2006

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NOTE

Does “Reparative” Therapy Really Constitute Child Abuse?: A Closer Look

Sean Young*

INTRODUCTION

The political rhetoric surrounding children and homosexuals often overlooks the interests of children who are themselves homosexual. Yet under the political radar, legal scholars are becoming increasingly cognizant of the need to discuss the rights of sexual minority children vis-à-vis their parents. As one author notes, “Psychological abuse from family members affects queer youth more than any other group of adolescents,”¹ and sixty percent of gay-related violence suffered by these children takes place in the home.² Queer youth who disclose their sexual identity to unaccepting parents may suffer emotional and physical abuse. Parents “may banish the child from the house and shirk their legal duty to provide financial support because they want to disown the sexuality of their child.”³

Within this web of physical and emotional abuse lie parental efforts to change their child’s sexual orientation, otherwise known as “reparative therapy.”⁴

* J.D. candidate, Yale Law School.


4. Also known as “conversion therapy” or “reorientation therapy.” In 1996, Sonia Martin noted that parents’ reactions to their child’s coming out is often accompanied by “seeking psychiatric therapy or institutionalization for their queer children.” Martin, supra note 1, at 174.
In 1999, Karolyn Ann Hicks proposed that subjecting one’s child to reparative therapy can and should constitute child abuse. Using New York state child abuse law as a framework, Hicks claimed that abuse depends on the “reasonably prudent parent standard.” A reasonably prudent parent researching reparative therapies would discover that they are potentially dangerous and not accepted in the mainstream medical community. Further, taking existing societal homophobia into account, a parent would not subject her child to such therapy.

Therefore, a parent who subjects her child to reparative therapy should be guilty of child abuse. Hicks concluded with guarded optimism, however, by stating that since the Supreme Court’s 1986 decision in Bowers v. Hardwick held that a belief in homosexuality’s immorality was a valid public policy consideration, it would be difficult for states to prosecute parents under this theory.

Hicks’s theory has recently taken on new relevance. In 2004, what Hicks claimed as the primary obstacle to her theory’s implementation was removed: Bowers was overruled by Lawrence v. Texas, which held that a belief in homosexuality’s immorality could not serve as a rational basis for any state law. Regardless of whether Lawrence really means that Hicks’s theory may now be implemented, In re E.L.M.C. demonstrates that such a prospect is not

5. Karolyn Ann Hicks, “Reparative” Therapy: Whether Parental Attempts To Change a Child’s Sexual Orientation Can Legally Constitute Child Abuse, 49 AM. U. L. REV. 505 (1999). Hicks does not explicitly distinguish between the concepts of child abuse and child neglect. This is understandable, as both concepts generally depend on similar standards. “Neglect has also been broadly defined as the disregard of one’s duty, owing to indifference or willfulness.” 3 AM. JUR. 2D Proof of Facts § 1 (2005); see, e.g., In re C. Children, 583 N.Y.S.2d 499 (App. Div. 1992) (using same evidence to determine child abuse and child neglect). For the sake of simplicity, the differences between child abuse and neglect are beyond the focus of this Note, which focuses on child abuse; this is because subjecting a child to reparative therapy involves an affirmative act that more properly falls under the category of abuse. In any case, the distinction between child abuse and neglect should not be overemphasized.

6. Hicks, supra note 5, at 520.
8. Hicks, supra note 5, at 524-25.
9. 478 U.S. 186 (1986); Hicks, supra note 5, at 546.
11. Id. at 577 (“[T]he fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice.”) (quoting Bowers, 478 U.S. at 216 (Stevens, J., dissenting)).
12. There are likely other obstacles to Hicks’s theory being implemented. There are unique barriers to prosecuting child abuse in situations in which the abuse is emotional. The harmful effects of emotional abuse are hidden to third parties, who would ordinarily be able to report it. Adolescents themselves construe such abuse as “normal.” There is little awareness of intervention
implausible. That 2004 case involved a child custody dispute between a same-sex couple, in which one parent began to believe homosexuality was immoral after the separation. The trial court below awarded the parties joint parental responsibility but required the parent who believed homosexuality was immoral to “make sure that there is nothing in the religious upbringing or teaching that the minor child is exposed to that can be considered homophobic.”14 The appellate court remanded the case to determine whether homophobic teachings would “significantly impair her emotional development.”15 Although this was a child custody case, the evidence used to determine custody is often equally applicable in child abuse cases.16 And although this case did not involve reparative therapy, the motivating factor behind the parent’s potentially homophobic teachings and reparative therapy was the same: the belief, usually religious, that homosexuality is immoral. Therefore, this case shows that a court may not consider that belief to be sacrosanct territory immune from judicial intervention.

