
“THE DUSTBIN OF QUACKERY”? SENATE BILL 1172 AND THE LEGAL IMPLICATIONS OF BANNING REPARATIVE THERAPY FOR HOMOSEXUAL MINORS

MARLENA MCMURCHIE*

I tried everything to try to get rid of my homosexuality. Psychologist, Marriage, I tried to have demons what I thought was demons casted out of me, had hands laid on me, I ran from gay people like a plague, went to church almost every time the church door opened and many times after church services and everybody from church was gone, I was at the altar begging God to heal me, and I did these things all of my life and none of it helped.

—Anonymous recipient of “ex-gay” therapy¹

I. INTRODUCTION

On September 30, 2012, California became the first state in the nation to place restrictions on the practice of attempting to change an individual’s sexual orientation. The passage of this landmark legislation, known as Senate Bill (“SB”) 1172,² set off a firestorm of protest, with multiple lawsuits being filed within twenty-four hours of the bill’s passage.³ Though

* Class of 2014, University of Southern California Gould School of Law; B.A. History, University of California, Los Angeles. Thanks to Professor Elyn Saks for her guidance and input on this Note, as well as Professor James Preis for his suggestions and inspiration.

1. Elizabeth M. Weiss et al., *A Qualitative Study of Ex-Gay and Ex-Ex-Gay Experiences*, 14 J. GAY & LESBIAN MENTAL HEALTH 291, 303 (2010).

2. S.B. 1172, 2012 Leg., Reg. Sess. (Cal. 2012), available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172.

3. Erik Eckholm, *California Is First State to Ban Gay “Cure” For Minors*, N.Y. TIMES (Sept. 30, 2012), <http://www.nytimes.com/2012/10/01/us/california-bans-therapies-to-cure-gay-minors.html?>; Denny Walsh & Sam Stanton, *2 Federal Lawsuits Seek to Uphold ‘Gay Conversion.’* SACRAMENTO BEE, Dec. 17, 2012, <http://sd28.senate.ca.gov/news/2012-12-17-sacramento-bee-2-federal-lawsuits->

the issue of SB 1172's validity has been decided by the Ninth Circuit, which upheld the law in August 2013,⁴ other states are considering passage of similar measures,⁵ and many issues were debated minimally or not at all in the California cases. Thus, this Note seeks to examine the potential claims that may be brought on behalf of parents and children against these laws and how such challenges may be overcome. As it is thus far the only law of its kind, SB 1172 is treated as a case study and model in many parts of this Note, and some time is spent discussing the law itself in detail. For the purposes of analysis and simplicity, it is assumed that future laws will be substantively similar to SB 1172.

In order to properly examine the issues at stake, the reader must have a working knowledge of what practices are being limited and the history of such practices. Thus, Part II of this Note will examine the history of homosexuality's conception as a mental illness and the evolution of reparative therapy. The practices discussed are referred to as conversion therapy, reparative therapy, sexual orientation change efforts ("SOCE"), reorientation therapy, and many other names. This Note will follow the lead of the litigators in the SB 1172 cases and refer to such practices as SOCE. Part III will examine the law itself and discuss ways in which it may fall short of its stated goals.

Part IV will discuss the various challenges to the law that may be brought on behalf of children and parents and the ways in which they might be overcome. These challenges can be viewed from several different angles, including the rights of the parents versus the rights and powers of the state, and the rights of children versus the rights and powers of the state. Thus, Part IV is split into two main sections: Parents versus State and Children versus State. These sections have been further divided into subsections on the specific issue being discussed, for example, the Parental Right to Rear.

Part V will attempt to predict the future of SB 1172 and other similar legislation. Additionally, an amendment that may address the problems of SB 1172 is suggested. Part VI will conclude.

seek-uphold-gay-conversion.

4. *Pickup v. Brown*, 740 F.3d 1208, 1222 (9th Cir. 2013).

5. *Eckholm*, *supra* note 3.

II. THE ORIGINS AND HISTORY OF REPARATIVE THERAPY

A. THE EVOLUTION OF REPARATIVE THERAPY

The American Psychiatric Association officially removed homosexuality from the third edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM-III”) in 1973, following decades of research that failed to show the pathology necessary to define homosexuality as a mental disorder.⁶ The American Psychiatric Association’s recategorization led to a split between practitioners who accepted the deletion and those who continued to believe that homosexuality was a mental disorder that was in need of treatment and a cure. Those psy-practitioners who continued to believe in the possibility of curing homosexuality gathered to form the National Association for Research and Therapy of Homosexuality (“NARTH”) in 1992.⁷ NARTH promotes the practice of “change-oriented intervention”⁸ and stands against the American Psychiatric Association and other psy-organizations in their move away from conversion promotion and toward a more affirmational view of homosexuality.⁹

NARTH and its cohort have continued to promote the idea, also propagated by many religious institutions and political organizations, that homosexuality is a mental illness and can be “cured” with the right treatment. NARTH emphasizes psychological and social factors as causing homosexuality, and denies any genetic cause. While it agrees that biology may play some role, it asserts that this does not prevent changes in sexual

6. Gregory M. Herek, *Homosexuality*, in THE CONCISE CORSINI ENCYCLOPEDIA OF PSYCHOLOGY AND BEHAVIORAL SCIENCE 439, 439 (W. Edward Craighead & Charles B. Nemeroff eds., 3d ed. 2004); Robert L. Spitzer, *The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues*, 138 AM. J. PSYCHIATRY 210, 210 (1981).

7. Benjamin Kaufman, *In Defense of the Need for Honest Dialogue*, NARTH.ORG, <http://www.narth.org/docs/indefense.html> (last visited July 23, 2014).

NARTH’s website has changed substantially since the original drafting of this Note and since the court rulings on SB 1172. NARTH’s official positions on many topics discussed in this Note appear to be more neutral now than they were previously. This section includes sources that cite to NARTH.ORG, which appears to be the archived version of the old NARTH official site. These pages are freely available at the addresses provided. The author acknowledges, however, that while these sources likely still reflect the views of some in the pro-SOCE movement, the practitioners who wrote them may no longer represent NARTH’s official position, and as such are not cited for that purpose. These sources are used solely for general information on SOCE practice and practitioners, and should not be associated with NARTH’s official positions.

8. *NARTH Statement on Sexual Orientation Change*, NAT’L ASS’N FOR RES. & THERAPY OF HOMOSEXUALITY, <http://www.narth.com/about-narth/#!about1/c1wab> (last visited July 23, 2014).

9. *NARTH Position Statements*, NAT’L ASS’N FOR RES. & THERAPY OF HOMOSEXUALITY, <http://www.narth.com/about-narth/#!narth-position-statements/c1ae> (last visited July 8, 2014).

preference from occurring. Put simply, adherents to this view do not believe that homosexuality is immutable, natural, or even inevitable.¹⁰

The practice of “curing” homosexuality has historically taken on many forms, which can generally be divided into two categories: physical interventions and psychoanalytic interventions. Physical interventions have had many incarnations. Psychosurgeries, such as lobotomies, were performed as attempts to physically remove unwanted sexual urges from patients. Other attempts to physically extract homosexuality included castration and surgical removal of women’s sexual organs. Electroconvulsive therapy was another popular practice, typically administered accompanying homoerotic stimuli as a means of conditioning an unpleasant and painful response to homosexual urges. Chemical intervention, including hormone treatment, has also been used.¹¹

Aversion therapy is another type of physical intervention that is based on the premise that homosexuality is a learned behavior and, thus, can be “un-learned.” Aversion therapy is considered to be “the most notorious” form of physical intervention and includes the electroconvulsive therapy described above. Chemicals were also used during aversion therapy, often to induce nausea or other unpleasant sensations in response to homosexual stimuli.¹² Other methods include masturbatory reconditioning and advising male subjects to visit female prostitutes.¹³

However, most of these so-called “therapies” have been denounced by those who continue to practice conversion therapy and have been replaced by psychoanalytic therapy. Some proponents of psychoanalytic intervention believe that homosexuality stems from incomplete psychosexual development. According to this view, homosexuality is a result of a lack of healthy same-sex relationships during childhood, both with the same-sex parent and with same-sex peers. Psychological need for same-sex relationships continues into puberty, when it takes the form of homosexual attraction.¹⁴ Psychotherapy seeks to address these underlying issues in several ways. First, therapists often advise patients to engage in stereotypically masculine or feminine behaviors as a way of enforcing

10. *Id.*

11. David B. Cruz, *Controlling Desires: Sexual Orientation Conversion and the Limits of Knowledge and Law*, 72 S. CAL. L. REV. 1297, 1304–06 (1999).

