Banning Sexual Orientation Change Efforts Targeting Minors

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Abstract

This essay explores the legal viability of a nationwide ban on sexual orientation change efforts (SOCE) for minors in the United States of America. Most legal scholars agree that a ban is legally viable because of the potential harm caused by the therapy. Opponents of a ban argue that this kind of regulation would violate the Constitution, but similar state legislation has previously been upheld in federal court. The ban would apply to licensed mental health professionals (LMHP), but not to religious leaders. Research conducted by The American Psychological Association (2009) (APA) and Ariel Shidlo & Michael Schroeder (2002) provides data supporting the conclusion that SOCE risks the mental health of the patient. Based on the potential for harm, lack of evidence supporting SOCE, and the weak arguments against the practice, a ban on SOCE for minors is legally viable in the United States.
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Introduction

Sexual orientation change efforts (SOCE) refers to any process that aims to change the sexual orientation of an individual from homosexual to heterosexual. In popular culture, it is commonly referred to as conversion or reparative therapy. Historically, SOCE utilized physical methods of achieving its goal, including shock therapy, masturbatory reconditioning, and other forms of aversive conditioning (Cyphers, 2014). After being condemned by the American public as torture, SOCE has primarily taken the form of psychoanalysis between a counselor and patient, also known as talk therapy. The counselor and individual use conversation in order to help the patient manage their homosexual behavior.

In recent years, SOCE has fallen under scrutiny as it was realized that aspects of the practice may still pose a threat to mental health. A two-year report published by the American Psychological Association (2009) (APA) on the safety and efficacy of SOCE states that “these negative side effects included loss of sexual feeling, depression, suicidality, and anxiety” (p. 83). Because they are so impressionable, individuals under the age of eighteen may be especially susceptible to these harmful side effects. As the movement supporting lesbian, gay, bisexual, and transgender (LGBT+) rights has progressed in the past few years, the opposition to SOCE has grown. A 2011 poll completed by the Greenberg Quinlan Rosner Research consulting firm showed that only a quarter of Americans believed sexual orientation could be changed through therapy or prayer (Blake, 2015). By 2014, a YouGov poll showed that only 8% of Americans believed in the efficacy of SOCE, and a little less than a quarter were unsure about the practice. According to both of these national polls, the majority of Americans reject SOCE as a legitimate
practice. Moreover, scientific communities have begun to oppose SOCE as a pseudoscience. In fact, the medical and scientific communities could be considered the most important voices in its rejection (Cyphers, 2014). However, current legislation does not reflect public opinion. Despite the rejection of SOCE, only California, New Jersey, and Oregon have enacted laws protecting minors from these practices.

The current laws regarding SOCE have been challenged in court by advocates of the practice for violating the First and Fourteenth Amendments. They claim that because the therapy occurs through conversation, it is protected under the freedom of speech promised by the First Amendment. As lawyer Brian McGinnis (2015) explains, “[U]nder their argument, there is no distinction between the act of providing professional mental health services and constitutionally-protected speech” (p. 266). The Fourteenth Amendment ensures that life, liberty, and property cannot be deprived without due process. The plaintiffs use this to claim that parents have the right to enroll their child in therapy without government interference (Fore, 2014). Upon examination, these arguments fail to prove a constitutional violation. A nation-wide ban protecting minors from SOCE is a legally viable option because homosexual behavior is not abnormal, the treatment poses a risk for negative side effects, and a ban does not violate the Constitution under the First or Fourteenth Amendments.

**The State Interest in Banning SOCE**

In order for the state to intervene in a market, they must have a valid reason. The rationale can range from protection of consumers to ensuring public health. For example, the Food and Drug Administration (FDA) regulates the meat industry to maintain a standard of public health that prevents the spread of diseases related to meat processing. This reasoning is
referred to as the driving interest of the state. Usually, the state interest is related to the ethics of the market (Lumen). In the example above, the state interest is concerned with the ethics of meat manufacturers benefiting financially by neglecting important safety precautions at the cost of public exposure to disease. In relation to SOCE, there are many ethical factors contributing to the interest of establishing a ban. These include the ethics of treating homosexuality as a disease, the validity of SOCE, and the risks associated with SOCE.