This Note argues that, for evidentiary reasons, contrary to what Hicks may suggest, reparative therapy cannot be considered child abuse under current law.17 There is no reliable evidence that reparative therapy works, and there is also no empirical evidence that reparative therapy is harmful. Professional psychological associations’ codes of ethics continue to remain silent on the practice, and the courts do not require psychological treatments to empirically demonstrate their effectiveness in order to justify their appropriateness. This Note discusses these evidentiary factors in detail.

In responding to Hicks’s piece, this Note also presents a nuanced, up-to-date, and practical legal framework through which to analyze reparative therapy. This is necessary to the extent legal scholars continue to theorize causes of action against and protections from reparative therapy. For instance, Laura Gans options. And states require children to be represented by an adult. John Alan Cohan, Parental Duties and the Right of Homosexual Minors To Refuse “Reparative” Therapy, 11 BUFF. WOMEN’S L.J. 67, 78-79 (2002-2003); see also Sana Loue, Redefining the Emotional and Psychological Abuse and Maltreatment of Children, 26 J. LEGAL MED. 311, 336 (2005) (discussing reasons for underreporting of emotional child abuse as compared to physical child abuse and listing recommendations to encourage the prosecution of emotional child abuse).

14. Id. at 563.
15. Id.
17. This is not to ignore the fact that political reasons play a role in whether such prosecutions could happen. It is simply more useful to legal scholarship to analyze the evidentiary barriers rather than to attribute an undue amount of influence to politics.
proposes an "intentional infliction of emotional harm" cause of action against reparative therapists;18 David Cruz advocates a less deferential standard of informed consent in reparative therapy;19 John Alan Cohan asserts that adolescents should have the constitutional right to refuse reparative therapy;20 and James Gilliam highlights the problem of placing homosexual children in the foster care of those who employ reparative therapy.21 In addition to these theories, this Note's framework will also affect the standards for determining whether the institutionalization of homosexual juveniles for reparative therapy purposes is constitutional,22 as well as determining how child custody is awarded.

Part I critiques Hicks's definition of reparative therapy and proposes a useful alternative. Part II shows that Hicks's analysis turns on the admissibility of psychological testimony as evidence. It discusses the evidentiary standards set out in Daubert v. Merrell Dow Pharmaceuticals, Inc.23 and Frye v. United States,24 surveys the way the standards have been applied to psychological testimony generally, and then applies the standards to the reparative therapy scenario. Part III distinguishes among and analyzes the legal significance of the data presented by Hicks and other reparative therapy opponents and shows how this evidence would be ineffective in demonstrating that reparative therapy constitutes child abuse. Part IV explores the ambivalent relationship between professional codes of ethics and position statements of psychology associations and explains how only the codes of ethics are relevant to whether reparative therapy constitutes child abuse. Part V discusses the "empirically validated treatment" (EVT) controversy that is brewing in the practice of psychology. Part VI discusses the implications of these analyses for whether reparative therapy constitutes child abuse, discusses the implications for reparative therapy in other legal contexts, and proposes recommendations for dealing with reparative


20. Cohan specifically advocates for adolescents to possess the right to refuse reparative therapy, just as they currently have the constitutional right to contraceptives, testing for sexually transmitted diseases, and abortions. Cohan, supra note 12, at 75.


22. See infra Section I.B. (discussing Farham standard of due process for committing youths to mental institutions).


24. 293 F. 1013 (D.C. 1923).
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therapy in the legal system generally.

