I.B.

102. "*Primum non nocere*" or "first, do no harm" is widely considered to be the fundamental credo of the medical and mental health professions. Lilienfeld, *supra* note 48, at 53.

103. See discussion *supra* Section I.B.

concluded that the legislature’s assumptions were “plausible” and thus warranted deference.¹⁰⁴

A more probing inquiry might have concluded that while banning *some* forms of SOCE—such as aversion therapy—rests squarely within the state’s power to regulate professional conduct, SB 1172 may also, in effect, ban a certain type of stigmatizing speech¹⁰⁵ that falls outside the scope of pure professional conduct. Indeed, it is possible that a ban on all forms of SOCE as per se harmful improperly attempts to cut off First Amendment scrutiny by claiming that SOCE is categorically professional conduct, and thus outside the scope of the First Amendment, despite a lack of clear evidence that it should be considered as such.¹⁰⁶

It is important to highlight that this Section has only argued that a SOCE ban should not necessarily be categorically considered a regulation of “professional conduct” outside the scope of the First Amendment. But even if a court recognized that a SOCE ban implicates some First Amendment protection, it might not necessarily find such a ban unconstitutional. While full explication of the First Amendment status of SOCE is outside the scope of this

104. *Pickup*, No. 12-17681, slip op. at 44. There is something tautological about the court’s reasoning here. The court determined, as a threshold matter, that a SOCE ban was a regulation of professional conduct because it forbids activities that would fall outside the “accepted standard of care,” *id.* at 36, because of their harmfulness. In making this determination, the court implicitly needed to rely on the legislature’s finding that SOCE is per se harmful. But it only directly addressed this question *after* having decided that the ban is a regulation of professional conduct and thus only subject to rational basis review. Under rational basis review, the court concluded that it “need not decide whether SOCE actually causes ‘serious harms’; it is enough that it could ‘reasonably be conceived to be true by the governmental decisionmaker,’” *id.* at 43 (quoting *Nat’l Ass’n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043 (9th Cir. 2000)). In this respect, the court’s acceptance of the legislature’s findings, under rational basis review, informed even the court’s decision that rational basis review, rather than intermediate or even strict scrutiny, was warranted.

105. *See supra* Section I.B.

106. *Cf. Texas v. Johnson*, 491 U.S. 397, 409 (1989) (holding that the government may not “assume that every expression of a provocative idea” can be categorically considered “fighting words” that are outside the scope of the First Amendment; rather, the government must provide evidence that such speech indeed falls outside the coverage of the First Amendment); *NAACP v. Claiborne Hardware Co.*, 458 U.S. 886, 916-17 (1982) (demanding “precision of regulation” in determining when someone can be held liable for damages while engaging in a First Amendment activity, on the assumption that while violence is not protected by the First Amendment, incidents of violence in a protected First Amendment context do not cause all other activities in that context to categorically lose the protections of the First Amendment) (quoting *NAACP v. Button*, 371 U.S. 415, 438 (1963)).

Note, the low public value of speech used in SOCE practices—especially considering the growing consensus that SOCE is ineffective¹⁰⁷—might very well lead a court to find that a SOCE ban can survive a First Amendment challenge.¹⁰⁸

While this analysis is now generally inapplicable in California, it is clear that the SB 1172 approach treads on a particularly contested and hazy area of the First Amendment.¹⁰⁹ Similar lawsuits are therefore likely to emerge in other states that pass legislation modeled after SB 1172—indeed, the recent New Jersey ban has already been challenged on First Amendment grounds¹¹⁰—at least until the courts more carefully define the nature of professional speech in First Amendment doctrine¹¹¹ or greater evidence emerges that SOCE is per se harmful under the professional standards of mental health professionals (and thus regulable as pure professional conduct). Courts that are less deferential to legislative findings that SOCE is per se harmful may be unwilling to treat such bans as pure regulations of professional conduct, thus opening the door to greater First Amendment scrutiny and the potential for the bans to be struck

107. See *infra* Section III.A.

108. See, e.g., Appellants' Corrected Reply Brief at 13-24, *Welch v. Brown*, No. 13-15023, 2013 WL 950392 (9th Cir. 2013) (arguing that even if the court found that SB 1172 implicated the First Amendment, the legislation could still survive either intermediate or strict scrutiny); Paul Sherman & Robert McNamara, *Protecting the Speech We Hate*, N.Y. TIMES, Oct. 9, 2013, <http://www.nytimes.com/2013/10/10/opinion/protecting-the-speech-we-hate.html> (“[T]he plaintiffs in the California case would not have automatically won their case had the Ninth Circuit held that the First Amendment applied. Instead, the government would then have had the burden of coming forward with actual evidence that the law addressed a real problem and limited speech no more than was necessary. That burden is serious, but it is not insurmountable. . . . It is possible, maybe even likely, that California will be able to meet this burden with regard to its reparative therapy law.”).

109. See sources cited *supra* note 94.

110. See sources cited *supra* note 20.

111. Judge O’Scannlain, in his dissent from the Ninth Circuit’s recent denial of rehearing en banc in *Pickup*, highlighted just how ambiguous this area of First Amendment doctrine remains. He argued that all professional speech carries some degree of First Amendment protection. In his view, treating SB 1172 as a regulation of professional conduct that is completely immune from First Amendment scrutiny contravenes Supreme Court precedent and improperly creates a new category of unprotected speech. Order Denying Petition for Panel Rehearing and Rehearing En Banc, *Pickup v. Brown*, No. 12-17681, slip op. at 9 (9th Cir. Jan. 29, 2014) (O’Scannlain, J., dissenting), http://cdn.ca9.uscourts.gov/datastore/general/2014/01/29/12-17681_order_amended_opinion.pdf.

down on First Amendment grounds.¹¹² From a purely strategic perspective, then, it would seem advisable for SOCE opponents to work around this problem using alternative regulatory strategies that are less likely to generate contentious litigation, as Part III explores.

C. SB 1172 Could Foment Political Backlash

Because SB 1172 operates as a direct ban on parents' ability to seek SOCE therapy for their children, it has already been criticized for undermining a parent's right to control his child's upbringing. Immediately after the legislation was passed, conservative activists began accusing the California legislature of privileging gay rights over "parental rights."¹¹³ As one activist put it, "[t]his legislation is a grotesque violation of the rights of parents over their children."¹¹⁴

The argument that SB 1172 infringes on "parental rights" probably has little merit from a purely constitutional perspective. Opponents of the bill argued, in their original motion for a preliminary injunction before Judge Mueller, that SB 1172 implicates the Supreme Court's decisions that read the Due Process Clause as protecting parents' rights to control their children's education, such

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112. Understanding a SOCE ban as implicating protected speech might also subject a similar ban to a more powerful overbreadth challenge. As in its discussion of whether SB 1172 infringed on protected speech, the Ninth Circuit dismissed the appellants' overbreadth challenge by deferring to the state's finding of SOCE's harmfulness. *Pickup v. Brown*, No. 12-17681, slip op. at 49-50 (9th Cir. Jan. 29, 2014), *amending and denying reh'g*, 728 F.3d 1042 (9th Cir. 2013) (holding that the "overbreadth of a statute must not only be real, but substantial as well, judged in relation to the statute's plainly legitimate sweep" and that any potential overbreadth "is small in comparison with the 'plainly legitimate sweep' of the ban" (quoting *Broadrick v. Oklahoma*, 413 U.S. 601, 615 (1973))). A less deferential court might be more likely to find an overbreadth challenge compelling.
113. See, e.g., Audrey Barrick, *Ex-Gay Advocates Blast Calif. Senator over Bill Banning Reparative Therapy*, CHRISTIAN POST (Aug. 10, 2012, 4:42 PM), <http://www.christianpost.com/news/ex-gay-advocates-blast-calif-senator-over-bill-banning-reparative-therapy-79847>; Ben Johnson, *Democrat Admits, 'Attack on Parental Rights' Is 'the Whole Point' of Banning Sex Orientation Therapy*, LIFESITENEWS (Aug. 2, 2012, 5:09 PM), <http://www.lifesitenews.com/news/democrat-admits-attack-on-parental-rights-is-the-whole-point-of-banning-sex>; *Open Letter From Parents of Homosexuals and Former Homosexuals to State Senator Ted Lieu of Torrance, Cal.*, PARENTS & FRIENDS OF EXGAYS & GAYS, <http://pfox.org/Parental-Rights-Under-Attack.html> (last visited May 19, 2012, 9:03 PM).
114. Pete Winn, *California Considers Legislation Making It a Crime to Counsel Children Not to Be Homosexual*, CNS NEWS (May 9, 2012, 10:09 PM), <http://cnsnews.com/news/article/california-considers-legislation-making-it-crime-counsel-children-not-be-homosexual>.