12. Douglas C. Haldeman, *Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy*, 33 PROF. PSYCHOL.: RES. & PRAC., 260, 260 (2002).

13. Cruz, *supra* note 11, at 1306–07.

14. Julie C. Harren, *Educating the Public on the Causes of Homosexuality*, NARTH.ORG, <http://www.narth.org/docs/coll-harren.html> (last visited July 28, 2014).

“proper” gender identity and distinctions between the sexes. For example, therapists will advise men to play more sports and engage in other stereotypical male bonding behavior, while encouraging women to wear more makeup, get manicures, and engage in other stereotypical female behavior.¹⁵

Another belief held by some conversion therapy proponents is that homosexuality stems from childhood sexual abuse or trauma. This is linked with the above-described belief that homosexuality is a result of insufficient or unbalanced relationships with one’s parents. Proponents argue that men who were sexually abused as children are four times more likely to practice homosexuality as adults. They also argue that the insufficient child-parent bond leaves children more vulnerable to sexual abuse and more likely to experience such abuse as their first source of male affection, thus leading to homosexuality later in life.¹⁶ Homosexual women who were sexually abused as children, presumably by men, take the opposite approach according to these beliefs, turning away from men as abusers and embracing women as a safer alternative.¹⁷

B. THE RELIGIOUS RIGHT AND THE “EX-GAY” MOVEMENT

Many religions view homosexuality as essentially immoral. In the United States, evangelical Christian denominations have taken the lead in publicly denouncing homosexuality, often framing it as a “choice” rather than a biological imperative. This sentiment has grown from political posturing to the promotion of a religiously oriented form of reparative therapy that is commonly referred to as the “ex-gay” movement. It is estimated that there are hundreds of “change ministries” in operation throughout the country. The ex-gay movement is one of the largest proponents of reparative therapy in the country,¹⁸ and some conversion therapists often see the religious component of the movement as their allies.¹⁹

15. Tyler Talbot, *Reparative Therapy for Homosexual Teens: The Choice of the Teen Should Be the Only Choice Discussed*, 27 J. JUV. L. 33, 40–41 (2006).

16. *Mothers of Male Homosexuals: A Study*, NARTH.ORG, <http://www.narth.org/docs/mothersof.html> (last visited July 28, 2014). For fuller discussion, see generally Gregory L. Dickson et al., *An Empirical Study of the Mother-Son Dyad in Relation to the Development of Adult Male Homosexuality*, 30 AMCAP J. 48 (2006).

17. Julie Harren, *Homosexuality 101: What Every Therapist, Parent, and Homosexual Should Know*, NARTH.ORG, <http://www.narth.org/docs/hom101.html> (last visited July 28, 2014).

18. Laura A. Gans, *Inverts, Perverts, and Converts: Sexual Orientation Conversion Therapy and Liability*, 8 B.U. PUB. INT. L.J. 219, 225–26 (1999).

19. See Philip M. Sutton, *Do You Do Reparative Therapy: The Making of a NARTH Psychologist*, AFFIRMATION MINISTRIES (Aug. 10, 2008, 8:12 PM),

Religious conversion groups, perhaps predictably, generally take a different approach to reparative therapy than their secular counterparts. These groups often combine attempts to change their clients' sexuality with efforts to change their spirituality. Both efforts are marked by intensive prayer and Bible study. Group therapy focused on "lifestyle" changes is common, as is a fourteen-step recovery program similar to that used by Alcoholics Anonymous.²⁰

Ex-gay groups are also responsible for some of the worst excesses of the current reparative therapy movement. Many adolescents are placed by their parents in residential facilities run by conversion ministries. Such ministries often advertise to parents that homosexuality is sinful and can be changed if the right methods are used. They are often not licensed by appropriate licensing boards and essentially operate under the radar of regulation. Once the children arrive at the facilities, the staff often use fear and threats of negative spiritual and health repercussions to coerce children into trying to change their sexual orientation. Many facilities also "use seclusion or isolation and escort services to transport unwilling youth to program locations."²¹ The American Psychological Association considers programs that use such tactics coercive and has expressed grave concerns about the ethical ramifications of such conduct.²²

However, the ex-gay movement has begun to suffer a crisis of confidence. In 2012, Alan Chambers, the president of Exodus International, one of the most prominent ex-gay groups, stated publicly that there was no cure for homosexuality, and that reparative therapy offered false hopes to those who wished to change their orientation and could even be harmful. Such statements have led to a schism within the movement, as some organizations embraced Mr. Chambers's views while others condemned it, believing that change was still possible.²³ More recently, a lawsuit has been filed in New Jersey by several young men who underwent reparative therapy under the auspices of Jews Offering New Alternatives for Healing

<http://www.affirmationministries.org/resources/sexuality-others/sexuality-do-you-do-reparative-therapy> (encouraging religious activities such as listening to audio tapes from religiously-affiliated ministries and networking with religiously-based ministries for people with unwanted same-sex attractions).

20. Gans, *supra* note 18, at 225–26.

21. AM. PSYCHOLOGICAL ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 75 (2009) [hereinafter APA TASK FORCE REPORT], available at <http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

22. *Id.*

23. Erik Eckholm, *Rift Forms in Movement as Belief in Gay 'Cure' is Renounced*, N.Y. TIMES (July 7, 2012), <http://www.nytimes.com/2012/07/07/us/a-leaders-renunciation-of-ex-gay-tenets-causes-a-schism.html>.

(“JONAH”). The men have alleged deceptive practices under New Jersey’s Consumer Fraud Act for their experience of paying thousands of dollars for “treatment,” which included stripping naked in front of therapists and beating effigies of their mothers, only to be told that their inability to be cured was their own fault.²⁴ Finally, in May of 2012, Dr. Robert L. Spitzer, the author of the primary study relied on by conversion therapists in defending the efficacy of their practices, publicly denounced his own findings, saying that they were not scientifically rigorous, and apologized to the gay community as a whole for any pain he may have caused in stating that homosexuality could be cured.²⁵

C. ETHICAL CONSIDERATIONS AND THE EFFECTIVENESS OF REPARATIVE THERAPY

Most mainstream psychological organizations have spoken out against conversion therapy and advised their members against practicing it. The American Psychological Association, the American Psychiatric Association, the American School Counselor Association, the American Academy of Pediatrics, and the American Medical Association, to name a few, have all made various statements and resolutions condemning conversion therapy.²⁶ The reasons that each organization offers for its position are similar, and the American Psychological Association’s comprehensive report from its Task Force on Appropriate Therapeutic Responses to Sexual Orientation²⁷ (“Task Force”) offers a detailed and rigorous example.

The American Psychological Association convened the Task Force in 2007 to review its previous resolution on sexual orientation change efforts and to refine the American Psychological Association’s response to groups that promoted conversion therapy as a viable alternative to “affirmative” therapy.²⁸ To accomplish this, the Task Force undertook a rigorous review of the peer-reviewed literature on the subject of homosexuality and SOCE. The findings are too extensive to be fully summarized here.²⁹ However,

24. Erik Eckholm, *Gay ‘Conversion Therapy’ Faces Test in Court*, N.Y. TIMES (Nov. 27, 2012), <http://www.nytimes.com/2012/11/28/us/gay-conversion-therapy-faces-tests-in-courts.html>.

25. Heather Rudow, *Researcher of Reparative Therapy Study Retracts Claims, Says He Owes Gay Community Apology*, COUNSELING TODAY (May 22, 2012), <http://ct.counseling.org/2012/05/researcher-of-reparative-therapy-study-retracts-claims-says-he-owes-gay-community-apology/>.

26. S.B. 1172, 2012 Leg., Reg. Sess. (Cal. 2012), available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172.

27. APA TASK FORCE REPORT, *supra* note 21, at 1.

28. *Id.*

29. For a full description of the literature, see *id.* at 81–92.

several of the Task Force's findings are particularly relevant to the debate surrounding SB 1172 and will be stated in brief. The Task Force found that most current, nonreligious SOCE are based on the outdated notion that homosexuality is a mental illness in need of a cure, ideas which "have been directly discredited through evidence or rendered obsolete."³⁰ Review of the scientifically rigorous literature showed that SOCE were generally ineffective and that "a very small number of people in these studies show any credible evidence of reduced same-sex sexual attraction."³¹ It is similarly rare for SOCE to result in increased sexual attraction to the opposite sex.³² The Task Force's language regarding the efficacy of SOCE for minors is even more stark: "There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation."³³ Further, SOCE may increase the isolation and distress that homosexual minors feel.³⁴

However, it must be acknowledged that rigorous, peer-reviewed literature on the efficacy of reparative therapy is practically nonexistent. Both sides in the debate rely almost exclusively on anecdotal evidence to support their claims regarding the effects of reparative therapy. While anecdotal evidence has its place, the lack of empirical data supporting or contradicting reparative therapy's efficacy makes in depth analysis of the practice difficult. For every person who claims reparative therapy was unsuccessful, there is another person claiming the opposite. Until meticulous, empirical research is done on reparative therapy, neither side of the debate will be the clear victor.