I. DEFINING REPARATIVE THERAPY

Hicks provides the following definition of reparative therapy: "Reparative therapy, a program of psychotherapy, attempts to 'cure' homosexuals by turning them into heterosexuals."25 These therapies may include:

[B]ehavioral therapy, electrical shock therapy, chemical aversive therapy, drug and hormone therapy, surgery, and psychotherapy. Other accounts are similar and include homophobic counseling, religious propaganda, isolation, unnecessary medication (including hormone treatment), subliminal therapies designed to inculcate 'feminine' or 'masculine' behavior and 'covert desensitization' therapies that teach a young person to associate homosexual feelings with disgusting images.26

This definition is too broad to be analytically or practically useful. This Part explains why this is the case and proposes a revised definition for purposes of legal analysis.

A. From Electroshock Therapy to Psychotherapy: A Critical Distinction

Hicks's account of reparative therapy is misleading, because it does not recognize the decline in the more physically invasive methods of reparative therapy and the rise of "purely" psychotherapeutic reparative therapies. A child "praying to be saved"27 is quite different from a child undergoing electrical shock therapy.28

Other scholars, on the other hand, have made this critical distinction. For instance, Gans notes, "The earliest forms of conversion therapy included injecting patients with substances, such as testosterone, estrogen, animal organ extracts, and cocaine, performing 'castration, hysterectomy, and vasectomy,' and surgically removing the ovaries and clitoris."29 Then she distinguishes psychotherapy, explaining that "psychiatrists also employed [other] techniques specifically targeting the mind. . . . Psychotherapy appears to be one of the more popular therapeutic formats through which to carry out conversion attempts."30

25. Hicks, supra note 5, at 513.
26. Id. at 515.
27. Id. at 521.
28. Id. at 515.
30. Id. at 223-24.
Kenji Yoshino specifically notes that reparative therapy today is primarily focused on psychotherapy. He remarks that “[e]ven mental health professionals who currently advocate psychoanalytic therapy for homosexuals deride such physical interventions as ‘quackeries,’” and that “[v]irtually every sexual orientation therapy ever formulated has typically passed into history along with its originators, . . . [but that] [p]sychoanalysis has proved one exception to this rule of obsolescence.” As early as 1996, commentators noted that reparative therapy was most often “conducted through ‘conventional’ therapy, i.e., psychotherapy.”

Cruz also recognizes that “perhaps the most enduring psychic approaches [to reparative therapy] besides aversive techniques have been psychoanalytic in nature,” and that “[t]he psychic, primarily verbal conversion techniques in current circulation avoid the appearance of outright torture that marked many past practices.”

State statutes themselves already generally recognize the unconscionability of more physically invasive practices by permitting minors to refuse such treatments. “The laws in many states” support a minor’s right to refuse extreme treatments such as electroconvulsive therapy, psychosurgery, and behavior modification programs utilizing deprivation or aversive techniques.” On the


33. Cruz, supra note 19, at 1307.

34. Id. at 1309-10.

35. See, e.g., ALASKA STAT. § 47.30.825(g) (2004) (“In no event may treatment include psychosurgery, lobotomy, or other comparable form of treatment without specific informed consent of the patient, including a minor . . . .”); CAL. WELF. & INST. CODE § 5326.6(d) (West 2005) (“Under no circumstances shall psychosurgery be performed on a minor.”); CALIF. CODE ANN. art. 1409.O (2005) (“Prefrontal lobotomy shall be prohibited as a treatment solely for medical or emotional illness of a minor patient.”). But see KAN. STAT. ANN. § 59-2978(a)(6) (2004) (“Every patient being treated in any treatment facility, in addition to all other rights preserved by the provisions of this act, shall have the following rights: . . . not to be subject to such procedures as psychosurgery, electroshock therapy, experimental medication, aversion therapy or hazardous treatment procedures without the written consent of the patient or the written consent of a parent or legal guardian, if such patient is a minor or has a legal guardian provided that the guardian has obtained authority to consent to such from the court which has venue over the guardianship following a hearing held for that purpose . . . .”).