as *Pierce v. Society of Sisters*¹¹⁵ and similar cases.¹¹⁶ But Judge Mueller in *Pickup* thoroughly rejected this argument, holding that SB 1172 is consistent with the limitations, identified by the Supreme Court in *Prince v. Massachusetts*¹¹⁷ and subsequent cases, that the state may place on parental rights in the interest of a child's welfare.¹¹⁸ Judge Shubb declined to address the parental rights argument altogether in *Welch*, enjoining implementation of SB 1172 exclusively on First Amendment grounds.¹¹⁹ Perhaps recognizing the weakness of these arguments, opponents of SB 1172 only cursorily mentioned the parental rights challenge in briefs before the Ninth Circuit.¹²⁰ And the Ninth Circuit ultimately accepted Judge Mueller's holding, concluding that "SB 1172 does not infringe on the fundamental rights of parents."¹²¹

But even if the argument that SB 1172 infringes on parental rights has little legal merit, it could still prove to be a powerful rhetorical device in mustering opposition to legislation on the model of SB 1172. In the modern era, opponents of LGB rights have often employed rhetoric that frames state "promotion" of homosexuality as infringing on the rights of heterosexuals. Rather than employing the once-prevalent attacks that LGB people are "sinful" or "biologically degenerate," opponents of LGB rights now frequently employ "social republican arguments," contending that a policy that affirms basic LGB rights invariably disrupts elements of the social order and especially family life.¹²² This "no promo homo" discourse is based on the assumption that citizens should have the right to be free from the "promotion" of

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115. 268 U.S. 510 (1925) (striking down an Oregon state law requiring parents to send their children to public schools on the ground that the Due Process Clause protects a parent's right to make this decision).
116. Memorandum in Support of Preliminary Injunction at 37-42, *Pickup v. Brown*, No. 2:12-CV-02497-KJM-EFB, 2012 WL 5983762 (E.D. Cal. 2012).
117. 321 U.S. 158 (1944) (holding that a statute prohibiting minor children from working in certain unsafe jobs did not violate parental rights because the state maintains an interest in securing the welfare of children).
118. *Pickup v. Brown*, No. 2:12-CV-02497-KJM-EFB, 2012 WL 6021465, at *16-23 (E.D. Cal. Dec. 4, 2012).
119. *Welch v. Brown*, 907 F. Supp. 2d 1102 (E.D. Cal. 2012), *rev'd sub nom.* *Pickup v. Brown*, No. 12-17681 (9th Cir. Jan. 29, 2014).
120. *See, e.g.*, Plaintiff-Appellants' Reply Brief, *Pickup*, No. 12-17681, 2013 WL 792995.
121. *Pickup*, No. 12-17681, slip op. at 53.
122. William N. Eskridge, Jr., *No Promo Homo: The Sedimentation of Antigay Discourse and the Channeling Effect of Judicial Review*, 75 N.Y.U. L. REV. 1327, 1337-55 (2000) (documenting this shift in rhetoric).

homosexuality in order to safeguard religious liberty, family values, or parental rights.

No promo homo arguments have been most directly employed in the context of public schools and other state-controlled areas that implicate the lives of children, under the assumption that “wavering” children might become gay if exposed to a favorable or neutral conception of homosexuality.¹²³ Considering the strong public values that favor parents’ control over their children’s upbringing,¹²⁴ these arguments have proven quite powerful rhetorically and politically.¹²⁵ And this strategy is still alive and well: The recent “Yes on 8” campaign, which succeeded in convincing California voters to pass a referendum revoking same-sex couples’ right to marry, invoked the parental-rights oriented, no promo homo narrative with great success. Yes on 8 activists used advertisements that painted the marriage equality movement as privileging same-sex marriage over a parent’s right to control her children’s moral and religious upbringing.¹²⁶ For example, the “Everything to Do With Schools” ad, which aired on California television networks, argued that if marriage equality were allowed to stand, public schools would be forced to teach a more inclusive definition of marriage and parents would not be able to opt their children out of such lessons.¹²⁷

123. *Id.* at 1359-62, 1366-69 (observing that, for example, some states have maintained laws allowing public school teachers who “encourag[e]” homosexuality to be dismissed, and that child custody cases have often been decided against LGBT parents because of “the unproven belief that children raised by gay parents will themselves become gay”).

124. *See Troxel v. Granville*, 530 U.S. 57, 65 (2000) (noting that “the interest of parents in the care, custody, and control of their children[] is perhaps the oldest of the fundamental liberty interests recognized by this Court”). Even *Prince*, despite holding that the state maintains an interest in protecting children, recognized the importance of parental authority over a child’s upbringing. *See Prince v. Massachusetts*, 321 U.S. 158, 165 (1944) (describing a parent’s “control of the child and his training” as a “serious” interest that implicates basic democratic values).

125. For example, in the 1970s and 1980s, Anita Bryant famously spearheaded efforts to defeat gay civil rights ordinances by fostering fears of “recruitment” and “molestation.” In the 1990s, right-wing and religious groups employed anti-gay pamphlets and videos that depicted LGB people as pedophiles in order to question whether such a group truly deserves “special rights” and “special protection” from discrimination. *See* GEORGE CHAUNCEY, *WHY MARRIAGE? THE HISTORY SHAPING TODAY’S DEBATE OVER GAY EQUALITY* 38-39, 45-47 (2004).

126. For a detailed description of this strategy, see Melissa Murray, *Marriage Rights and Parental Rights: Parents, the State, and Proposition 8*, 5 *STAN. J. C.R. & C.L.* 357 (2009).

127. *Id.* at 381 (describing the “Everything To Do With Schools” commercial).

As the opposition to the bill demonstrates, SB 1172 brazenly plays into the basic fears over the state usurping parental authority that underlie aspects of the no promo homo narrative. Removing parents' ability to seek SOCE therapies for their children not only reinforces anti-gay fears about "wavering" children being "converted" to homosexuality (however irrational those fears might be) but also, at least superficially, appears to "violate" a fundamental element of parental authority: the right to control a child's medical treatments. While it is impossible to know how ubiquitous the anti-parental-rights rhetoric surrounding SB 1172 will become, the bill at least carries a risk of encouraging a kind of popular political mobilization similar to what the Yes on 8 campaign provoked.

It is important to note that fears about "backlash" to gains by minority groups can often be overstated.¹²⁸ Furthermore, any concern about backlash must be weighed against the broader goals of the social movement; even if there is a true risk of backlash, the risk may be worth taking. The goal of this Note is not to argue that concerns about backlash should take precedence over the importance of addressing the genuine harms posed by SOCE. Rather the Note's aim is to identify the risk of counter-mobilization and propose solutions—as the next Part does—that might partially mitigate it, while still allowing the state to regulate minors' exposure to SOCE.

III. AN ALTERNATIVE: DECEPTIVENESS-BASED REGULATION

In November 2012, a group of former patients of a SOCE-practitioner group called Jews Offering New Alternatives for Healing (JONAH)¹²⁹ filed suit against the organization in the Superior Court of New Jersey.¹³⁰ The plaintiffs,

128. See Linda Greenhouse & Reva B. Siegel, *Before (and After) Roe v. Wade: New Questions About Backlash*, 120 YALE L.J. 2028, 2077 (2011) (analyzing the history of the abortion debate and *Roe v. Wade* and arguing, inter alia, that "countermobilization and escalating conflict (often referred to as 'backlash') is a normal response to increasing public support for change" and should not be viewed as a particularly exceptional phenomenon).

129. JONAH was formerly known as Jews Offering New Alternatives for Homosexuality. *JONAH's History*, JONAH, <http://www.jonahweb.org/sections.php?secId=11> (last visited Nov. 12, 2013).

130. Complaint, *Ferguson v. JONAH*, No. L-5473-12 (N.J. Super. Ct. Law Div. Nov. 27, 2012), http://www.splcenter.org/sites/default/files/downloads/case/Ferguson_v._JONAH_-_Complaint.pdf.

represented by the Southern Poverty Law Center and several private firms,¹³¹ allege that JONAH's promise to "cure" them of their homosexuality was fraudulent and deceptive in violation of New Jersey's Consumer Fraud Act.¹³² The plaintiffs maintain that JONAH's practices rest on the "false premise that gay sexual orientation is a mental disorder" and thus treatable, and that JONAH fraudulently claims that its specific SOCE practices are supported by "[e]mpirical evidence" attesting to their efficacy and are "well-grounded in science."¹³³ These claims "induced" the plaintiffs to pay JONAH several thousand dollars for treatments, which had no effect on their sexual orientations.¹³⁴

The *JONAH* case, which seems to be the first of its kind,¹³⁵ has yet to be resolved.¹³⁶ But the plaintiffs certainly face an uphill battle; the New Jersey Consumer Fraud Act has an "intent" requirement,¹³⁷ which may be difficult to

131. *SPLC Files Groundbreaking Lawsuit Accusing Conversion Therapy Organization of Fraud*, S. POVERTY L. CENTER (Nov. 27, 2012), <http://www.splcenter.org/get-informed/news/splc-files-groundbreaking-lawsuit-accusing-conversion-therapy-organization-of-frau>.