III. THE LAW

SB 1172 was introduced by State Senator Ted Lieu on February 22, 2012.³⁵ After several months of amendments and rewrites, the bill was passed by both houses of the legislature in late August 2012. Governor Jerry Brown signed the bill into law on September 30, 2012.³⁶ In its final form, the law was sponsored by most of the most prominent mental health associations in the state, including the California Psychiatric Association,

30. *Id.* at 82.

31. *Id.* at 83.

32. *Id.*

33. *Id.* at 85.

34. *Id.* at 86.

35. *S.B. 1172 Senate Bill Introduced*, LEGIS. COUNSEL'S DIGEST (Feb. 22, 2012), http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1151-1200/sb_1172_bill_20120222_introduced.html.

36. *Complete Bill History S.B. 1172*, http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1151-1200/sb_1172_bill_20120930_history.html (last visited June 20, 2014).

the California Council of Community Mental Health Agencies, and several chapters of the California Association of Marriage and Family Therapists.³⁷ Senator Lieu intended the bill to put a stop to the “bogus efforts” by some therapists to change minors’ sexual orientations. He specifically cited the potentially dangerous side effects of SOCE, including depression and suicide amongst adolescents.³⁸

The law begins by categorically stating that “[b]eing lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming.”³⁹ It continues by recognizing the positions of many mental health and psychological professional organizations regarding SOCE, namely that they are ineffective and potentially harmful, particularly for adolescents. It explicitly lays out the “compelling interest” that the State has in the health and safety of its minor citizens, including protection from the harms associated with reparative therapy. Finally, it reiterates that nothing in the law prevents minors over age twelve from consenting to any form of therapy other than SOCE.⁴⁰

The essential portion of the law provides definitions of pertinent terms and lays out exactly what is prohibited by its passage. A “mental health provider” is defined in essence as any professional psychologist, psychiatrist, therapist, or counselor, and those training or interning to become part of those professions. “Sexual orientation change efforts” are broadly defined as “any practices by mental health providers that seek to change an individual’s sexual orientation.”⁴¹ Interestingly, the law elaborates by stating that “efforts to change behaviors or gender expressions” are included in this definition.⁴² Finally, no mental health provider, as defined, shall be allowed to administer SOCE to minors under eighteen, and those who do shall be considered to have engaged in unprofessional conduct and will be subject to discipline by their licensing entity.⁴³

37. Senate Rules Committee, *Bill Analysis*, http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1151-1200/sb_1172_cfa_20120828_204445_sen_floor.html (last updated Aug. 28, 2012).

38. *Senate Panel Cracks Down on Deceptive Sexual-Orientation Conversion ‘Therapies’*, YOUR VOICE IN SACRAMENTO: SENATOR TED W. LIEU (Apr. 23, 2012), <http://sd28.senate.ca.gov/news/2012-04-23-senate-panel-cracks-down-deceptive-sexual-orientation-conversion-%E2%80%98therapies>.

39. S.B. 1172, 2012 Leg., Reg. Sess. (Cal. 2012), available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172.

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

While some have said the law goes too far, in some ways it may not go far enough. As Senator Lieu stated, SB 1172 was enacted to protect minors from an often-harmful therapeutic practice.⁴⁴ However, by limiting the ban to professional psy-practitioners, the law leaves much of the religious sector of conversion therapists unregulated. As discussed above, unregulated religious ex-gay organizations are responsible for some of the more extreme reparative therapy practices.⁴⁵ Leaving such practices unregulated creates a massive loophole in the law that could conceivably lead to more harm than good. It is possible that the ex-gay facilities that employed psychiatric professionals before SB 1172's passage may stop using their services in order to evade liability under the law. In a segment of society that already flies far under much of society's radar, forcing these practices deeper into the shadows may not be wise. Of course, attempting to regulate religious organizations' attempts at SOCE would almost certainly run into First Amendment issues, which is undoubtedly why the legislature left the loophole in place. The existence of the loophole is important to note, however, in light of the previous discussion of the ex-gay movement.

IV. POTENTIAL CHALLENGES TO SOCE BANS AND RESPONSES

Almost immediately after Governor Jerry Brown signed SB 1172 into law, lawsuits challenging the constitutionality of the law were filed.⁴⁶ It is certain that similar challenges will be made to any other law that bans or limits practicing SOCE on minors.⁴⁷ This part will examine the claims, made only briefly by challengers to the California law, that could be made on behalf of parents and children in those suits and how these challenges can be overcome by proponents of these reparative therapy laws. In order to effectively examine the rights involved, this part will be divided according to the interests that are being promoted. Section A will examine the interests of the parents of children prohibited from engaging in reparative therapy and which of their rights may be violated by enforcement of the law. Section B will examine the interests of the children themselves and different ways the state may regulate their actions that would not be feasible with regard to adults.

44. *Senate Panel Cracks Down on Deceptive Sexual-Orientation Conversion 'Therapies'*, *supra* note 38.

45. APA TASK FORCE REPORT, *supra* note 21, at 75.

46. *See* Eckholm, *supra* note 3 (discussing the bill and its opposition); Walsh & Stanton, *supra* note 3 (discussing two federal lawsuits).

47. *See* Eckholm, *supra* note 3 ("Legislators in New Jersey and a few other states have discussed introducing similar bills to ban the use of the therapy for minors.").

A. PARENTS VERSUS STATE

There are two main rights that parents opposing SOCE bans will likely claim have been violated. The rights are distinct, but related. The first is the right of parents to raise children in whatever ways they see fit. The second is the right to practice religion free from intervention by the state and to raise children according to those religious principles.

1. Right to Raise Children

The right to raise children has long been established as a substantive due process right.⁴⁸ It is an assumption on behalf of the state that parents have their children's best interests at heart and act in furtherance of those interests, and the state must have a compelling reason to intervene in parenting decisions. However, the Supreme Court has repeatedly recognized that a parent's interest in rearing her child must be balanced against the state's *parens patriae* power and interest in protecting children who cannot protect themselves.⁴⁹ Thus, the right to rear is not absolute, and it is subject to limitations where the state perceives that the child's interests are in jeopardy.

The right to rear was established in the seminal case *Meyer v. Nebraska*,⁵⁰ decided in 1923. In *Meyer*, the state of Nebraska had outlawed the teaching of foreign languages in public schools. Robert Meyer, a teacher at a parochial school, was convicted of violating the law by teaching German to a ten-year-old boy.⁵¹ The Supreme Court held that he had been convicted in error. In its reasoning, the Court defined the liberty interest guaranteed by the Fourteenth Amendment in part as "the right of the individual to . . . establish a home and bring up children."⁵² This language became the basis for what is known as the right to raise children.

A more recent case supporting the right to rear is *Troxel v. Granville*.⁵³ In that case, grandparents petitioned for visitation rights to the children of their deceased son. The children's mother did not object to the visitation, but did object to the amount of visitation granted. The Supreme Court affirmed the lower court's ruling that a Washington statute allowing

48. *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399–400 (1923).

49. *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Troxel v. Granville*, 530 U.S. 57, 88 (2000) (Stevens, J., dissenting).

50. *Meyer v. Nebraska*, 262 U.S. 390 (1923).

51. *Id.* at 396–97.

52. *Id.* at 399.

53. *Troxel v. Granville*, 530 U.S. 57 (2000).

“[a]ny person’ to petition for visitation ‘at any time’” violated the mother’s fundamental right to rear.⁵⁴ In its reasoning, the Court “recognized the fundamental right of parents to make decisions concerning the care, custody, and control of their children.”⁵⁵ Since the statute as applied placed the determination of what would be in the child’s best interest solely in the hands of a judge, the statute unconstitutionally infringed on the parent’s right to decide what was best for her child.⁵⁶

However, a parent’s right to rear is not absolute. The state has a compelling interest in the health and safety of children that allows it to override the parental interest when such health and safety is in danger.⁵⁷ There are several examples of such limitations in the realm of mental health that are analogous to the restrictions on parental rights embodied in SOCE bans. I will examine each of these in turn.