36. Cohan, supra note 12, at 82 (referring to “[a]versive techniques” as the use of physical restraints or seclusion to negatively condition undesired behaviors); see also, e.g., Heller v. Doe ex rel. Doe, 509 U.S. 312, 345 (1993) (listing examples of such techniques used on mentally retarded); Natrona County Sch. Dist. No. 1 v. McKnight, 764 P.2d 1039, 1044 (Wyo. 1988) (including the following definition of “aversive” techniques: “ignoring, [saying] no, token fine, water spray, vapor

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other hand, no state appears to give minors the right to refuse psychotherapy. 37

B. Institutionalization of Adolescents

Hicks also highlights another unique method used by parents who wish to change their child’s sexual orientation: the institutionalization of adolescents in psychiatric centers against their will. 38 In some cases, children are “kidnapped, taken to an in-patient center, and drugged for most of their teenage years . . . .” 39

However, this attempt to change a minor’s sexual orientation does not fall under child abuse law, because legal doctrine attributes the act of institutionalization to the state, not the parent. 40 As both Hicks and Cohan

37. One Florida statute may give minors a right to refuse psychotherapy. It provides that: “When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive outpatient crisis intervention services including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional . . . .” FLA. STAT. ANN. § 394.4784 (West 2005). Although the statute appears to give the minor a right to “consent to . . . psychotherapy,” the context of the statute is meant to give minors a right to psychotherapy. Consent is mentioned, because typically consent by the parent is required; but in a situation in which a minor has an emotional crisis, the minor receives the right to consent for himself instead of relying on the parent. This concept is better illustrated by an analogous Illinois statute: “Any minor 12 years of age or older may request and receive counseling services or psychotherapy on an outpatient basis. The consent of his parent, guardian or person in loco parentis shall not be necessary to authorize outpatient counseling or psychotherapy.” 405 ILL. COMP. STAT. ANN. 5/3-501 (West 2005). A New Mexico statute contains a similar provision and is immediately followed by its prohibition on the more invasive treatments being performed on a minor, which emphasizes the fact that no such protections exist for psychotherapy: “(A) Any child shall have the right, with or without parental consent, to consent to and receive individual psychotherapy, group psychotherapy, guidance, counseling or other forms of verbal therapy that do not include any aversive stimuli or substantial deprivations. (B) No psychosurgery or convulsive treatment shall be performed on a child . . . .” N.M. STAT. ANN. § 32A-6-14 (Michie 2005).

38. Hicks, supra note 5, at 521; see also Ruthann Robson, Our Children: Kids of Queer Parents & Kids Who Are Queer: Looking at Sexual Minority Rights from a Different Perspective, 64 ALB. L. REV. 915, 934 n.77 (2001) (citing literature).

39. Hicks, supra note 5, at 521. It is worth noting that, legally, a parent cannot “kidnap” her own children absent a court order denying custody.

40. This is presumably because upon the parent’s request, the state is the actor that ultimately decides whether a child may be institutionalized. See Parham v. J.R., 442 U.S. 584, 598-99 (1978) (“In an earlier day, the problems inherent in coping with children afflicted with mental or emotional abnormalities were dealt with largely within the family . . . . As medical knowledge about the
recognize, the institutionalization of children generally is reviewed under the Due Process Clause of the Federal Constitution, which governs actions by the state. In *Parham v. J.R.*, the Supreme Court held that before a parent may commit her child, a neutral fact-finder, relying upon psychiatric standards, must determine whether the child can be committed. Because juvenile institutionalization does not properly fall under child abuse doctrine, this Note’s definition of reparative therapy will not include it.

**C. A Revised Definition of Reparative Therapy**

This Note defines reparative therapy as the attempt, through psychotherapy, to ‘cure’ homosexuals by turning them into heterosexuals. It adopts the view that “[p]sychotherapy is distinct from therapy that employs ‘medical treatments directed primarily at the patient’s body or treatment involving the use of chemical or mechanical means.’ Instead, it is a ‘treatment of mental and emotional problems by psychological methods.’”

There is no “standard” method of performing reparative therapy. A vast number of books and guides articulate various methodological and theoretical

mentally ill and public concern for their condition expanded, the states, aided substantially by federal grants, have sought to ameliorate the human tragedies of seriously disturbed children. Ironically, as most states have expanded their efforts to assist the mentally ill, their actions have been subjected to increasing litigation and heightened constitutional scrutiny.”.