In order to reach an understanding about the morality of SOCE, the nature of homosexuality must be investigated. The idea that homosexuality is damaging or immoral is based on religious ideology, whereas both biologists and psychologists agree that homosexual behavior is neither abnormal nor harmful. Kenneth Rosenberg (1994) cites animal studies in which scientists monitored the relationship between certain hormones and sexual behavior. The results show homosexuality to be a normal biological process resulting from the influence of hormones on the brain. Rosenberg states that “these biological studies argue against the harmful and unsubstantiated generalization that homosexuality is a pathological condition” (p. 149). In addition, a study conducted by J. Michael Bailey and Richard Pillard (1991) revealed that male homosexuality has a genetic basis. The scientists interviewed 161 gay men and compared their sexuality with that of their brothers. Results showed that the identical twin of a homosexual individual has a 50% chance of also identifying as homosexual, compared to fraternal twins who have a 20% chance. In response to this study, Rosenberg (1994) says that “given this new information, homosexuals who were never attracted to the opposite sex need not waste years in psychotherapy trying to rid themselves of their lifelong desires” (p. 149).
Moreover, professionals in the psychological field acknowledge that homosexual behavior is a normal aspect of human sexuality; in response to SOCE, the APA’s Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) says that “advocates of these treatments see homosexuality as a mental disorder, a concept that has been rejected by the mental health professions for more than 35 years” (p. 79). Homosexuality has not been considered a mental disorder by any legitimate organization since the late 1900s. In 1948, Alfred Kinsey published his world-changing research proving that sexuality is fluid (Kirby, 2003). He cited that 37% of the population examined had engaged in overt homosexual activities and only 4% reported exclusive homosexual attractions since adolescence. This research caused other psychologists to investigate further. Ultimately, the investigation led to the realization that homosexuality is not a pathological disorder and prompted the removal of homosexuality as a disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Because homosexuality is known to be a natural behavior, it would be unethical for a licensed mental health professional (LMHP) to inform their patient that it is anything other than normal and healthy.

Despite scientific evidence, some individuals still feel conflicted by their sexuality and desire to change it; however, there is no strong data indicating that a change in sexuality is possible or has ever occurred. After carefully reviewing all research on the efficacy of SOCE in the past sixty years, the APA’s Task Force on Appropriate Therapeutic Responses To Sexual Orientation (2009) concluded that “the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex sexual attractions or increase othersex attractions through SOCE” (p. 83). In addition, they specify that there is “no empirical evidence
that providing any type of therapy in childhood can alter adult same-sex sexual orientation” (p. 79). In *The Gay and Lesbian Review Worldwide*, Wayne Besen (2012) discusses the ex-gay myth, the idea that some individuals have changed from homosexual to heterosexual. He points out how that ideology fell apart in a few short years when the most prominent “ex-gays” revealed that they were in fact still homosexual and denied the ability to change. Among them were Alan Chambers, the former president of Exodus International, which is the largest provider of SOCE in the United States. He admitted that he did not believe homosexuality could be “cured.” Additionally, John Smid, who also led Exodus, said that he has never met anybody who successfully converted from homosexual to heterosexual. Furthermore, Sergio Viula, the most recognized ex-gay activist in Brazil, acknowledged that a change in sexuality is impossible.

SOCE has neither anecdotal nor empirical supporting evidence. Because the practice is not based in any scientific evidence, but rather religious ideology, it is inappropriate in the professional mental health field.

However, the state does not desire to regulate SOCE simply because it is unethical and ineffective. The driving interest behind a ban on SOCE would be the risk for troubling mental health complications (McGinnis, 2015). The APA’s Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) found that these “negative side effects included loss of sexual feeling, depression, suicidality, and anxiety” (p. 83). Other scientific studies support the conclusion drawn by the APA. In 2002, Ariel Shidlo and Michael Schroeder conducted a survey of 202 consumers of SOCE. The results revealed that participants who did not achieve a change in sexuality were likely to experience worsened mental health. The effects documented included
frustration, self-blame, loneliness, anxiety, depression, confusion, and self-destructive behavior such as increased substance abuse, self-harm, and suicidal actions.

Some scholars supporting SOCE would argue that only anecdotal accounts exist to support the idea that the practice is harmful to mental health (Sutton, 2014). This argument fails to acknowledge that professional studies agree there is not enough empirical evidence to conclude that SOCE is definitely harmful to mental health (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009) (Shidlo & Schroeder, 2002). But there is enough evidence to confidently say that there is a risk of harm to mental health for those who participate in any form of SOCE, and that harm can be as dangerous as suicide. Combining the evidence that homosexuality is not abnormal, SOCE does not work, and there is a risk involved which could lead the client to commit suicide, it can be concluded that the practice of SOCE is inappropriate in a professional mental health setting. As the APA Task Force (2009) puts it: “The key scientific findings relevant to the ethical concerns… in the area of SOCE are the limited evidence of efficacy or benefit and the potential for harm” (p. 70).

The three points above prove that a ban on SOCE is necessary, especially for any practice that may be targeting minors. These points also serve as the driving interest of the state. SOCE is based in pseudoscience and an ideology that has been disproven. LMHPs should administer appropriate therapy to patients feeling conflicted by their sexuality by providing acceptance, information about LGBT+ life, and building positive, supportive relationships to decrease feelings of isolation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Moreover, even if an individual desires to change their sexuality, the most
recent evidence shows that it is likely impossible. It would be extremely unethical for a LMHP to engage in a non-evidence based practice, especially at the risk of maleficence.