One example of a restriction on parental rights, which is particularly noteworthy in the current context because it applies to mental health care, appears in *Parham v. J.R.*⁵⁸ In *Parham*, children admitted for treatment under Georgia’s voluntary civil commitment statute challenged the validity of that law, specifically the clause that stated parents and guardians could voluntarily commit children without any sort of adversarial hearing.⁵⁹ The Court recognized that the state had, and should have, the power to override parental discretion when the child’s “physical or mental health is jeopardized.”⁶⁰ Though the Court took pains to declare that the state’s interest should rarely completely override the parental interest, the insertion of a neutral fact finder into the parental decisionmaking process regarding voluntary civil commitment was deemed sufficient oversight to promote the State’s interest while still protecting parents.⁶¹

In addition, limitations to parental rights have been recognized in the area of abortion. In *Planned Parenthood of Central Missouri v. Danforth*,⁶² the Supreme Court examined a Missouri statute that required, among other things, parental consent for a minor’s abortion. The Court held that requiring parental consent violated the rights of the minor, and that parental consent for a minor’s abortion was not part of the fundamental right to

54. *Id.* at 57.

55. *Id.* at 66.

56. *Id.* at 67.

57. *Id.* at 88 (Stevens, J., dissenting).

58. *Parham v. J.R.*, 442 U.S. 584 (1979).

59. *Id.* at 587.

60. *Id.* at 603.

61. *Id.* at 606–07.

62. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976).

rear.⁶³ The State has “broader authority to regulate the activities of children than of adults,”⁶⁴ and there was not a significant state interest in forcing minors to obtain parental consent before securing an abortion. The Court specifically rebutted the argument made by appellees that the interest of safeguarding the family unit and ensuring parental authority were enough to allow the statute to stand.⁶⁵

In the context of bans on reparative therapy, SOCE bans are not an unconstitutional infringement on the right to rear because the State has a compelling interest in protecting the mental health and welfare of its minor citizens. As explained above, evidence suggests that reparative therapy is not only ineffective, but often harmful, especially for adolescents.⁶⁶ This is similar to *Parham*, in which minor children were deemed in need of protection by the state to ensure their mental health needs were being met under Georgia’s civil commitment statute.⁶⁷ In addition, almost all mental health professional organizations have passed resolutions describing the inefficacy of reparative therapy and are urging their members to cease the practice. This sets the issue of reparative therapy apart from many of the issues dealt with in case law regarding the right to rear; it is unlikely that a court would rule to protect a parent’s right to place her child in a situation which is generally acknowledged to be harmful.

This is exemplified by the case law regarding electroconvulsive therapy for minors. *Parham* represented a significant expansion of the states’ *parens patriae* power into the lives of children.⁶⁸ Some states continued this expansion by enacting legislation designed to protect children from mental health treatments deemed dangerous by the legislature. The most widespread examples of this expansion are the bans on electroconvulsive therapy (“ECT”) on minors of varying ages that have been enacted in several states. In Texas, ECT is banned outright for minors under the age of sixteen.⁶⁹ The same ban is enacted in Colorado.⁷⁰ Several other states, including Missouri and Minnesota, require a court order for ECT to be administered to minors.⁷¹ There is minimal case law regarding

63. *Id.* at 74–75.

64. *Id.* at 74.

65. *See id.* at 75 (noting the difficulty in determining whether providing parents with absolute power to prevent abortion would strengthen the family unit).

66. *See supra* notes 30–34 and accompanying text.

67. *Parham v. J.R.*, 442 U.S. 584, 606–07 (1979).

68. *See supra* notes 58–61 and accompanying text.

69. 25 TEX. ADMIN. CODE § 405.104(b) (2014).

70. COLO. CODE REGS. § 21.280.51(B)(5) (2013).

71. *E.g.*, MINN. R. 9525.3060 subpt. 1 (2013); MO. REV. STAT. § 630.130.3 (2013).

these bans, indicating that they have not been subject to very many challenges in court.

As the examples above suggest, a State interest in the mental health of minors can allow it to limit certain treatments that it deems harmful. Comparison of the bans on ECT and on SOCE help illuminate why states' intrusion into parental rights should stand. ECT is a widespread practice that is approved as effective by most mainstream psychological organizations.⁷² This is in sharp contrast to reparative therapy, which, as discussed above, is denounced by most of the same organizations as ineffective and even dangerous to the mental health of those who receive it.⁷³ If states can ban a practice that many practitioners deem effective at combating mental illness without unduly interfering with parental rights, it is logical that they should be able to ban a practice that most deem ineffective and dangerous without violating such rights.

2. Intervention in Practice of Religion

Many parents who want to enroll their children in reparative therapy are motivated by a religious belief that homosexuality is a sin.⁷⁴ They may thus argue that their religious freedom is violated by SOCE bans because their religion states that homosexuality is a sin, and they have a right to ensure that their children are free from sin in accordance with their religious teachings. This argument is a subset of the argument advocating the right to rear. I have chosen to separate the two because I believe examining the freedom of religion issue separately from a "secular" right to rear argument allows for more simplicity in analogizing and distinguishing the issues involved.

The Free Exercise Clause of the First Amendment guarantees freedom in the practice of religion. When multiple constitutional rights are implicated, the State's interest is judged by a higher standard than it would be if only one right were implicated.⁷⁵ Thus, in the case of reparative

72. Am. Psychiatric Ass'n, *Electroconvulsive Therapy (ECT)*, ECT.ORG, <http://www.ect.org/resources/apa.html> (last visited Aug. 10, 2014).

73. APA TASK FORCE REPORT, *supra* note 21, at 12.

74. See Talbot, *supra* note 15, at 37–38 (explaining that people turn to faith-based data in making conclusions about homosexuality).

75. See *City of Boerne v. Flores*, 521 U.S. 507, 534 (1997) (requiring a State to demonstrate a compelling interest and show that it has adopted the least restrictive means of achieving that interest). See also Carolyn Ann Hicks, Note, "Reparative" Therapy: Whether Parental Attempts to Change a Child's Sexual Orientation Can Legally Constitute Child Abuse, 49 AM. U. L. REV. 505, 531–35 (1999) (addressing whether a finding that reparative therapy constitutes child abuse or neglect unconstitutionally interferes with a parent's First and Fourteenth Amendment rights).

therapy, in which the right to free exercise of religion and the right to raise children may be paired, the State will likely have to meet a higher standard in order to prove that its interest in protecting children from reparative therapy should override the individual rights involved. Fortunately, there are several lines of case law that support this position.

First, there are many cases in which Jehovah's Witnesses attempted to block blood transfusions to their children due to their religious beliefs that such transfusions are contrary to God's command.⁷⁶ In *State v. Perricone*,⁷⁷ parents who were Jehovah's Witnesses attempted to obtain redress when a court ordered a blood transfusion for their son over their objections. The child suffered from a heart condition that required surgery, which left his blood starved of oxygen, an issue for which the only treatment was a blood transfusion. The mother consented to all necessary treatments with the exception of a blood transfusion. The Court ordered a blood transfusion on testimony from the child's doctor over the Perricones' vociferous objections.⁷⁸ The Perricones argued on appeal that their rights of religious freedom and parental care were violated. The New Jersey Supreme Court disagreed, stating that while the freedom to believe was absolute, the freedom to act was not.⁷⁹ The State was entitled to intervene where it felt the safety and welfare of the child was at risk, even when two constitutional rights were implicated.⁸⁰

Perhaps the most famous case involving a combination of parental rights and the right to freedom of religion is *Prince v. Massachusetts*.⁸¹ In *Prince*, the guardian and aunt of a young girl allowed the girl to come with her to proselytize on the street one evening. She was warned by a police officer to take the child home, and after some protest, she did so.⁸² The State brought suit against her for violating child labor laws, and she defended herself by invoking the right to rear and the right of freedom of religion.⁸³ In its decision, the Court acknowledged the line of cases stemming from *Meyer* establishing parental rights as fundamental and the

76. See, e.g., *Novak v. Cobb Cnty.-Kennestone Hosp. Auth.*, 849 F. Supp. 1559, 1563–64 (N.D. Ga. 1994); *Jehovah's Witnesses in State of Wash. v. King Cnty. Hosp. Unit No. 1*, 278 F. Supp. 488, 491 (W.D. Wash. 1967).

77. *State v. Perricone*, 181 A.2d 751 (N.J. 1962).

78. *Id.* at 753–55.

79. *Id.* at 756.