41. *Id.*

42. *Id.* at 606-09 (describing procedures required by due process).

43. There do not appear to be any cases in which the act of a parent committing a child to an institution was alleged to be child abuse. The Supreme Court has recognized that the institutionalization of a minor is a separate issue from the existence of child abuse: “In defining the respective rights and prerogatives of the child and parent in the voluntary commitment setting, we conclude that our precedents permit the parents to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse . . . .” *Id.* at 604.

44. Nonetheless, because the constitutionality of juvenile institutionalization ultimately rests upon the psychiatric standards on which the neutral fact-finder bases her decision, and because psychiatric standards are a prominent factor in determining whether reparative therapy is child abuse, this Note’s analysis also indirectly affects *Parham* cases. See infra Section VI.A.


46. The best description of the reparative therapy method from a non-reparative therapist is Douglas C. Haldeman, *Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy*, 33 PROF. PSYCHOL.: RES. & PRAC. 260, 260 (2002) (noting that “[p]sychoanalytic theories, still promoted by some advocates of conversion therapy, suggest that homosexuality constitutes a form of arrested psychosexual development. According to this notion, lesbians and gay men suffer from an incomplete bond and resultant identification with the same-sex parent, which is then symbolically repaired in psychotherapy”).

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approaches to conversion therapy. Theories are usually complemented by a formal or informal support network. Therapy also attempts to undo psychological or emotional patterns of thinking, such as rejection, shame, and animosity toward the same-sex parent. The patient is also encouraged to develop non-sexual bonds with members of the same sex. Religion, through prayer or Bible study, is often integrated into the practice.

This Note focuses on psychotherapy for three reasons. First, the conscience-shocking physical interventions listed above, as opposed to psychoanalysis, are themselves derided by some reparative therapists. Second, although such physical interventions undoubtedly still occur today, the pervasiveness of non-physical psychoanalytical reparative therapy provides an easy moral and legal defense for parents facing critics, who usually base their criticism on such physical interventions. Third, limiting the definition to psychoanalysis is more analytically useful. If the definition includes the invasive physical interventions, an analysis of whether reparative therapy constitutes child abuse would be confused with an analysis of whether physically invasive therapy in general constitutes child abuse. By limiting the definition to psychoanalysis, the inquiry is limited to whether the act of attempting to change a child’s sexual orientation without physically invasive techniques is itself child abuse.

Limiting the definition of reparative therapy to psychotherapy should not be read to imply that psychotherapy is somehow more benign or harmless by nature. As Judge Stephen Hjelt notes:

Psychotherapy is the principle product, good, or service of the mental health


49. These broad generalizations of reparative therapy are drawn from several examples of positive and negative testimonials regarding experiences with conversion therapy. See generally Ben Newman [pseud.], Nat’l Ass’n for Research & Therapy, Change of Heart: “My Two Years in Reparative Therapy,” http://www.narth.com/docs/ben.html (last visited Nov. 11, 2005); HUMAN RIGHTS CAMPAIGN FOUNDATION, FINALLY FREE: PERSONAL STORIES: HOW LOVE AND ACCEPTANCE SAVED US FROM “EX-GAY” MINISTRIES 7 (2000), available at http://www.hrc.org/Content/ContentGroups/PublicationsI/Finally_Free/FinallyFREE.pdf.

50. Gans, supra note 18, at 226 (“One ‘discipleship program’ combines ‘four meetings a week of Bible study, church worship, and group therapy to examine behavior patterns, lifestyle changes, and the underlying psychological causes of homosexuality.’ Some of the other techniques reportedly used include a ‘14-step recovery program’ and the playing of team sports, such as baseball and basketball.”).

51. See supra notes 31-32.
profession. It is a treatment that can do great good or great harm. It is a functional analog to a drug or medical device. It can relieve symptoms and resolve conditions. It can cure. It can kill. It can also cause adverse reactions. Like any drug or medical device, psychotherapy has contraindications as well as dose-specific impacts.52

Therefore, focusing on psychotherapeutic forms of reparative therapy does not lessen the critical stakes involved—the health and well-being of homosexual children.