132. N.J. STAT. ANN. § 56:8-1 to -195 (West).

133. Complaint, *supra* note 130, ¶¶ 38-42.

134. *Id.* ¶¶ 43-44. The plaintiffs also allege that JONAH's specific SOCE practices are "psychologically abusive" and involve denigration of LGB people, reliving of past trauma, frequent requests that the patient "undress" in front of the therapist, and inappropriate "group cuddling sessions." *Id.* ¶¶ 45-64. While these practices could arguably give rise to claims under other areas of law—including sexual harassment law—the complaint seeks damages only under the New Jersey Consumer Fraud Act.

135. See Trudy Ring, *Groundbreaking Lawsuit Challenges 'Ex-Gay' Therapy*, ADVOCATE (Nov. 27, 2012, 7:57 PM), <http://www.advocate.com/society/law/2012/11/27/groundbreaking-lawsuit-challenges-exgay-therapy>.

136. The defendants' motion to dismiss was recently denied and the case appears to still be in discovery. Order Denying Motion Dismissing Plaintiffs' Complaint for Failure to State a Cause of Action for Which Relief Can Be Granted, *Ferguson v. JONAH*, No. L-5473-12 (July 19, 2013), <http://www.splcenter.org/sites/default/files/downloads/case/order-denying-motion-to-dismiss.pdf>; *Judge Rejects Conversion Therapy Group's Attempt to Have SPLC Case Thrown Out*, S. POVERTY L. CENTER (July 19, 2013), <http://www.splcenter.org/get-informed/news/judge-rejects-conversion-therapy-group-s-attempt-to-have-splc-case-thrown-out-o>. The most recent information about the case can be found at *Case Docket: Michael Ferguson, et al., v. JONAH, et al.*, S. POVERTY L. CENTER, <http://www.splcenter.org/get-informed/case-docket/michael-ferguson-et-al-v-jonah-et-al> (last visited Jan. 30, 2014).

137. N.J. STAT. ANN. § 56:8-2 (West 2012) ("The act, use or employment by any person of any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment, suppression, or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise or real estate, or with the subsequent

meet. Furthermore, the New Jersey Consumer Fraud Act is designed primarily to target fraudulent sales of “merchandise or real estate”¹³⁸ and a court might hesitate to apply it to therapists. But the case is still significant because it points to the fact that claims made by SOCE practitioners are quite similar to other kinds of deceptive promises made by doctors and commercial entities. In this respect, SOCE could potentially be targeted using wide-ranging anti-deception regulation, rather than through legislation specifically designed to ban SOCE practices.

This Part argues that anti-SOCE activists and lawmakers should focus on the deceptiveness of SOCE and target these therapies in the context of a more wide-ranging regime. All states regulate the behavior of licensed mental health professionals by requiring adherence to a code of professional conduct as a condition of maintaining a license to practice.¹³⁹ Through these codes of conduct, some states forbid therapists from engaging in deceptive practices;¹⁴⁰ indeed, California law already allows the state Board of Psychology to de-license therapists who use deceptive advertising or make deceptive or unrealistic promises to their existing patients.¹⁴¹ Such anti-deception provisions in state laws that regulate mental health professionals could potentially be applied to SOCE practitioners. The scientific literature clearly supports the conclusion that all forms of SOCE are ineffective, which means that most self-defined SOCE practitioners engage in practices that might be actionable under anti-deception provisions like California’s. Using a broader deceptiveness-oriented regime, rather than a targeted ban like SB 1172, would allow SOCE to be curtailed without necessarily triggering the essentialism, First Amendment, and backlash concerns discussed in Part II. In this respect, an anti-deception approach poses a promising alternative to the SB 1172 approach in general, but it might prove especially attractive in states that are unwilling to pass targeted SOCE bans like SB 1172.

performance of such person as aforesaid, whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice” (emphasis added)).

138. See *id.* § 56:8-2 to 8-2.32 (describing specific rules for “misrepresenting geographic origin of merchandise” or illegitimately using a “going out of business sale” advertisement).

139. See Michael R. Espina, *An Introduction to the Mental Health Professions: What Lawyers Should Know*, PA. LAW., March/April 2004, at 40, 41-42.

140. See, e.g., MINN. R. 7200.5100 (2013); N.Y. COMP. CODES R. & REGS. tit. 8, § 29.1(b)(12) (2013).

141. See discussion *infra* Section III.B.

This Part proceeds in four Sections. Section III.A outlines the broad consensus among psychologists that SOCE is ineffective and explains that SOCE practitioners almost uniformly hold themselves out as being able to change a patient's sexual orientation despite this consensus. Section III.B considers the practicalities of developing a regime that would generally prohibit deceptive psychotherapeutic practices, including SOCE. Since existing provisions of the California Business and Professions Code already prohibit deceptive advertising by medical professionals, and also limit a therapist's ability to make unrealistic promises to his patients, this Part uses California as a case study for how an anti-deception regime may provide sufficient grounds for de-licensing SOCE-practicing therapists. Section III.C then explains why this broader deception-based approach could be an especially promising strategy in states unlikely to pass targeted SOCE bans, and might also be advisable even in states like California, since it is less likely to succumb to the criticisms of SB 1172 discussed in Part II. Finally, Section III.D addresses potential objections to this approach.

A. SOCE's Ineffectiveness and the Case for Deception

The question of whether the promises made by SOCE therapists are deceptive hinges on whether these therapies are ever effective in changing sexual orientation. The mental health establishment has indeed come to the consensus that no compelling scientific evidence exists that SOCE treatments are effective in bringing about changes to sexual orientation. The 2009 APA report, for example, concluded that "the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE."¹⁴² The report also highlighted the specific lack of evidence that SOCE treatments can prove effective in leading children to "develop" heterosexual orientations.¹⁴³ Similarly, the American Psychiatric Association, the National Association of Social Workers, and the Pan American Health Organization have all issued reports or policy statements declaring that there is no evidence that SOCE therapy is ever effective in changing sexual orientation.¹⁴⁴

¹⁴² APA Report, *supra* note 27, at 3; *see also id.* at 26-43.

¹⁴³ *Id.* at 4.

¹⁴⁴ Nat'l Comm. on Lesbian, Gay & Bisexual Issues, "Reparative" and "Conversion" Therapies for Lesbians and Gay Men: Position Statement, NAT'L ASS'N OF SOC. WORKERS (Jan. 21, 2000), <http://www.naswdc.org/diversity/lgb/reparative.asp>; *Position Statement on Therapies Focused*

Though SB 1172 was primarily framed around preventing SOCE's harms, the legislation also pointed to the fact that "there is no evidence that sexual orientation can be altered through therapy."¹⁴⁵ Because of this lack of evidence, the drafters claimed, SOCE therapists' promises to "cure" homosexuality could be considered deceptive. In a legislative report submitted during negotiations, the sponsor of the bill, Senator Ted Lieu, explicitly stated that California's children require protection from the "deceptive" and "sham" promises of SOCE.¹⁴⁶ An early draft of the legislation even created a special cause of action for non-minor SOCE patients "if the sexual orientation change efforts were conducted [on a non-minor] . . . by means of therapeutic deception."¹⁴⁷ "Therapeutic deception" was defined as "a representation by a psychotherapist that sexual orientation change efforts are endorsed by leading medical and mental health associations or that they can or will reduce or eliminate a person's sexual or romantic desires, attractions, or conduct toward another person of the same sex."¹⁴⁸ This provision, however, was removed in later drafts that modified the bills to focus primarily on the state's interest in preventing harm to minors.¹⁴⁹

As SB 1172's drafters understood, there is indeed a strong case that SOCE therapists' claims of being able to change sexual orientation could be considered deceptive, in light of the broad consensus that sexual orientation

on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies), AM. PSYCHIATRIC ASS'N (2000), http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2000_ReparativeTherapy.pdf; "Therapies" to Change Sexual Orientation Lack Medical Justification and Threaten Health, PAN AM. HEALTH ORG. (May 17, 2012), http://new.paho.org/hq/index.php?option=com_content&view=article&id=6803.