80. See *id.* at 757 (holding that the trial court's action did not violate the federal or the state constitution).

81. *Prince v. Massachusetts*, 321 U.S. 158 (1944).

82. *Id.* at 161–63.

83. *Id.* at 160–61, 164.

cases stemming from *Pierce v. Society of Sisters* regarding the right of parents to give children religious training.⁸⁴ However, “[t]he state’s authority over children’s activities is broader than over like actions of adults”⁸⁵ and “neither rights of religion nor rights of parenthood are beyond limitation.”⁸⁶ The State’s authority to protect and regulate the lives of its minor citizens was not diminished by the fact that the parent based her right to control her child’s upbringing on religious tenets.⁸⁷ The State continued to have the power to protect minors, even when religious issues were brought up.⁸⁸

The issue of reparative therapy is analogous to the line of cases involving Jehovah’s Witnesses for several reasons. First, reparative therapy is an issue that involves the health of the child. As the Task Force, among other reports, indicates, children undergoing reparative therapy have an increased risk of negative mental health repercussions as a result of the “treatment,” including depression and social isolation.⁸⁹ This risk indicates that the state should have a *parens patriae* interest in issues involving reparative therapy for minors, a suggestion that is borne out by the language of the law itself, which specifically lays out the state’s interest.⁹⁰ Like in *Perricone*, in which the parents were deemed free to believe that blood transfusions were banned by their religion but were barred from acting on such beliefs when those acts would harm their child,⁹¹ the State here has a strong argument that while parents are free to believe that homosexuality is sinful, immoral, or wrong, they are barred from acting on that belief when the act, namely reparative therapy, would harm their child. The State’s argument is strengthened by *Prince*, in which the Supreme Court acknowledged that states have a greater right to control the actions of children than adults,⁹² and that even if a portion of a parent’s rearing choices are based on religious tenets, it would not exempt those choices from state scrutiny and potential override.⁹³ Thus, even if a parent bases her

84. *Id.* at 165–66.

85. *Id.* at 168.

86. *Id.* at 166.

87. *Id.*

88. *See id.* (“[The State’s] authority is not nullified merely because the parent grounds his claim to control the child’s course of conduct on religion or conscience.”).

89. APA TASK FORCE REPORT, *supra* note 21, at 85.

90. S.B. 1172, 2012 Leg., Reg. Sess. (Cal. 2012), available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172.

91. *See State v. Perricone*, 181 A.2d 751, 756–57 (N.J. 1962) (discussing the limitations to the rights of religion and the rights of parenthood).

92. *Prince*, 321 U.S. at 168.

93. *See id.* at 166–67 (“[T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child’s welfare; and that this includes, to some extent, matters of

decision to enroll her child in reparative therapy on religious tenets stating that homosexuality is sinful, that religious basis does not exempt her action from interference by the state if the state's *parens patriae* interest is invoked, as it likely would be in the case of reparative therapy.

On the other hand, the state's power to interfere with parental decisions based on religious convictions is more limited than its power in other circumstances. In *Wisconsin v. Yoder*,⁹⁴ Amish parents were convicted of violating the State's compulsory education law by keeping their children home after the eighth grade, according to their religious customs and beliefs.⁹⁵ On appeal, Wisconsin's Supreme Court reversed that determination and the United States Supreme Court affirmed on several grounds.⁹⁶ First, keeping children away from higher education and training them vocationally within the Amish community was a central tenet of the Amish faith without which the entire community was likely to collapse. Their practice through their lifestyle and their beliefs themselves were so deeply intertwined as to be inseparable.⁹⁷ Second, the State's interests in preparing children to participate in a democratic society and preparing them to be self-sufficient members of that society were equally well-served by allowing the children to stay and be trained within their community as they would be if the children were required to attend "traditional" school.⁹⁸ The Court acknowledged that if there was a chance of "any harm to the physical or mental health of the child," then its reasoning would be different, but since neither were implicated, the State's *parens patriae* interest was not sufficient to outweigh the parents' constitutional rights.⁹⁹ Finally, the Court gave specific credence to the fact that the Amish way of life had remained unchanged for nearly 300 years, and that the tenets of their faith had lasted just as long. The fact that the community had remained self-sufficient and successful in its own way for several centuries lent credence to the Amish parents' argument that training their children themselves past the eighth grade would be beneficial rather than

conscience and religious conviction.").

94. *Wisconsin v. Yoder*, 406 U.S. 205 (1972).

95. *Id.* at 207.

96. *Id.* at 205.

97. *See id.* at 216–19 ("[T]he unchallenged testimony of acknowledged experts in education and religious history, almost 300 years of consistent practice, and strong evidence of a sustained faith pervading and regulating respondents' entire mode of life support the claim that enforcement of the State's requirement of compulsory formal education after the eighth grade would gravely endanger if not destroy the free exercise of respondents' religious beliefs.").

98. *Id.* at 221–22.

99. *Id.* at 230.

harmful.¹⁰⁰

As Karolyn Ann Hicks argued in her discussion of making SOCE constitute child abuse,¹⁰¹ the case of SOCE should be distinguished from the precedent set by *Yoder* for several reasons. First, unlike in *Yoder*, in which the practice at issue was an essential part of the Amish way of life and was “inseparable and interdependent” from their belief system,¹⁰² SOCE is in no way an essential part of any religious denomination. In fact, several religions denounce the practice as unethical.¹⁰³ While taking children out of the mainstream educational system after the eighth grade was essential to Amish children’s development as members of the Amish community and the continuity of that community as a whole,¹⁰⁴ SOCE fills no comparable role in modern religions. At most, children who do not “pray away the gay” may be denounced individually by the congregation—an experience that would doubtless be agonizing for the individual, but not threatening to the life of the congregation as a whole, like the Amish community in *Yoder*.¹⁰⁵ As this was one of the main lines of reasoning compelling the Court to rule in favor of the Amish, an analogy to SOCE without that basis does not make sense.

Further, the state interest at stake in *Yoder* is very different from that at stake in the case of SOCE. Unlike in *Yoder*, in which the State had dual interests in the preparation of young citizens for democratic participation and self-sufficiency in society that the Court determined were already being met by Amish vocational training,¹⁰⁶ the State here has a superior interest in protecting the mental health of minors, an interest which is not being met by parents enrolling their children in SOCE. On the contrary, the *Yoder* court ruled that the Amish were still serving the State’s interest by teaching their children from home, albeit in a different manner than the State wanted. Thus, the State’s interests were still being met, just in a different way.¹⁰⁷ In the case of reparative therapy, however, the State’s

100. *Id.* at 224–26.

101. *See Hicks, supra* note 75, at 539–40 (arguing that the facts of *Yoder* are fundamentally different from the issues presented by reparative therapy and distinguishing between the fundamental way of life at stake for the Amish and the recent onset of reparative therapy as a treatment option for homosexual religious youth).

102. *Yoder*, 406 U.S. at 215.

103. Hicks, *supra* note 75, at 539–40.

104. *Yoder*, 406 U.S. at 218–19.

105. Hicks, *supra* note 75, at 539–40.

106. *See id.* at 224 (“[N]ot only do the Amish accept the necessity for formal schooling through the eighth grade level, but continue to provide what has been characterized . . . as an ‘ideal’ vocational education for their children in the adolescent years.”).

107. *See id.* (“A way of life that is odd or even erratic but interferes with no rights or interests of

interest in the mental health of its children would not be met by SOCE. The evidence compiled by various psy-professional organizations suggests that the opposite is true—that parents who enroll their children in SOCE are putting them at risk of mental and emotional harm,¹⁰⁸ so much so that the State is justified in stepping in to ban the practice. In this way the *Yoder* court’s second line of reasoning is also inapplicable to the SOCE context.

In short, challenges based on parental right to raise children or free exercise of religion can likely be overcome. Though precedent supporting the abolishment of the ban exists, the precedent supporting the ban is likely strong enough to overcome challenges on the bases discussed above.

B. CHILDREN VERSUS STATE

The legal system has a long history of treating children differently than adults. Children are variously viewed as property of their parents, property of the state, and autonomous beings capable of making their own decisions.¹⁰⁹ This last conception is the one that will be examined in depth in this section, particularly in the context of adolescents. The issue here is whether a child should be able to decide for himself, free of parental influence, that he wishes to undergo SOCE. Even literature on reparative therapy that advocates various punishments for parents attempting to enroll children against their will make an exception for the child who wishes to undergo the therapy without influence from his parents.¹¹⁰ For example, Tyler Talbot, in his article examining the use reparative therapy on minors, states that “a child facing the controversial and illusive ideas surrounding homosexuality and its origins and treatment should have some choice in the area of ‘reparative’ therapy.”¹¹¹ The fact that Mr. Talbot himself unsuccessfully and painfully underwent three years of reparative therapy as a young man makes this statement particularly affecting.¹¹²

But what about the state’s *parens patriae* interest in protecting the mental health of its youth? Does protecting children from themselves fall

others is not to be condemned because it is different.”).