II. THE EVIDENCE PROBLEM: THE ADMISSIBILITY OF PSYCHOLOGICAL TESTIMONY

Hicks’s thesis that reparative therapy ought to constitute child abuse is based upon child abuse law in the state of New York.53 Generally, a parent in New York who does not treat her child as would a “reasonably prudent parent” is subject to child abuse prosecution. Hicks argues that when a “reasonably prudent parent” considers whether to send her child to a reparative therapist, she would discover that the practice is harmful and consequently refrain from subjecting her child to reparative therapy.54 Thus, if that parent still sends her child to reparative therapy, thereby violating the “reasonably prudent parent” standard, she will have abused her child.

Hicks fails to recognize the evidentiary problems with her analysis by failing to acknowledge that the judicial determination of child abuse in the reparative therapy context rests largely on expert testimony. In order to show why such a case depends largely on expert testimony, it is necessary to briefly examine what legally constitutes child abuse and the evidentiary standards required to prove it.

A. Why the Determination of Whether Reparative Therapy Constitutes Child Abuse Depends on Expert Testimony

The definition of child abuse varies by state statute, but the minimum standard is defined by a federal statute, the Child Abuse Prevention and Treatment Act, which conditions federal funding on state adoption of this definition of child abuse: “Any recent act or failure to act on the part of a parent

53. See Hicks, supra note 5, at 520 ("The State of New York is a sizable state with thorough statutory law and sufficient case law on child abuse and neglect. This Comment, therefore, selected the laws of the State of New York as a framework for analyzing whether 'reparative' therapy constitutes child abuse and neglect.").
54. Hicks, supra note 5, at 523-25.
or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Since this Note’s definition of reparative therapy excludes physically invasive techniques, the analysis of whether reparative therapy constitutes child abuse focuses on the emotional or psychological form of child abuse. According to the National Clearinghouse on Child Abuse and Neglect Information, emotional abuse is now widely considered to be a form of child abuse:

All States and territories except Georgia and Washington include emotional maltreatment as part of their definitions of abuse or neglect. Typical language used in these definitions is ‘injury to the psychological capacity or emotional stability of the child as evidenced by an observable or substantial change in behavior, emotional response, or cognition,’ or as evidenced by ‘anxiety, depression, withdrawal, or aggressive behavior.’

As the above quotation suggests, and as J. Robert Shull explains in his detailed survey of state statutory treatment of emotional child abuse, despite the fact that popular and professional psychological conceptions of “emotional child abuse” focus on the actions of the parent, the legal system focuses on the existence of actual emotional harm in the child, in addition to whether the parent’s actions caused the harm.

55. 42 U.S.C.A. § 5106g(2) (West 2003).
56. See supra Section I.C.
57. Nat’l Clearinghouse on Child Abuse & Neglect Info., Definitions of Child Abuse and Neglect, http://nccanch.acf.hhs.gov/general/legal/statutes/define.cfm#bfn6 (last visited Oct. 10, 2005); see, e.g., CAL. WELF. & INST. CODE § 18951(e)(4) (West 2001) (“Child abuse’ as used in this chapter means a situation in which a child suffers from any one or more of the following: ... Willful mental injury.”); N.Y. FAM. CT. ACT § 1012(e-i) (McKinney 2005) (”protracted impairment of physical or emotional health”); WIS. STAT. § 948.04(1) (West 2005) (“Whoever is exercising temporary or permanent control of a child and causes mental harm to that child by conduct which demonstrates substantial disregard for the mental well-being of the child is guilty of a Class F felony.”); see also Cohan, supra note 12, at 77 (“Today most states recognize that mental and emotional abuse fall under child abuse and neglect statutes.”).
59. Id. at 1672 (analyzing Alaska statute as an example, noting that “[t]he emphasis is not on the actions of the parent—verbal castigation, close confinement, whatever—but instead on the results, the measurable (‘observable’) and severe (‘substantial’) effects on the child’s development (‘impairment in the child’s ability to function’). Damage, apparently, must be actual and not inferred”); see also Loue, supra note 12, at 317 (discussing professional psychological definitions of emotional child abuse, and noting that “[t]here exists a tension between those definitions
Whether actual emotional harm exists and whether the parent caused such emotional harm are factual inquiries, and the most effective and widely used method for convincing the fact-finder that abuse exists is to use expert opinion testimony. In fact, some statutes explicitly require such testimony to establish the existence of emotional abuse.