145. S.B. 1172 § 1(k), 2011-12 S., Reg. Sess. (Cal. 2012) (quoting Stewart L. Adelson et al., *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 967 (2012)).
146. S. JUDICIARY COMM., REPORT ON SB 1172 (LIEU) AS AMENDED APRIL 30, 2012, 2011-12 sess., at 5 (Cal.).
147. S. RULES COMM., OFFICE OF S. FLOOR ANALYSES, S.B. 1172: THIRD READING, 2d Sess., at 3-4 (Cal. Apr. 30, 2012).
148. *Id.*
149. The bill was later amended to focus exclusively on the use of SOCE treatments on minors, removing provisions that provided less burdensome legal restrictions, such as an "informed consent" requirement, for SOCE practices used on non-minors. It was during this amending process that the "therapeutic deception" cause of action was also removed. S. RULES COMM., OFFICE OF S. FLOOR ANALYSES, S.B. 1172: THIRD READING, 2d Sess., at 1 (Cal. May 25, 2012).

cannot be altered through therapeutic intervention. Despite this consensus, SOCE therapists almost uniformly assert that sexual orientation can be changed and often advertise their service by citing to spurious authorities that purport to substantiate these claims.¹⁵⁰

“Deception” is a nebulous term that encompasses a broad range of activities. This Note adopts the definition set forth by the Federal Trade Commission in its policy papers: that deception involves a material “representation, omission or practice that is likely to mislead the consumer” acting reasonably given the circumstances.¹⁵¹ In keeping with this definition, many states forbid salespeople from defrauding consumers using misleading claims or false information. As in the case of the New Jersey commercial statute described above, such anti-deception statutes may sometimes require a showing of fraudulent intent on the part of the salesperson.¹⁵² But an intent requirement is not integral to a showing of deception and many states, including California, use a more open-ended test for deception when regulating professions that are already under closer state control because of a state-granted licensing scheme, such as the mental health professions.¹⁵³ As the next Section explains, SOCE could potentially be actionable under these provisions of California law that are already designed to regulate deception in the mental health professions: specifically, those that forbid a therapist from engaging in deceptive advertising and from making unrealistic guarantees to a patient.

B. A Deceptiveness-Based Approach to Regulating SOCE: California as a Case Study

There are two distinct, though not mutually exclusive, approaches that

150. See, e.g., sources cited *supra* note 8 and *infra* note 155.

151. *FTC Policy Statement on Deception*, FED. TRADE COMM’N (Oct. 14, 1983), <http://www.ftc.gov/bcp/policystmt/ad-decept.htm>.

152. See *supra* note 137.

153. For example, California forbids licensed mental health professionals from using advertising that includes “false, fraudulent, misleading, or deceptive statement[s]” (including scientific assertions that are not verifiable through peer reviewed studies) where the statements are “for the purpose of or [are] likely to induce . . . the rendering of professional services.” CAL. BUS. & PROF. CODE § 651(a), (b)(7) (West 2013). Fraudulent intent (“purpose”) on the part of the practitioner seems to satisfy this requirement, but so can false statements that are simply “likely to induce” the consumer to purchase the professional’s services, notwithstanding any true fraudulent intent. See discussion *infra* Subsection III.B.1.

might be used in crafting a regime to regulate deceptive psychological practices and thereby regulate SOCE implicitly. The regime could censure therapists for making deceptive promises in advertising, or it could censure therapists for making unrealistic guarantees (unsupported by the mainstream understanding of what can be accomplished through psychotherapeutic intervention) to a patient, even in an existing patient-therapist arrangement. This Section considers both of these possibilities and explains how they may already be reflected in California's code of professional conduct for mental health professionals. While either of these approaches could be used to regulate the use of SOCE on any patient, regardless of age, this Section also considers the specific benefits of crafting a regime designed to protect minors from deceptive therapies. Finally, the last Subsection considers the practicalities of how SOCE, as a specific type of deceptive therapy, might be targeted under California's existing general restrictions on deceptive psychological advertising and practices.

1. *Deceptive Advertising*

Many SOCE practitioners explicitly advertise their supposed ability to "cure" patients of homosexual attraction. In so doing, they frequently claim that sexual orientation can be changed¹⁵⁴ and often cite to allegedly "scientific" evidence of SOCE therapy's efficacy.¹⁵⁵ In this respect, SOCE practitioners' activities could be curtailed under a regime that prohibits mental health professionals from making deceptive and misleading claims about the effectiveness of their practices in advertising.

Such an approach would be consistent with the ways that states regulate the advertising of licensed therapists. Indeed, California already maintains several statutes that prohibit fraudulent or deceptive advertising by mental health professionals. For example, practitioners of the "healing arts" (which

154. See, e.g., sources cited *supra* note 8.

155. See, e.g., *Is Change Really Possible?*, PEOPLE CAN CHANGE, <http://www.peoplecanchange.com/change/possible.php> (last visited May 22, 2013) ("In more than 50 years of research, including 48 studies . . . there are data and published accounts documenting easily more than 3,000 cases of change from homosexual to heterosexual attraction, identity and functioning."); *Scientific and Anecdotal Evidence*, AUTHENTIC REPARATIVE THERAPY, <http://www.davidpickuplmft.com/#!what-does-the-science-say/c806> (last visited November 16, 2013) ("There is significant scientific evidence which demonstrates that sexuality is rather fluid in nature and can be changed."); see also Godfrey, *supra* note 8 (citing a NARTH study).

includes medical doctors and psychologists) are prohibited from disseminating any “public communication containing a false, fraudulent, misleading, or deceptive statement” (which, notably, would include any “scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies”) and that does so “for the purpose of,” or such that it is “likely to induce,” the “rendering of professional services.”¹⁵⁶ Under these provisions, any statement that is *likely* to encourage patients to retain the therapist’s services, but is based on false information, is sufficient to implicate the statute, whether or not the therapist had fraudulent intent.¹⁵⁷ Practitioners who violate these requirements can be de-licensed.¹⁵⁸ California also incorporates this exact definition of deceptive advertising into the lists of “unprofessional conduct” (which provide grounds for license revocation) for several additional therapeutic professions, including “marriage and family therapists,”¹⁵⁹ “educational psychologists,”¹⁶⁰ “social workers,”¹⁶¹ and “professional clinical counselors.”¹⁶²

The advertising used by many SOCE practitioners could easily be encompassed by a regime like California’s. As explained above, the consensus of the mainstream mental health community is that SOCE is ineffective and that sexual orientation cannot be changed through therapeutic intervention.¹⁶³ In this respect, any claims made by SOCE practitioners that their therapies are “substantiated by reliable, peer reviewed, published scientific studies”¹⁶⁴—or even a more guarded assertion regarding SOCE’s efficacy that still creates

156. CAL. BUS. & PROF. CODE § 651(a), (b)(7) (West 2013). Such deceptive statements include, *inter alia*, a statement that “[c]ontains a misrepresentation of fact,” “[i]s likely to mislead or deceive because of a failure to disclose material facts,” is “intended or is likely to create false or unjustified expectations of favorable results,” or “[m]akes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.” *Id.* § 651(b)(1)-(3), (7).

157. Additionally, the set of California laws that prohibit businesses from making “false or misleading statements” in advertising their products or services, *id.* § 17500, also applies to psychologists, *id.* § 2960(g).

158. *Id.* § 651(g).

159. *Id.* § 4982(p).

160. *Id.* § 4989.54(e).

161. *Id.* § 4992.3(q).

162. *Id.* § 4999.90(p).

163. See *supra* Section III.A.

164. CAL. BUS. & PROF. CODE § 651(b)(7).

“unjustified expectations of favorable results”¹⁶⁵—may provide grounds for de-licensing under California law. While this approach would not provide a blanket ban on SOCE practices—as SB 1172 does—it would deprive practitioners of one of the main resources used to attract patients.¹⁶⁶ The next Subsection considers a regime that might allow for a more comprehensive ban of SOCE practices.

2. *Making Unrealistic Promises to a Patient*

SOCE practices could also be targeted through a regime that prohibits therapists from directly making deceptive or unrealistic promises to a patient even after therapy has commenced. Such restrictions would be consistent with the state’s general authority to censure licensed practitioners who deviate from the professional standards of the healthcare-provider community.

Parts of California’s Business and Professional Code may already be up to this task and could provide a useful example to other states. Under California law, a therapist may be de-licensed for acts that involve “[f]unctioning outside of his or her particular field or fields of competence as established by his or her education, training, and experience.”¹⁶⁷ Similar restrictions also apply to marriage and family therapists,¹⁶⁸ educational psychologists,¹⁶⁹ social workers,¹⁷⁰ and clinical counselors.¹⁷¹

The scope of what kinds of behavior can be considered a professional service outside a therapist’s “fields of competence” is ambiguous and not well defined in California’s case law or the Board of Psychology’s regulations. But a promise or attempt to treat a condition that is not understood by experts to be treatable might very well fall under these provisions. Equality California appeared to accept this definition of “competence” during the SB 1172 litigation before the Ninth Circuit.¹⁷² This definition is also supported by the APA’s code

165. *Id.* § 651(b)(3)(A).

166. *See* sources cited *supra* notes 8, 155.

167. CAL. BUS. & PROF. CODE § 2960(p).

168. *Id.* § 4982(s).

169. *Id.* § 4989.54(r).

170. *Id.* § 4992.3(m).

171. *Id.* § 4999.90(s).