108. See S.B. 1172, 2012 Leg., Reg. Sess. (Cal. 2012), available at https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172 (noting the disapproval of SOCE by various psy-professional organizations); APA TASK FORCE REPORT, *supra* note 21, at 12 (same).

109. See ROBERT H. MNOOKIN & D. KELLY WEISBERG, CHILD, FAMILY, AND STATE: PROBLEMS AND MATERIALS ON CHILDREN AND THE LAW 2–3 (5th ed. 2005) (discussing the parent-child relationship).

110. See, e.g., Talbot, *supra* note 15, at 46.

111. *Id.*

112. *Id.*

within the state's purview, or should it allow children to make their own decisions regarding their mental health care? California, for example, seems to answer that question with a law allowing children over the age of twelve to consent to mental health treatment free from restriction by their parents.¹¹³ Somewhat ironically, that law, the Mental Health Services for At-Risk Youth Act, was enacted in part to allow Lesbian, Gay, Bisexual, Transgender, and Queer ("LGBTQ") youth to obtain counseling services without parental consent, if their mental health services provider deemed them sufficiently mature and competent.¹¹⁴ However, SB 1172 specifically states that the ban on SOCE is a narrow exception to that law, and that minors cannot consent to SOCE under any circumstances.¹¹⁵ It is logical to assume that future SOCE bans in other jurisdictions will follow California's lead on this issue. The tension between these conflicting views on children's autonomy provides the basis for this discussion.

1. A Child's Right to Privacy and Medical Decisionmaking

In his dissent to the decision in *Wisconsin v. Yoder*, Justice William O. Douglas stated unequivocally that "children are 'persons' within the meaning of the Bill of Rights" and that "children should be entitled to be heard."¹¹⁶ Similarly, Justice John Paul Stevens opined in his dissent in *Troxel v. Granville* that "[a]t a minimum, our prior cases recognizing that children are . . . constitutionally protected actors require that this Court reject any suggestion that when it comes to parental rights, children are so much chattel."¹¹⁷ Such statements are supported by some modern reformers who suggest that a "children's liberation movement" is needed to restore balance to society's dealings with minors.¹¹⁸ Further support for such affirmations can be found in minors' privacy rights and rights to make certain medical decisions.

Minors may have a constitutionally protected right to privacy, at least to a certain extent and in certain states.¹¹⁹ While there is no specific federal

113. CAL. HEALTH & SAFETY CODE § 124260(b) (2014).

114. See *New CA Minor Consent Law Increases Teens' Access to Mental Health Care*, NAT'L CENTER FOR YOUTH LAW: YOUTH LAW NEWS, (July–Sept. 2010), http://www.youthlaw.org/publications/yn/2010/july_sept_2010/new_ca_minor_consent_law_increases_teens_access_to_mental_health_care/ (noting that many LGBT youths benefit from the law).

115. S.B. 1172, 2012 Leg., Reg. Sess. (Cal. 2012), available at https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172.

116. *Wisconsin v. Yoder*, 406 U.S. 205, 243–44 (1972) (Douglas, J., dissenting).

117. *Troxel v. Granville*, 530 U.S. 57, 88–89 (2000) (Stevens, J., dissenting).

118. MNOOKIN & WEISBERG, *supra* note 109, at 2–3.

119. See *id.* at 136 ("Florida voters overwhelmingly approved an amendment to the state constitution that exempts parental notification for purposes of abortion from the state constitutional

right of minors to privacy, several states, including Florida and California, have included explicit privacy clauses in their state constitutions.¹²⁰ With regard to abortion, the Florida Supreme Court twice struck down parental notification and parental consent laws on the grounds that “few decisions are more private . . . than a woman’s decision whether to continue her pregnancy” and seemed to make no distinction between a pregnant minor and a pregnant adult.¹²¹ The Court also noted that minors were allowed to make autonomous decisions concerning themselves or their own existing children, and that refusing to allow them to do the same in the case of abortion would be nonsensical.¹²²

Further, though most medical procedures for minors are subject to parental consent, there are important statutory exceptions that allow a minor to make her own decisions regarding medical care. State statutes vary in this regard. All states allow minors of varying ages to consent to treatment for pregnancy and sexually transmitted diseases.¹²³ Some states permit minors to seek treatment for mental health issues, drug or alcohol abuse, prenatal issues, and contraception without the consent of a parent.¹²⁴ In California, emancipated minors are considered adults for purposes such as consenting to all medical and dental treatments.¹²⁵ Other states allow minors who demonstrate that they understand and appreciate the consequences of proposed medical procedures to consent to such procedures without parental consent. This is often known as the “mature minor” doctrine.¹²⁶

In the case of SOCE, it can be argued that a minor’s right to privacy and to consent to mental health services after a certain age should allow him or her to be able to consent to SOCE. California and many other states have chosen to specifically grant rights that many states and the federal government do not.¹²⁷ By choosing to enshrine the right to privacy in the state constitution, it can be argued that the State accepted the responsibility of protecting that right. Although minors’ rights are often truncated, the

right to privacy.”).

120. See, e.g., *N. Fla. Women’s Health & Counseling Servs. Inc. v. State*, 866 So. 2d 612, 640–41 (Fla. 2003) (Anstead, C.J., concurring) (discussing Florida’s express constitutional right to privacy).

121. *Id.* at 632 (majority opinion).

122. See *id.* at 633–34 (affirming the trial court’s rejection of the State’s “abortion is different” argument).

123. B. Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL’Y 37, 41–43 (2012).

124. *Id.* at 42–43.

125. CAL. FAM. CODE § 7050(e)(1) (2014).

126. MNOOKIN & WEISBERG, *supra* note 109, at 363–71; Hill, *supra* note 123, at 40–42.

127. E.g., CAL. CONST. art. I, § 1 (enshrining right to privacy in state constitution).

State still may have a duty to uphold a right to privacy, even when it seems inconvenient or goes against other beliefs that the legislature chooses to espouse. In a similar vein, by explicitly granting minors the right to consent to mental health services at age twelve,¹²⁸ the State may have granted minors autonomy over their minds and treatment for their minds' illnesses, however they may perceive them. Arguably, the state cannot take a child's right away just because the legislature disagrees with the particular methods a minor may use to achieve peace of mind.

The flip side of this argument is, of course, that the state can control minors' actions to an extent that would be impermissible with adults,¹²⁹ even if it has already granted minors certain rights. Courts, lawmakers, and society as a whole generally view minors as lacking the capacity to make such decisions "in an informed, mature manner."¹³⁰ In order for minors to properly give informed consent to a medical procedure, three conditions must be met: consent must be informed, voluntary, and competent. It is the final requirement, competency, that is called most into question for minors. Most scholars agree that competency requires an appreciation of the nature of the treatment and its probable consequences, and most believe that minors generally lack the capacity to so appreciate the nature and consequences in question.¹³¹

However, studies show that adolescents over a certain age have essentially the same cognitive capabilities as adults with regard to competency. As adolescents age, they become more equipped to evaluate the various causes and consequences of illness and medical decisions. By the time they are between fifteen and seventeen, studies have shown that adolescents are likely capable of giving voluntary consent on their own.¹³² Further, in one study that compared the medical decisionmaking skills of children, adolescents, and adults, scientists found that fourteen-year-olds were able to make decisions at the same level as adults.¹³³ Though this finding has been criticized, many scientists believe that adolescents aged fifteen and older have the same capacity to give consent as adults.¹³⁴ Given that many states already give statutory authorization to adolescents to

128. *E.g.*, CAL. HEALTH & SAFETY CODE § 124260(b) (2014).

129. *Bellotti v. Baird*, 443 U.S. 622, 635–36 (1979).

130. *Id.* at 634. *See also* Hill, *supra* note 123, at 40 ("It is a commonplace that minors are assumed to be incompetent to give legally effective consent.").

131. MNOOKIN & WEISBERG, *supra* note 109, at 396–98.

132. Tara L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent*, 38 *ADOLESCENCE* 343, 347–48 (2003).

133. *Id.* at 349–50.