Therefore, in order to successfully prosecute a parent who subjects her child to reparative therapy, expert testimony is almost always required. Presumably, expert testimony conveying the arguments and data presented by Hicks’s piece would be sufficient to establish the link between the reparative therapy and the resulting emotional harm. But would such testimony even be admissible in court? This Part argues that it is doubtful.

focusing primarily on the resulting harm to the child, such as causing impairment, and those that focus on the behavior of the abuser, such as exposing the child to verbal insults. Still other definitions focus on the child’s response to the abuser’s behavior”.

60. Jenna Mella, Annotation, Termination of Parental Rights Based on Abuse or Neglect, 9 Causes of Action 2d 483 § 6 (1997) (“A finding of abuse is usually based, on the testimony or evidence given by an expert witness, usually a doctor, who is qualified to make a judgment on whether the child’s injuries were the result of abuse, or accidental in nature based on a thorough physical examination.”).

61. See, e.g., Smith v. Smith, No. 2004 CU 2168, 2005 WL 2374721, *8 (La. Ct. App. Sept. 28, 2005) (“After Dr. Pellegrin reviewed the tape, she opined that the child was clearly being subjected to severe emotional abuse by Michaelle Duncan, in that Michaelle Duncan was clearly alienating the child from her father, encouraging the child to spy on her father and family, and asking her to perform poorly in school. This testimony was not contradicted by Michaelle Duncan or by any other evidence . . .”); In re K.A.W., 133 S.W.3d 1, 14 (Mo. Super. Ct. 2004) (reversing trial court determination of existence of emotional child abuse by evaluating competing testimonies by experts); Skye W. v. Jennifer W., 704 N.W.2d 1 (Neb. Ct. App. 2005) (holding that state failed to establish existence of emotional abuse to seek termination of parental rights because state provided no expert testimony).

62. E.g., ALASKA STAT. § 47.17.290(9) (2004) (“[M]ental injury’ means a serious injury to the child as evidenced by an observable and substantial impairment in the child’s ability to function in a developmentally appropriate manner and the existence of that impairment is supported by the opinion of a qualified expert witness . . .”); S.C. CODE ANN. § 20-7-490(5) (2004) (“‘Mental injury’ means an injury to the intellectual, emotional, or psychological capacity or functioning of a child as evidenced by a discernible and substantial impairment of the child’s ability to function when the existence of that impairment is supported by the opinion of a mental health professional or medical professional.”); TENN. CODE ANN. § 37-1-102(21)(B) (West 2001) (“‘Severe child abuse’ means . . . [s]pecific brutality, abuse or neglect towards a child which in the opinion of qualified experts has caused or will reasonably be expected to produce severe psychosis, severe neurotic disorder, severe depression, severe developmental delay or retardation, or severe impairment of the child’s ability to function adequately in the child’s environment, and the knowing failure to protect a child from such conduct.”).
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The discussion deserves its own Part for three reasons. First, the evidentiary rules concerning this important factor are complex and vary by state. Second, as this Part shows, psychological testimony is fundamentally different from traditional scientific testimony, introducing additional wrinkles that will be relevant to the reparative therapy scenario. Third, there is an enormous amount of literature that appears to make conflicting assertions concerning how these rules apply specifically to psychological testimony, and these conflicting assertions deserve analysis.

There are two primary evidentiary standards. Frye generally governed federal and state courts for most of the twentieth century, but was replaced in federal courts by Daubert in 1993. Since then, twenty-four states have incorporated the Daubert test into their jurisprudence, while sixteen states and the District of Columbia still adhere to the Frye test. Six states apply a hybrid of the tests and four states have developed their own tests.