172. *See* Response of Equality California in Opposition to Plaintiff-Appellants’ Emergency Motion for Temporary Injunction Pending Appeal at 17, *Pickup v. Brown*, No. 12-17681, 2012 WL 6801742 (9th Cir. 2012) (claiming that section 2960(p) would be violated by a

of ethics, which states that a psychologist working within her “competence” must use skills “based upon established scientific and professional knowledge of the discipline.”¹⁷³ On this account, SOCE practices that attempt to change a patient’s sexual orientation—against the understanding of the mental health establishment that sexual orientation cannot be changed through therapeutic intervention¹⁷⁴—could qualify as a deceptive attempt to perform a service outside the therapist’s field of competence.¹⁷⁵ If this interpretation is correct, many of the kinds of guarantees made and practices used by the National Association for Research & Therapy of Homosexuality (NARTH), JONAH, and other “ex-gay” groups could already be considered unprofessional conduct under California law. Indeed, one might argue that acting outside a therapist’s “field of competence” is inherent in the very nature of practicing SOCE qua SOCE (i.e., actively attempting to change a patient’s sexual orientation), considering the mental health establishment’s consensus that sexual orientation cannot be changed through psychotherapeutic intervention.¹⁷⁶

3. *A Note on the Potential for a Minors-Specific Approach*

It is important to note that the two more broad-ranging approaches to regulating SOCE, described above, would be able to ban (or at least limit) the access of SOCE practitioners to *any* patient, rather than minors specifically.

therapist who “[t]ell[s] a patient that the therapist is able to treat a particular condition” when she is actually unable to do so).

173. *Ethical Principles of Psychologists and Code of Conduct*, AM. PSYCHOL. ASS’N § 2.04 (2010), <http://www.apa.org/ethics/code/principles.pdf>.

174. *See supra* Sections I.B, III.A.

175. Some might object that this type of regulation is not a true regulation of “deceptive” practices, but rather has other goals. But, as explained above, this Note operates under the assumption that deception is defined by any “representation, omission or practice that is likely to mislead the consumer,” *see supra* note 151 and accompanying text, and such behavior need not be limited to the context of advertising. California’s requirement that a therapist function within the fields of her competence seems based on the assumption that there is a risk that therapists can deceive patients about the scope of their professional abilities, even in one-on-one encounters, presumably because of the great sense of authority conferred by a mental health professional degree and state license.

176. Of course, this may be an overly ambitious reading of current California law. But California (and other states) could certainly adopt legislation that explicitly identifies as unprofessional conduct making unrealistic promises and attempting to treat a condition that is not considered treatable by the mental health community. Such a statute would clearly encompass most SOCE practices.

This contrasts with the approach of SB 1172, which only restricts minors' access to SOCE therapies on the assumption that the state maintains a special interest in preventing harm to children (who presumably lack the ability to fully consent to SOCE's potential harms, as adults do). The proponents of SB 1172 originally favored more comprehensive legislation, which would have mandated that practitioners receive a non-minor patient's "informed consent" before commencing SOCE treatments, but later withdrew these proposals.¹⁷⁷ The alternative schemes described above—which would focus primarily on SOCE's deceptiveness rather than on its potential psychological harms—might in fact allow for greater regulation of SOCE practices across different age groups.

The state's interest in regulating deceptive practices extends across all age groups because deception leads consumers to make choices they might not make if presented with accurate information.¹⁷⁸ This is a problem that can potentially affect anyone, regardless of age. But there might be a still more compelling case for regulating a child's exposure to deceptive psychological practices. The FTC, in its policy statements, has pointed out that the metric for deception is whether a reasonable person would accept the deceptive claim at face value and rely on it.¹⁷⁹ For children, this standard may sometimes be lower since "[a]n interpretation that might not be reasonable for an adult may well be reasonable from the perspective of a child."¹⁸⁰

Thus, while the California law that restricts mental health professionals from making deceptive promises does not single out minors, there might nonetheless be a compelling case for adding special provisions to state definitions of unprofessional conduct that create a lower burden of proof or harsher penalties for the use of therapeutic practices that deceptively promise unattainable results to children (either in advertising or during the course of therapy).

177. S. RULES COMM., OFFICE OF S. FLOOR ANALYSES, S.B. 1172: THIRD READING, 2d Sess., at 1 (Cal. May 25, 2012) (describing the amendments withdrawing provisions of the legislation related to non-minors).

178. *FTC Policy Statement on Deception*, *supra* note 151.

179. *Id.* ("[W]e examine the practice from the perspective of a consumer acting reasonably in the circumstances. If the representation or practice affects or is directed primarily to a particular group, the Commission examines reasonableness from the perspective of that group.")

180. Roscoe B. Starek, III, Comm'r, Fed. Trade Comm'n, *The ABCs at the FTC: Marketing and Advertising to Children*, Summary of Prepared Remarks to the Minnesota Institute of Legal Education (July 25, 1997), <http://www.ftc.gov/speeches/starek/minnfin.shtm> (making this point in the context of advertising to children).

4. *The Practicalities of Targeting SOCE Through an Anti-Deception Regime*

The problem with targeting SOCE using a more general anti-deception regime—like the areas of California law that already prohibit therapists from engaging in deceptive advertising or in conduct outside their areas of “competence”—is that such a strategy would require using non-legislative processes to establish that SOCE clearly falls under such a regime.

While the potential hurdles that might be encountered during such processes are addressed further in Section III.C, it is worth outlining, in practical terms, how SOCE might be regulated under existing California law. One possibility is that the California Board of Psychology could use its rulemaking authority¹⁸¹ to adopt a regulation¹⁸² that clarifies that SOCE advertising and SOCE efforts within a doctor-patient relationship are covered by the state’s definitions of unprofessional conduct (for the reasons described above). Such a regulation would seem to be generally consistent with the Board’s practice of issuing regulations that clarify the scope of the state’s unprofessional conduct legislation.¹⁸³

A more likely scenario is that individual victims of SOCE could file complaints against SOCE practitioners for deceptiveness-based professional misconduct on a case-by-case basis, in a manner similar to the targeted approach of the *JONAH* litigants described above.¹⁸⁴ California law makes it relatively easy for individual patients to file complaints against therapists for professional misconduct.¹⁸⁵ Upon receiving such a complaint, a peace officer from the Medical Board of California begins an investigation. If compelling

181. CAL. BUS. & PROF. CODE § 2930 (West 2013) (“The board shall from time to time adopt rules and regulations as may be necessary to effectuate this chapter.”).

182. Under California law, “[r]egulation” means every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure.” CAL. GOV’T CODE § 11342.600 (West 2013).

183. For example, the Board has issued a regulation clarifying that psychologists’ advertising may “not promote the excessive or unnecessary use of . . . services” that the licensed psychologist is authorized and competent to provide and that such advertising can be considered professional misconduct under the California Business and Professional Code. CAL. CODE REGS. tit. 16, § 1397 (2013).

184. See *supra* notes 129-136.

185. See Cal. Bd. of Psychology, *Filing a Complaint with the Board of Psychology*, CAL. DEP’T CONSUMER AFF., <http://www.psychboard.ca.gov/consumers/filecomplaint.shtml> (last visited Dec. 4, 2013).

evidence of unprofessional conduct is discovered, the case is turned over to the Attorney General's Office, which may begin pursuing disciplinary actions (often license revocation) against the accused therapist. While the therapist and the state may reach a settlement, such cases sometimes end up before an administrative law judge, who issues a proposed decision that, if adopted by the Board of Psychology, then becomes final and publicly available.¹⁸⁶ These decisions can be appealed directly to the Superior Court of California through a writ of administrative mandamus.¹⁸⁷

Former SOCE patients could use these existing administrative and judicial mechanisms to challenge therapists who continue to engage in SOCE practices. These therapists would likely need to cease advertising that sexual orientation can be changed and engaging in SOCE practices—or face sanctions, including license revocation. Former SOCE patients could likely be aided by anti-SOCE organizations, such as the Southern Poverty Law Center, which has begun keeping track of all active SOCE practitioners, and inviting former SOCE patients to share their stories.¹⁸⁸ Indeed, it is possible that members of these organizations could themselves pursue claims against SOCE therapists even if they never experienced SOCE therapy, at least in California, since California allows “[a]nyone who thinks that a psychologist, psychological assistant or registered psychologist has acted illegally, irresponsibly, or unprofessionally” to file a complaint.¹⁸⁹

While a case-by-case approach might prove tedious and time-consuming,¹⁹⁰ it could still successfully limit the ability of licensed therapists to engage in SOCE practices. First of all, if sufficient complaints were brought against SOCE practitioners, the California Board of Psychology might be galvanized to issue a formal regulation clarifying that SOCE is prohibited (for deceptiveness reasons) under the state's rules of professional conduct. Furthermore, the vast majority of SOCE therapists are generally affiliated with

186. *See id.*

187. Adam G. Slote, ADMIN. L.: BUS. & PROF. LICENSES (last updated Oct. 20, 2009), <http://www.licenselaw.com> (describing options open to professionals facing de-licensing proceedings in California); *see also, e.g.,* *Rand v. Bd. of Psychology*, 142 Cal Rptr. 3d 288 (Ct. App. 2012) (affirming a trial court's denial of a psychologist's application for a writ of administrative mandamus challenging a Board of Psychology decision revoking his license).