134. *Id.* at 350.

choose their own mental health treatment, and given that the adolescent brain is likely as capable of competency to choose medical treatment as adults, can the state justify refusing to allow minors to choose reparative therapy? The answer is ambiguous at best. Comparisons to other ways in which the state limits minors' actions, regardless of competency, may be illustrative.

The federal government has placed express limits on child labor since 1938. In that year, Congress passed the Fair Labor Standards Act ("FLSA"), which placed the first successful federal limits on child labor. In its current form, it prohibits "oppressive child labor," which is defined as any labor for those under age sixteen, and for those older than sixteen, any labor that is dangerous or detrimental to the child's health and well-being.¹³⁵ The states each have their own limitations on child labor as well, often connected to mandatory school attendance. The state and federal governments limit child labor for several reasons: to ensure children stay in school instead of working, to prevent exploitation of child workers, and to keep children out of occupations that are dangerous to them, to name a few.¹³⁶ The state's right to regulate child labor has been essentially unchallenged for decades.¹³⁷

State governments also limit the ability of minors to drive. All states have age-based limitations on when minors may obtain drivers licenses. Even within the age limits, states treat minors differently from adults. Young drivers must take driver's education courses, they often must obey curfew laws, and states make it easier to suspend or revoke their licenses for infractions.¹³⁸

Furthermore, the federal government has effectively made the national drinking age twenty-one by tying highway improvement funding to state drinking age laws. This was in response to statistics stating that traffic fatalities could be reduced as the drinking age was raised. Minors are subject to criminal sanctions for failing to comply with drinking age statutes.¹³⁹

Finally, and perhaps most analogously to our case, many states either prohibit or seriously curtail the use of electroconvulsive therapy on minors. Texas and Colorado do not allow ECT to be used on minors under the age

135. MNOOKIN & WEISBERG, *supra* note 109, at 641–43.

136. *Id.* at 640–42.

137. *Id.* at 647.

138. *Id.* at 648–49.

139. *Id.* at 662–63.

of sixteen under any circumstances,¹⁴⁰ and several other states require a court order in order for ECT to be used on minors.¹⁴¹ This is in spite of the fact that most mainstream psychological organizations believe ECT is safe to be used on minors.¹⁴²

The above examples give ample support to the idea that the state has the power to restrict the actions of minors in many different circumstances. These examples also further the notion that even though the state may grant minors certain rights, such as the right to operate a motor vehicle, it can regulate such rights in ways that it could not for adults. Like statutes that allow minors to drive but subject them to certain limitations such as curfews,¹⁴³ the ban on reparative therapy can be viewed as merely a modification of a minor's more general right to choose his own mental health care. Refusing to allow minors to choose reparative therapy does not invalidate the right granted by states to choose their own mental health care; it merely modifies it in the same way that curfew provisions modify a minor's right to drive. This type of regulation, which has been demonstrated time and again, is permissible in order to protect minors. This characterization of SOCE bans is further strengthened by the laws banning ECT for minors in several states. While ECT is considered acceptable for minors by most mainstream psychological organizations,¹⁴⁴ it is apparently permissible to ban its use on minors if the legislature sees fit to do so.¹⁴⁵ The case should then be stronger for banning SOCE, a practice that no mainstream organization endorses and which many professionals believe leads to harm.¹⁴⁶

However, even if the state has precedent for restricting minors' rights in such a way, the question still remains whether it is the right thing to do. At the risk of sounding trite, just because the state can do something does not mean that it should. SB 1172 was clearly passed with the best of intentions, and future SOCE bans undoubtedly would be as well, but if children and adolescents are mentally able and competent to make their own decisions regarding their medical care, should the State deny them the right to do so? An argument can be made that the State already recognizes the fact that children are competent to make some of their own medical

140. 25 TEX. ADMIN. CODE § 405.104(b) (2014); COLO. CODE REGS. § 21.280.51(B)(5) (2013).

141. *E.g.*, MO. REV. STAT. § 630.130.3 (2013); MINN. R. 9525.3060 subpt. 1 (2013).

142. Hazem Shoiria & Hesham M. Hamoda, *Electroconvulsive Therapy in Children and Adolescents*, 11 EXPERT REV. NEUROTHERAPEUTICS 127, 133 (2011).

143. *See supra* note 138 and accompanying text.

144. *See supra* note 142 and accompanying text.

145. *See supra* notes 140–141 and accompanying text.

146. *See supra* notes 30–34 and accompanying text.

decisions, including those involving their mental health, but the State only wants children to make choices that it deems appropriate. The legislature is essentially saying, “we trust you to make decisions, just not that one.” The potential hypocrisy inherent in SOCE bans may weaken the State’s position.

In sum, the State has a strong basis in analogous precedent for regulating minors’ ability to choose mental health services through legislation such as SB 1172. Though adolescents are likely sufficiently competent to consent to SOCE, and it may make sense for the law to be amended to allow minors of a certain age to be able to consent to such therapies, the State can persuasively argue that it has the power to regulate minors’ actions in such a way.

2. SB 1172 as Consumer Protection

Another argument that can be made in favor of SB 1172’s restriction on children is based on consumer protection. Prior to the twentieth century, consumers were subject to the doctrine of *caveat emptor*, or buyer beware. If a buyer felt that he was deceived by a seller, he had few options other than direct confrontation. As transactions became more complicated in the new century, however, the State began to intervene to protect consumers from fraudulent and unfair practices. In 1938, Congress amended the Federal Trade Commission Act to specifically provide for consumer protection actions. Various acts regulating the securities markets soon followed as methods of protecting consumers of securities in the marketplace. Since then, federal and state governments have taken an ever-more active role in protecting consumers from everything from the health effects of cigarettes to privacy infringement.¹⁴⁷

Traditionally, professional services were exempt from consumer protection efforts. However, California’s Department of Consumer Affairs regulates therapists, psychologists, and psychiatrists through, respectively, its Board of Behavioral Sciences, Board of Psychology, and Medical Board.¹⁴⁸ Other states have similar regulatory bodies. In this case, as it is widely acknowledged that reparative therapy is, at best, ineffective,¹⁴⁹

147. DEE PRIDGEN & RICHARD M. ALDERMAN, CONSUMER PROTECTION AND THE LAW § 1.1 (2013).

148. CAL. DEP’T CONSUMER AFFAIRS: CAL. BOARD BEHAV. SCI., <http://www.bbs.ca.gov/> (last visited Aug. 17, 2014); DEP’T CONSUMER AFFAIRS: CAL. BOARD PSYCHOL., <http://www.psychology.ca.gov/> (last visited Aug. 17, 2014); DEP’T CONSUMER AFFAIRS: MED. BOARD CAL., <http://www.mbc.ca.gov/> (last visited Aug. 17, 2014).

149. See *supra* notes 30–34 and accompanying text.

states could defend SOCE bans on the grounds that they are protecting consumers from ineffective or harmful services. A recently filed lawsuit in New Jersey against the ex-gay organization JONAH alleges exactly that. As discussed in Part II, the plaintiffs have filed suit under New Jersey's Consumer Fraud Act, claiming that they were misled by therapists who falsely claimed they could "cure" the plaintiffs of their homosexuality.¹⁵⁰ Here, states can make a similar argument by claiming that reparative therapists have violated consumer protection laws by misleading potential minor clients about the efficacy and safety of their practices. Thus, the State could be justified in limiting minors' actions and choices of therapy because it is merely protecting children as consumers and preventing practitioners of reparative therapy from defrauding the public.

A second basis for comparison in the consumer affairs realm relates to talk therapy, which is now the primary mode of reparative therapy. Talk therapy can be considered primarily speech, or primarily medicine, depending on one's point of view. This is still a very open question, as exemplified by the extensive briefing undertaken in the SB 1172 cases, which focuses primarily on the First Amendment rights of SOCE practitioners.¹⁵¹ The issue, in essence, is that if talk therapy is primarily speech, then it is protected by the First Amendment, but if it is primarily medicine, then it can be regulated as the state would regulate any medical or professional practice. Given that an entire article can, and perhaps should, be written on whether talk therapy is primarily speech or primarily medicinal, for the purposes of this discussion I will proceed from the assumption that it is primarily medicine, and that it is subject to regulation by the state.