**Constitutional Challenges to Current SOCE Bans**

Now that the motivation for the state to enact a law protecting minors from SOCE has been established, the two main arguments against existing SOCE bans should be examined. In January of 2013 California became the first state to institute legislation protecting minors from SOCE, followed by New Jersey and Oregon (Cyphers). The law was immediately challenged in federal court for violating the Constitution under the First and Fourteenth Amendments. After much controversy, the court decided to uphold the legislation. In order to understand why the courts rejected the challenges, the logic behind them must be evaluated.

The argument supporting a violation of the First Amendment is based on the idea that modern SOCE occurs through conversation and therefore is protected speech. Ultimately, this argument was dismissed by the courts due to its lack of legitimacy. The weakest part of this argument is its failure to recognize the difference between protected speech and unprotected conduct (McGinnis, 2015). The court has a precedent of considering health care administration, including therapy, as conduct; even though it occurs through speech. In a case brief, The American Bar Association (2013) (ABA) states that “the court noted that the state regulates all kinds of conduct—often in cases where the conduct is deemed harmful—despite that the conduct is carried out by means of language” (p. 1). The government has the ability to regulate professional conduct, even though it may limit the counselor’s speech.

This is a concept known as incidental infringement of free speech. Cyphers (2014) explains that throughout United States history, “such restriction is constitutional as long as there
is a sufficiently important governmental interest in regulating [the practice]” (p. 547). Cyphers continues: “[A] SOCE ban, such as California’s prohibition, should be found to be constitutional because the infringement on free speech is incidental, and the state interest of protecting the public welfare is strong” (p. 550). The decision of the court supports this explanation. Brian McGinnis (2015) clarifies the court’s decision by putting it into simpler terms. He conceptualizes it this way:

Consider the lawyer who fails to keep his legal education up to date and as a result, advises his client to take actions that constitute fraud. Should the fact that this advice was transmitted via a phone conversation or an email mean that the lawyer is shielded from malpractice liability for engaging in “speech” protected under the First Amendment? (p. 278)

He relates this to SOCE by explaining that having been rejected as a pseudoscience, the LMHP’s choice to engage in this practice is not protected under free speech.

The challenge under the Fourteenth Amendment is even less compelling. Those opposing the ban claim that the law violates parents’ rights to direct their child’s destiny (Fore, 2014). Lynn Wardle (2015) argues that “efforts to ban sexual orientation change therapy seem to directly violate the rights of individuals with unwanted sexual attractions [and] infringes upon the rights of parents to provide medical treatment for their children” (p. 10). In addition, the court generally tends to favor parental rights over state rights when the subject is a child’s life (Fore, 2014). Despite this history, the court chose to reject the plaintiff’s case.

The court concluded that because the consequences of SOCE include mental health issues, the controversy falls under the domain of public health and therefore allows for necessary
government interference. Referring to the risk of suicide, Cyphers explains that the state interest “of promoting life and deterring death is much more important than a right to autonomy in this situation” (p. 549). The government’s ability to protect public interest overrides parents’ rights to make healthcare decisions for their child. The ABA (2013) says that “despite parents’ fundamental right to make important medical decisions for their children, parents do not have a right to opt for treatments the legislature deems harmful” (p. 1). Ultimately, the court concluded that parents do not have a right to demand access to a health care option that has been deemed improper by the government.

For individuals that desire to engage in SOCE, this conclusion may lead them to feel as though their religious freedom is being infringed upon. Philip Sutton (2014) contends that “persons who experience unwanted same-sex attractions and behaviors deserve the right to receive professional care to try to change” (p. 166). However, he fails to acknowledge that homosexuality is not a mental disorder, and therefore should not be cared for by a LMHP. Additionally, the claim that individuals are being forbidden from attempting to change their sexual orientation is unjustified. A SOCE ban would not apply to religious leaders, only to LMHPs. If an individual chooses to partake in SOCE, they may do so with the help of a religious leader. Cyphers (2014) explains that “there are ample alternative channels for communications regarding SOCE: anywhere except a medical care provider’s office” (p. 550). A nationwide ban on SOCE does not infringe upon anyone’s ability to practice their religion, it simply ensures unethical practices have no place in the professional world.

Conclusion
The idea that homosexuality is unnatural or immoral has been disproven and should no longer be allowed to influence healthcare. The practice of SOCE is disruptive to society because it enables this anti-homosexual myth and allows for professionals to engage in pseudoscience and discrimination on the basis of religion. Individuals who pursue the option of SOCE may do so under the guidance of a religious leader. However, the practice has been proven to put mental health at risk, and all citizens under the age of eighteen must be protected from this danger. Despite opposition, the possibility of a nationwide ban in the United States has been tested in federal court and was found to be legally viable. The most current research supports the conclusion that the United States should pursue a nationwide ban on SOCE for minors because the practice is unethical, can severely injure young patient’s mental health, and does not violate protected rights.
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