188. *Conversion Therapy*, *supra* note 12.

189. Cal. Bd. of Psychology, *supra* note 185 (emphasis added).

190. This problem is discussed further *infra* Section III.D.

larger organizations¹⁹¹ (of which JONAH and NARTH are examples) and several targeted and successful license revocation proceedings against members of these organizations might be able to quickly destabilize the broader network and infrastructure of SOCE practitioners.

C. Benefits of an Anti-Deception Approach

Some of the benefits of curtailing SOCE through a general anti-deception regime—rather than targeted legislation like SB 1172—are obvious. While some liberal states seem poised to pass legislation like SB 1172,¹⁹² most states, especially those with poor records on LGB rights, are unlikely to follow suit. Using existing anti-deception statutes of general applicability would allow LGB rights groups to target SOCE practitioners even in states that would never pass targeted SOCE bans, or in states where legislative efforts are moving too slowly. Even in states that do not yet have rules of professional conduct as robust as California’s (namely, statutes that prohibit therapists from engaging in deceptive advertising or from making unrealistic promises to patients), it would likely be far easier to convince legislatures to pass general anti-deception statutes than to pass a targeted SOCE ban. Even legislators who might hesitate to support an overt anti-SOCE ban would likely feel comfortable opposing quack psychological practices generally.¹⁹³

But even in states that might be willing to pass a targeted ban like SB 1172, it could still be advisable to use an anti-deception regime to curtail SOCE. As the remainder of this Section argues, such an anti-deception approach would not suffer from the normative and political-strategic problems that plague the SB 1172 approach.

191. The Southern Poverty Law Center maps the locations of SOCE practitioners. It shows that most are associated with larger groups like NARTH. *Conversion Therapy*, *supra* note 12.

192. See sources cited *supra* note 17 (describing ongoing legislative efforts in Pennsylvania, New York, and Massachusetts).

193. Indeed, such a regime could curtail other potentially deceptive types of psychotherapy. For example, some psychologists have argued that many practitioners of eye movement desensitization and reprocessing (EMDR) therapy vastly overstate the therapy’s efficacy when “not a shred of good evidence exists that EMDR is superior to exposure-based treatments that behavior and cognitive-behavior therapists have been administering routinely for decades.” Scott O. Lilienfeld & Hal Arkowitz, *EMDR: Taking a Closer Look*, *Sci. Am.*, Jan. 3, 2008, <http://www.scientificamerican.com/article.cfm?id=emdr-taking-a-closer-look>.

1. *This Approach Does Not Require the State to Adopt and Impose Definitions of Sexual Identity*

The proposals described above—which would limit SOCE practices under a broader regulatory regime—would allow the state to avoid adopting a categorizing and essentializing conception of LGB identity like the kind used by SB 1172. Indeed, a deception-oriented scheme would not require the legislature to adopt any definition of sexual orientation at all. Such a regime would therefore not preclude a therapist from engaging fully with patients who may conceive of their sexual orientation in more fluid or shifting terms (like the hypothetical lesbian-identified but possibly bisexual woman described above).¹⁹⁴ A deception-oriented regime would not suffer from such collateral effects because it would, implicitly, only be capable of targeting therapists who *intend* to attempt to “convert” a client from gay to straight (namely, those who affirmatively advertise that they are able to change a patient’s sexual orientation in therapy or those who make unrealistic promises to a same-sex-oriented person about the efficacy of SOCE practices).¹⁹⁵ In contrast, a therapist who simply seeks to help a patient with an ambiguous sexual identity sort out his feelings¹⁹⁶—but does not hold herself out as having the power to actively diminish same-sex attraction or increase opposite-sex attraction—would not be affected. In this respect, such a regime would likely encompass only the type of therapists who seem to have been of greatest concern to the drafters of SB 1172: those who actively attempt (most often due to some kind of ideological opposition to same-sex sexual behavior)¹⁹⁷ to alter the sexual

194. See *supra* Section II.A. It is important to note that the deceptiveness argument does not assume that a person can never organically reevaluate his or her avowed sexual orientation. Indeed, as explained above, some people experience their sexuality in fluid terms over the course of their lifetime. See *supra* Section II.A. Rather, this argument assumes that same-sex sexual attraction—which we would commonly label homosexuality—*cannot actively be altered through psychotherapeutic intervention*. See *supra* Section III.A. As explained further below, this distinction is important because it means that an anti-deception regime would implicitly only target therapists who actively *intend* to try to alter the feelings of those who experience same-sex attraction.

195. The intent described here is not true intent to defraud, of the kind required by New Jersey’s commercial code, see *supra* note 137. Rather, it is simply the intent to convince others that sexual orientation can be changed, despite the lack of supporting scientific evidence.

196. See *supra* notes 69-71 and accompanying discussion (describing the hypothetical problems posed by SB 1172 for a non-SOCE therapist seeking to counsel a lesbian patient who describes growing heterosexual attraction).

197. See, e.g., sources cited *supra* notes 154-155.

attraction of individuals who otherwise recognize that they are sexually oriented toward people of the same sex.¹⁹⁸

Furthermore, a deception-oriented approach would not require the state to normalize, through legislation, its assumptions about different “categories” of sexual orientation or about whether sexual orientation should be thought of as constitutive of an individual’s sense of self.¹⁹⁹ As legislation of general applicability, anti-deception legislation would not require the legislature to iterate any definitions of sexual orientation at all. In this respect, this approach would not contribute to marginalizing those who do not conceive of sexual orientation in mainstream terms.²⁰⁰

The proposal described above is, in some ways, consistent with recent arguments in antidiscrimination law that have focused on adopting universalized, rather than group-specific, policies, in order to avoid using state power to define a group’s identity. In the LGB context, Sonia Katyal has argued that LGB civil rights groups should focus on a more universalized conception of “sexual autonomy,” rather than a group-based conception that emphasizes “equality” between the LGB minority and the heterosexual majority, in order to avoid marginalizing those who fall outside of conventional conceptions of sexual orientation.²⁰¹ Under a sexual autonomy framework, which emphasizes the right of *all* people to define their sexuality free from state coercion, “no particular ‘sexual orientation’ or ‘naming’ is required for inclusion.”²⁰² Kenji Yoshino has pointed out that this type of argument may weigh in favor of greater reliance on an individualized conception of liberty

198. The *Ferguson v. JONAH* plaintiffs present a useful example. These men all experienced same-sex attraction (of the kind that would generally lead someone to identify as gay) but sought therapy from SOCE practitioners who claimed they could limit this same-sex attraction and/or instill heterosexual attraction through SOCE methods. See *supra* notes 130-135 and accompanying text.

199. See discussion *supra* Section II.A.

200. A specific administrative de-licensing proceeding against a SOCE therapist, see *supra* Subsection III.B.4, may require some discussion of what defines sexual orientation. For example, in order to make a finding that a SOCE therapist engaged in deceptive advertising and/or acted outside his competence, an administrative law judge would presumably need to accept that the patient bringing the allegation maintains a certain identifiable sexual orientation and that that orientation is fixed at least insofar as the SOCE therapist could not possibly have changed it through direct psychotherapeutic intervention. But this type of case-by-case “labeling” is very different than imposing a set of assumptions *ex ante* using legislation.

201. Katyal, *supra* note 76, at 172.

202. *Id.*; see also *supra* notes 76-80.

(under the Due Process Clause) over a group-oriented conception of equality (under the Equal Protection Clause) in assessing equal rights claims brought by members of minority groups.²⁰³ The regulation of SOCE does not necessarily touch on the Court's equal protection jurisprudence, but the distinction between individual-oriented and group-oriented approaches is nonetheless relevant. By framing the state's regulation of SOCE as stemming from *everyone's* interest in being free from deceptive psychological practices (rather than as an issue that is only relevant to LGB people), the proposal described above would accomplish the same goals as SB 1172 while allowing the state to avoid defining "gays, lesbians, and bisexuals" as a concrete and cohesive group.

2. *This Approach Would Not Lead to Substantial First Amendment Litigation*

While the approach of SB 1172 engages directly with the complicated question of how much protection the First Amendment affords to "professional speech,"²⁰⁴ an anti-deception approach would be on far more secure First Amendment ground. This would be true regardless of whether SOCE was targeted using an approach focused on regulating deceptive advertising, one focused on regulating unrealistic promises made in the course of therapy, or both.