If talk therapy is, at its core, medicine, then it is subject to regulation by the state in order to protect consumers from ineffective or harmful medical procedures or medicines. The Food and Drug Administration ("FDA") rigorously tests food and medicines to determine whether they are safe for consumption, and whether, in the case of drugs, they effectively work as advertised.¹⁵² In many cases, the FDA decides that they do not, and it also occasionally changes its opinion on a drug after it has been approved. For example, the popular cancer drug Avastin, which has been approved to treat multiple cancers, had its approval to treat breast cancer

150. Complaint and Jury Demand at 1–2, 3, *Ferguson v. JONAH*, No. L-5473-12 (N.J. Super. Ct. Nov. 27, 2012).

151. See Walsh & Stanton, *supra* note 3.

152. *About FDA: What We Do*, FOOD & DRUG ADMIN., <http://www.fda.gov/aboutfda/whatwedo/default.htm> (last visited Aug. 17, 2014).

revoked because the FDA determined it was “not . . . safe and effective for that use.”¹⁵³ California has similar authority to regulate practices within the psy-professions under the findings of the legislature in California Business and Professional Code section 2900, which declares that the practice of psychology “affects the public health, safety, and welfare and is to be subject to regulation and control in the public interest to protect the public.”¹⁵⁴ Like the FDA in its decision to disallow Avastin in certain circumstances due to its proven inefficacy in those circumstances, states, under their mandate to protect consumers, can justify SOCE bans in certain situations—namely for use on minors—as protecting their citizens from medical treatments that are ineffective and harmful in those situations.

The main difference between reparative therapy and outlawed drugs such as Avastin is that there is some evidence that reparative therapy is more than ineffective—it is actively harmful. Anecdotal evidence from former patients of reparative therapists contends that many adolescent and adult patients experienced increased depression, isolation, and suicidal ideation during and after experiencing reparative therapy.¹⁵⁵ Further, as Senator Lieu stated, several adolescents have committed suicide after going through reparative therapy.¹⁵⁶ This evidence, though mainly anecdotal rather than empirical, makes the case that the State had an obligation to intervene in the practice of reparative therapy in order to prevent harm to the state’s LGBTQ youth. While the State is not required to intervene and stop ineffective medical practices, in the case of reparative therapy, more is at stake than disappointed hopes when a “procedure” does not work as promised. Undergoing reparative therapy can lead, and has already led, to serious harm to adolescent patients—harm that could have been prevented by the State had it acted earlier. SB 1172 rectifies this mistake and will ensure that no other adolescents are made to feel that their lives are worth less simply because their sexuality is “different.”

In sum, the State can rely on two separate lines of argument grounded in consumer protection principles. First, it can claim that it is using SB 1172 to prevent practitioners from defrauding the public. Second, it can argue that it is using its power to regulate the psy-professions to protect the public from ineffective and harmful practices.

153. *FDA Commissioner Announces Avastin Decision*, FOOD & DRUG ADMIN. (Nov. 18, 2011), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm280536.htm>.

154. CAL. BUS. & PROF. CODE § 2900 (2014).

155. APA TASK FORCE REPORT, *supra* note 21, at 83–85.

156. *Senate Panel Cracks Down on Deceptive Sexual-Orientation Conversion ‘Therapies’*, YOUR VOICE IN SACRAMENTO: SENATOR TED W. LIEU (Apr. 23, 2012), <http://sd28.senate.ca.gov/news/2012-04-23-senate-panel-cracks-down-deceptive-sexual-orientation-conversion-%E2%80%98therapies>.

V. THE FUTURE OF SB 1172 AND SIMILAR BANS

While many opponents of SB 1172 will undoubtedly think it goes too far, in reality it, like laws that are similarly structured, may not go far enough to fulfill its mission. It admirably regulates professionals in the mental health field, but leaves unregulated nonprofessionals operating in unregulated institutions, ostensibly the most dangerous institutions for vulnerable youth.¹⁵⁷ In order to fulfill its purpose, the law should be amended to close the loophole allowing unofficial practitioners to continue practicing SOCE on minors unregulated.

Though such an amendment would likely run into First Amendment challenges for those operating in religiously-affiliated institutions, it could be justified by referring to the *Department of Human Resources v. Smith* line of cases.¹⁵⁸ The Supreme Court ruled in *Smith* that a law banning the use of peyote did not violate the Free Exercise Clause rights of Native Americans because it was a law of general and neutral applicability and, as such, requiring religious practitioners to obey it was not a violation of their First Amendment rights.¹⁵⁹ SB 1172 is a “neutral law of general applicability”¹⁶⁰ in that it is in no way directed at strictly religious conduct; on the contrary, it is directed at medical practices that the State has deemed harmful to children. Though the Court in *Smith* acknowledged that the ruling may change if the Free Exercise Clause argument were combined with parental rights arguments,¹⁶¹ the previous discussion of why the parental right to raise should not present a substantial challenge to SOCE bans should lay such arguments to rest. Thus, put simply, the fact that unlicensed practitioners, even those affiliated with religious or quasi-religious institutions, would be forced to comply with SB 1172 and suspend SOCE would not violate their Free Exercise Clause rights.

Furthermore, on a policy level, the law as it stands simply lacks the

157. See *supra* notes 44–45 and accompanying text.

158. Emp’t Div., Dep’t of Human Res. of Or. v. Smith, 494 U.S. 872 (1990). See also Hicks, *supra* note 75, at 531–35 (applying *Smith* to SOCE on minors in the context of legislatively defining such efforts as child abuse or neglect and concluding that “[u]nder the theory that religious beliefs are protected but certain religious acts are not, parents are constitutionally permitted to believe that homosexuality or bisexuality is immoral and should be changed. If parents act consistent with this belief in violation of an otherwise valid law, however, they could be subject to government regulation”).

159. *Smith*, 494 U.S. at 876, 879–82.

160. *Id.* at 879 (quoting *United States v. Lee*, 455 U.S. 252, 263 n.3 (1982) (Stevens, J., concurring)).

161. See *id.* at 882 (acknowledging that *Smith* did not involve both a free exercise claim and a parental right claim).

teeth necessary to protect the most vulnerable portion of its target population. With the notable exception of the members of NARTH and other pro-SOCE psy-practitioners, most psy-practitioners adhere to the guidelines of their respective organizations and do not practice SOCE. Thus, it is logical to infer that most people who practice and advocate on behalf of reparative therapy are not licensed mental health professionals, and thus operate outside the scope of SB 1172. These practitioners, particularly those allied with the ex-gay movement, accordingly present the most danger to potential “patients” because not only are they not licensed and regulated, but also they have no incentive or obligation to obey SB 1172.

Thus, the law should be amended to ban *all* sexual orientation change efforts by anyone acting in a professional capacity. Obviously the legislature cannot regulate what parents choose to tell their children about homosexuality, or what happens in private interactions between individuals. The legislature should, however, expand the law to include any person practicing SOCE in the course of their employment. This could include teachers, life coaches, unlicensed therapists, and anyone who is employed in order to provide such “counseling.” Such an amendment would go a long way toward closing a large loophole that threatens the effectiveness of the entire statute.

VI. CONCLUSION

Reparative therapy is a divisive topic within a divisive topic. At the time this Note was written, two judges in the U.S. District Court for the Eastern District of California had just handed down decisions on two different injunction proceedings aimed at enjoining SB 1172. In a very rare turn of events, the opinions were in complete opposition with one another. One claimed that reparative therapy was a form of speech protected by the First Amendment, and without concrete, empirical proof of harm to recipients of such speech, the court could not condone the state’s intrusion. Conversely, the other conceived of reparative therapy as professional speech subject to regulation by the State and denied the request for an injunction.¹⁶²

The plaintiffs in both cases appealed to the Ninth Circuit Court of Appeals, which heard the consolidated case in April 2013. In August of that year, the Ninth Circuit upheld the validity of SB 1172, focusing

162. See *Pickup v. Brown*, 740 F.3d 1208, 1221–22 (9th Cir. 2013) (explaining the two lower court cases).

primarily on its holding that the law did not violate practitioners' free speech rights.¹⁶³ In its brief discussion of the parental right to raise, the court found that parents did not have a fundamental right to choose medical care for their children that the State deemed harmful.¹⁶⁴ Though this issue has been decided by the Ninth Circuit, other courts may face different arguments and make different decisions such as those outlined above.

This Note has attempted to predict what issues may face laws similar to SB 1172 in the courts, and to provide an analysis of how such issues may be overcome by proponents of SOCE bans. The various claims, both secular and religious, that may be brought on behalf of parents may be overcome by looking to the right precedent. The claims that may be brought on behalf of children are more easily defeated by analogy to policy. Regardless of the approach, SOCE's status within the psychological profession and the potential harm it can cause clearly suggest that more states will soon follow California's lead in banning such practices, and that the issue will be litigated for many years to come.

163. *Id.* at 1225–32.

164. *Id.* at 1235–36.