Fraudulent or deceptive advertising is widely considered to be outside the scope of the First Amendment, and the government may ban such speech.²⁰⁵ The FTC, for example, routinely censures corporations that deceptively or misleadingly advertise that their products can provide certain benefits.²⁰⁶ Despite the continuing erosion of the "commercial speech" doctrine—the notion that regulation of *any* speech made in the course of a commercial transaction is held to a lower standard of First Amendment review—in recent

203. Yoshino, *supra* note 75, at 795 (pointing out that an "advantage of liberty-based dignity analysis is that it is less likely to essentialize identity").

204. See discussion *supra* Section II.B.

205. *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557, 563 (1980) ("The government may ban forms of communication more likely to deceive the public than to inform it.").

206. See, e.g., Complaint, *In re KFC Corp.*, 138 F.T.C. 422 (2004) (No. C-4118) (bringing action against Kentucky Fried Chicken for stating in its advertisements that the consumption of fried chicken can be compatible with certain weight loss programs).

years,²⁰⁷ the general assumption that the state may prohibit fraudulent or misleading advertising seems to be secure.²⁰⁸ Therefore, a regime that censures licensed psychologists who make deceptive or misleading claims about the effectiveness of their therapies would likely pass First Amendment muster. Indeed, as explained above,²⁰⁹ precisely such a regime already exists in California. To my knowledge, it has never been challenged on First Amendment grounds.

Prohibiting a therapist from directly (rather than solely through advertising) making unrealistic promises about a treatment’s efficacy, outside the scope of his professional competence, would also be unlikely to offend the First Amendment. As explained in the last Part,²¹⁰ a speech restriction that is incidental to the regulation of the professional conduct of state-licensed professionals is generally not considered to be a free speech restriction at all.²¹¹ For this reason, the state may censure a doctor who withholds a diagnosis without violating the First Amendment.²¹² The last Part explained that, notwithstanding the Ninth Circuit’s decision to uphold SB 1172, a ban of *any* form of SOCE does not obviously fall within the regulation of professional conduct because of the lack of clinical evidence that SOCE is per se harmful.²¹³

207. See, e.g., *Sorrell v. IMS Health Inc.*, 131 S. Ct. 2653 (2011) (holding that a Vermont statute regulating the marketing of drugs by pharmaceutical manufacturers triggered heightened scrutiny under the First Amendment notwithstanding its commercial nature).

208. See, e.g., *id.* at 2658 (stating that had the statute in question been related to regulating “false or misleading speech” it would have easily survived a First Amendment challenge). *But cf.* Kathryn E. Gilbert, Note, *Commercial Speech in Crisis: Crisis Pregnancy Center Regulations and Definitions of Commercial Speech*, 111 MICH. L. REV. 591, 594 (2013) (pointing out that courts have begun striking down ordinances designed to regulate “crisis pregnancy centers”—centers that counsel women to forgo abortions but often use deceptive advertising practices to imply that they offer abortions—on First Amendment grounds). While ordinances such as those Gilbert discusses often entail *compelling* speech—namely, requiring that crisis pregnancy centers disclose the limitations of their services—and thus are not directly on point, these cases may portend a troubling attack on the state’s ability to regulate misleading speech in advertising.

209. See *supra* Subsection III.B.1.

210. See *supra* Section II.B.

211. See, e.g., *Nat’l Ass’n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043, 1054 (9th Cir. 2000) (holding that the requirements of California’s psychological licensing scheme do not implicate the First Amendment because “employ[ing] speech to treat [] clients does not entitle [psychoanalysts], or their profession, to special First Amendment protection”).

212. Post, *supra* note 94, at 951–53.

213. See *supra* Sections I.B, II.B.

But a regime focused only on prohibiting a therapist from making unrealistic promises about his ability to “cure” conditions that the mental health establishment does not consider curable (such as non-heterosexual sexual attraction) could more easily fall under the general regulation of professional conduct,²¹⁴ and thus not implicate the First Amendment. As the preceding Section explained, California already prohibits a therapist from “[p]erforming, holding himself or herself out as being able to perform, or offering to perform any professional services beyond the scope of . . . his or her field or fields of competence,”²¹⁵ a regulation that may encompass prohibiting therapists from promising or attempting to “treat” conditions that are not considered treatable. This provision would seem to be a pure regulation of professional conduct, outside the scope of the First Amendment.²¹⁶

3. *This Approach Would Be Less Politically Contentious Since It Avoids Implicating a “Parental Rights” Narrative*

Finally, a deception-oriented approach carries less risk of fomenting extreme political backlash, as compared to the SB 1172 approach. Embedding the regulation of SOCE in a universal anti-deception regime would make it far harder for SOCE proponents to argue that the state is “privileging” LGB concerns over the rights²¹⁷ (especially the parental rights) of other Americans. There are simply few politically appealing arguments against the state regulating deceptive promises made by therapists; after all, few people—gay or straight—want to be duped into paying for ineffective treatments.

Granted, targeting SOCE practitioners using a broader anti-deception regime could prove politically contentious, especially as anti-LGB activists begin to realize this strategy has been adopted and attempt to respond. Indeed,

214. See *supra* note 173 and accompanying text (explaining that, under the APA’s general ethical guidelines, psychologists are expected to perform or hold themselves out as being able to perform services that fall within their field of competence, as based on the “established scientific and professional knowledge of the discipline”).

215. CAL. BUS. & PROF. CODE § 4989.54(r) (West 2013); see also *id.* §§ 4982(s), 4992.3(m), 4999.90(s) (imposing similar restrictions on other professions).

216. Cf. *Nat’l Ass’n for the Advancement of Psychoanalysis*, 228 F.3d at 1047, 1053-55 (upholding the constitutionality of California’s licensing scheme for psychoanalysts, including the requirement that psychoanalysts not imply to patients that they are “licensed to practice psychology,” under the theory that this scheme only regulates professional conduct and therefore does not implicate the First Amendment).

217. See *supra* Section II.C.

using the administrative agencies or courts to curtail SOCE could even provide anti-SOCE activists with a powerful argument that SOCE opponents are employing unaccountable fora to achieve a result that should be left to the legislature.

While this backlash could certainly prove damaging to LGB-rights causes, there is reason to believe it would be less extreme than the kind of backlash that has already begun to emerge in response to SB 1172. As argued above, the history of the “no promo homo” anti-LGB discourse in America, coupled with the powerful public values in favor of leaving child-rearing decisions in the hands of parents, makes the optics of SB 1172 especially dangerous. By, at least superficially, appearing to privilege gay rights over the “rights” of parents to control their children’s upbringing, SB 1172 plays into a particularly vicious and powerful anti-LGB narrative.²¹⁸ While an anti-deception approach would be open to attack by more traditional tools of political discourse (such as accusations of countermajoritarianism), opponents would find it much harder to employ the powerful “no promo homo” narrative that has successfully galvanized anti-LGB sentiment in the past and is already being used against SB 1172.

D. Objections

As explained above, the process of bringing SOCE practices under the auspices of a non-SOCE-specific anti-deception regime could be slow.²¹⁹ At least in California, individual complainants would need to challenge SOCE practitioners on a case-by-case basis, arguing that SOCE practices can be considered misconduct under the existing California Code of Professional Conduct provisions that restrict engaging in deceptive advertising or practices that fall outside a psychologist’s “competence.”²²⁰ This process could gradually lead to the de-licensing of most major SOCE practitioners and might even galvanize the state Board of Psychology to use its rulemaking authority to clearly establish that SOCE runs afoul of the state’s code of professional conduct.²²¹ Either way, this case-by-case approach could, in effect, achieve the desired outcome of targeted ban like SB 1172.

²¹⁸. See *supra* Section II.C.

²¹⁹. See *supra* Subsection III.B.4.

²²⁰. See *supra* Subsection III.B.4 (explaining how individual SOCE patients might go about challenging SOCE practitioners).

²²¹. *Id.*

Proponents of exclusive use of the SB 1172 strategy might counter that a case-by-case approach would be problematic for several reasons. First, at least in California, this approach would require convincing administrative law judges, on a case-by-case basis, that SOCE qualifies as deceptive or is outside the scope of a psychologist's competence under the California code of professional conduct.²²² While some judges might be receptive to this argument, others might not be. Legislation like SB 1172 avoids this problem by unequivocally establishing that the use of SOCE practices on minors can provide grounds for de-licensing.

Proponents of the SB 1172 approach might also focus on the secondary public relations benefits that targeted, high-profile legislation can have. As the sponsor of SB 1172 explained during proceedings surrounding the legislation, the goal of the bill is not simply to ban the use of SOCE on minors, but "to provide awareness of the alternatives to and the potential harmful effects of sexual orientation change therapies."²²³ Indeed, the SB 1172 approach arguably presents a better strategy for challenging the homophobia and prejudice that lurks behind SOCE directly. A case-by-case approach of de-licensing SOCE practitioners would probably not attract the kind of high-profile attention that SB 1172 has received and, in this respect, would be less effective in raising awareness about SOCE patients' experiences.

While these concerns are valid, they do not necessarily overwhelm the benefits an anti-deception approach offers compared to the SB 1172 approach. First of all, concerns about the slow pace of targeted de-licensing actions may be exaggerated. As Section III.A explained, there is consensus among the mental health establishment that SOCE is ineffective and that promises made by SOCE practitioners to "cure" homosexuality have no grounding in scientific studies. In this respect, there are few barriers to demonstrating, in the course of proceedings against a SOCE practitioner, that any promises made by the therapist regarding the efficacy of her treatments were misleading and potentially provide grounds for license revocation.

Furthermore, as Subsection III.B.4 explained, most SOCE practitioners are affiliated with a relatively small number of larger organizations—such as JONAH and NARTH—which provide training, resources, and a support network. This means that several targeted de-licensing proceedings might

222. *Id.* (describing how the process of de-licensing a mental health professional in California culminates with a hearing before an administrative law judge).

223. S. RULES COMM., OFFICE OF S. FLOOR ANALYSES, S.B. 1172: THIRD READING, 2d Sess., at 4 (Cal. May 25, 2012).

quickly destabilize these larger organizations,²²⁴ thereby undermining the broader infrastructure of SOCE practitioners. Additionally, as soon as some have been de-licensed for professional misconduct, individual SOCE practitioners might recognize that continuing to engage in their practices would likely eventually lead to legal action and question whether that risk is worth taking.

Second, while the potential public relations and educational benefits of high-profile legislation like SB 1172 is likely to be greatest, a targeted and successful de-licensing campaign against SOCE practitioners might also attract some media attention. The strategy of the Southern Poverty Law Center in the JONAH case, described above, seems to be based on the assumption that individuated litigation can help raise awareness about the experiences of SOCE patients.²²⁵ Indeed, the JONAH case has already attracted significant media attention.²²⁶ Furthermore, the fact that an anti-deception approach might curtail SOCE *without* attracting large amounts of public attention may in fact make it a more appealing option in states that are generally more hostile to LGB-rights causes.

Indeed, it is important to emphasize that SOCE opponents could pursue a targeted-ban approach and an anti-deception approach concurrently. As explained above, the anti-deception approach may be most appealing in states

224. The recent and sudden closure of Exodus International, a large “ex-gay” organization, provides an interesting case study in how consistent criticism and controversy can weaken a SOCE-espousing organization. See Billy Hallowell, *Exodus Leader Explains Why Gay Ministry Is Ending Its ‘War with the Culture’ and Details ‘God’s Creative Intent for Sexuality,’* BLAZE, June 21, 2013, <http://www.theblaze.com/stories/2013/06/21/exodus-leader-explains-why-gay-ministry-is-ending-its-war-with-the-culture-and-details-gods-creative-intent-for-sexuality> (explaining that growing realization of the organization’s “negative impact” contributed to its decision to close); see also Sarah Pulliam Bailey, *Ex-Gay Group Exodus International Shuts Down, President Apologizes,* RELIGIONS NEWS SERVICE, June 20, 2013, <http://www.religionnews.com/2013/06/20/exodus-international-to-shut-down-after-presidents-apology-to-gay-community> (quoting former president Alan Chambers as saying that Exodus’s espousal of “reparative therapy was one of the things that led to the downfall of this organization”).

225. See *supra* notes 130-135 and accompanying discussion.

226. See, e.g., Alan Duke, *Gay Men Sue Counselors Who Promised to Make Them Straight*, CNN, Nov. 27, 2012, <http://www.cnn.com/2012/11/27/us/conversion-therapy-lawsuit>; Erik Eckholm, *Gay ‘Conversion Therapy’ Faces Test in Courts*, N.Y. TIMES, Nov. 27, 2012, <http://www.nytimes.com/2012/11/28/us/gay-conversion-therapy-faces-tests-in-courts.html>; Susan Donaldson James, *Gay Men, Moms Sue NJ Jewish Gay Conversion Therapists*, ABC NEWS, Nov. 27, 2012, <http://abcnews.go.com/Health/nj-lawsuit-alleges-jonah-gay-conversion-therapy-fraud/story?id=17814302>.

that are simply unlikely to pass targeted bans, since the anti-deception approach involves pursuing SOCE practitioners using administrative procedures, courts, and politically safer statutes of general applicability.²²⁷ The SB 1172 strategy could remain the favored option in the few liberal states that seem willing to consider such legislation. Thus, while this Note has expressed reservations about the SB 1172 approach, those arguments should not forestall the potential benefits of an anti-deception approach even for those who continue to favor the pursuit of targeted SOCE bans.

This Part's argument may also point to a broader claim: that proponents of specific causes should be more willing to harness laws of general applicability to achieve goals that cannot (or should not) be sought through targeted legislation. This Part has focused on statutes that generally prohibit psychotherapists from engaging in deceptive advertising or practices, pointing out that such statutes could be used to curtail SOCE. Such an approach would allow SOCE opponents to avoid the contentious issues of identity politics, constitutional litigation, and anti-LGB sentiment that would emerge from pursuing targeted bans. In this respect, this strategy might also be advisable in other politically contentious areas.²²⁸ For example, some have argued that environmental activists should bring common law nuisance claims against corporations that emit high levels of greenhouse gases, instead of or in addition to targeted legislative efforts,²²⁹ though this approach has proven challenging in the courts.²³⁰ While a full discussion of the broader benefits and implications

227. See discussion *supra* Section III.C.

228. Cf., e.g., Yoshino, *supra* note 75, at 794 (arguing that, in the constitutional antidiscrimination realm, appealing to general liberty claims under the Due Process Clause is more effective than specialized group-based claims under the Equal Protection Clause because liberty-based arguments “frame[] the right at a high enough level of generality that [all citizens] are urged to imagine a world in which they were denied the right”).

229. See, e.g., Randall S. Abate, *Automobile Emissions and Climate Change Impacts: Employing Public Nuisance Doctrine as Part of a “Global Warming Solution” in California*, 40 CONN. L. REV. 591 (2008) (suggesting this strategy); David Hunter & James Salzman, *Negligence in the Air: The Duty of Care in Climate Change Litigation*, 155 U. PA. L. REV. 1741, 1745 (2007) (same); Jonathan Zasloff, *The Judicial Carbon Tax: Reconstructing Public Nuisance and Climate Change*, 55 UCLA L. REV. 1827 (2008) (same); see also Thomas W. Merrill, *Global Warming as a Public Nuisance*, 30 COLUM. J. ENVTL. L. 293 (2005) (exploring challenges posed by this approach). See generally Douglas A. Kysar, *What Climate Change Can Do About Tort Law*, 41 ENVTL. L. 1, 2 n.3 (2011) (outlining the vast academic literature on tort law and climate change).

230. See, e.g., *Am. Elec. Power Co. v. Connecticut*, 131 S. Ct. 2527 (2011) (holding that the Clean Air Act displaces any nuisance claim brought against greenhouse gas emitters under federal common law, but holding open the option that such claims could potentially be brought

of using laws of general applicability to pursue social change is outside the scope of the Note, there are clearly strong arguments in favor of using this approach at least in the specific case of regulating sexual orientation change efforts.²³¹

CONCLUSION

This Note has argued that there are limitations to the SB 1172 strategy of using targeted legislation to ban therapists from engaging in “any practices . . . that seek to change a[] [minor] individual’s sexual orientation.”²³² Even those opposed to SOCE should recognize that adopting the SB 1172 approach in other states could collaterally affect people who do not conceive of their sexual identities in mainstream terms, could generate contentious constitutional litigation relating to the First Amendment status of professional speech, and could foster political backlash by playing into a rhetorically powerful narrative that sees LGB rights as antithetical to the strong public values in favor of parental control over a child’s upbringing.

This Note has also proposed an alternative approach that might be used to achieve the goals of SB 1172 without succumbing to the criticisms raised above. Such an approach would involve crafting—or using existing—legislation that restricts therapists from making deceptive claims in advertising their services, or from making promises or engaging in practices that defy the mainstream understanding of what psychotherapy is capable of accomplishing. Considering that the mental health establishment has come to the consensus that SOCE is ineffective in changing sexual orientation, and indeed that homosexuality is not something that can be “cured” to begin with, SOCE could potentially fall under the ambit of this type of anti-deception regime of general applicability. Though regulating SOCE under such a regime might prove slower and more complex, this approach would carry far fewer normative, constitutional, and political-strategic concerns, making it a compelling strategy going forward.

under state common law in the limited situations in which state law is not preempted); *Native Vill. of Kivalina v. ExxonMobil Corp.*, 663 F. Supp. 2d 863 (N.D. Cal. 2009), *aff’d*, 696 F.3d 849 (9th Cir. 2012) (dismissing federal common law nuisance claim on political question doctrine and standing grounds).

231. See discussion *supra* Section III.C.

232. S.B. 1172 § 2(b)(1), 2011-12 S., Reg. Sess. (Cal. 2012) (codified at CAL. BUS. & PROF. CODE § 865(b)(1) (West 2013)).