B. The "Conservative" Frye Standard

The Frye standard states that novel scientific knowledge must have gained "general acceptance" in the scientific community in order to be admissible. In 1923, the District of Columbia Appellate Court set the standard that would eventually be adopted by the rest of the United States. In deciding that a newly developed lie-detecting test was not well-established enough to be admitted into evidence, the court stated:

Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general

63. See Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 585 (1993) ("In the 70 years since its formulation in the Frye case, the ‘general acceptance’ test has been the dominant standard for determining the admissibility of novel scientific evidence at trial.").
64. See Alice B. Lustre, Annotation, Post-Daubert Standards for Admissibility of Scientific and Other Expert Evidence in State Courts, 90 A.L.R.5TH 453 (2005).
65. Id.
66. Id. (Alabama, Hawaii, Massachusetts, Nevada, New Hampshire, and New Jersey).
67. Id. (Georgia, Utah, Virginia, and Wisconsin). Discussing each of these unique jurisdictions is, unfortunately, outside the scope of this Note.
68. Daubert, 509 U.S. at 585.
acceptance in the particular field in which it belongs.\(^6\)

This has been considered a stringent test because it essentially shuts out new scientific theories which have not yet gained acceptance in the general scientific community, even when those theories are based on sound methodologies. This test was not revisited until 1993.

C. The “Liberal” Daubert Standard

The Daubert standard intended to liberalize the rule by adding other factors courts should consider when faced with novel scientific theories. Once it is established that the witness is qualified to serve as an expert, the judge must ensure that the scientific testimony is both relevant and reliable.\(^7\) In doing so, it must consider the following non-exhaustive factors: (1) whether the theory “can be (and has been) tested”;\(^6\) (2) whether the theory “has been subjected to peer review and publication”;\(^2\) (3) the “known or potential rate of error”;\(^7\) and (4) the “general acceptance”\(^4\) factor from Frye.\(^5\)

Daubert was meant to be a liberalizing rule. The Supreme Court notes that the Federal Rules of Evidence contain a “liberal thrust” and a “general approach of relaxing the traditional barriers to ‘opinion’ testimony.”\(^6\) The liberal nature of Daubert is often captured by the distinction between admissibility and weight. Admitting scientific evidence liberally does not mean a “free-for-all in which befuddled juries are confounded by absurd and irrational pseudoscientific assertions.”\(^7\) On the contrary, while such evidence may be admitted relatively easily, its weight can readily be “attacked by cross-examination and refutation.”\(^8\)

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70. Daubert, 509 U.S. at 589.
71. Id. at 593.
72. Id.
73. Id. at 594.
74. Id.
75. Federal Rule of Evidence 702 states that expert testimony in the form of “scientific, technical, or other specialized knowledge” may be admitted if it is probative, and Daubert only applies to “scientific” knowledge. But the question of whether psychology is “scientific,” “technical,” or “other specialized” knowledge became moot when, in 1999, Kumho Tire Co. v. Carmichael, 526 U.S. 137 (1999), extended the Daubert standard to apply to “technical” and “other specialized” knowledge as well.
77. Id. at 596.
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D. Whether Psychological Testimony Should Be Treated as Scientific Testimony

Doctrinally, psychological testimony should be treated in the same way as other scientific testimony. However, the legal scholarship is split as to whether this should be the case as a normative matter.

On the one hand, psychological testimony should be treated in the same way as other scientific testimony, because psychology is the “science of mind and behavior” and employs rigorous standards for determining the validity and reliability of psychological studies. Admitting psychological testimony does not force the trier of fact to accept it, and psychological evidence is not so ungraspable by the lay person that it will “elicit unquestioning acceptance by the trier of fact.” On the other hand, a psychologist often relies on subjective observations and experience; many psychology studies rely on retrospective observation rather than controlled experimentation; and psychological testimony does not “utilize machines or formulas that result in calculated and tangible findings.” Furthermore, triers of facts, faced with an “aura of certainty, glossed by a psychiatric diploma and the façade of superior knowledge,” can be led to overlook the testimony’s “merely conjectural nature,” erroneously crediting psychological testimony with as much weight as other scientific testimony.

As a predictive matter, many scholars felt that instead of liberalizing evidentiary standards, Daubert would make such standards more rigid as applied specifically to psychological testimony, since it explicitly introduced traditionally “scientific” factors such as error rate and testability, which do not apply well to the psychological field. For instance, immediately following Daubert, one

80. See id. (“These standards include, but are not limited to, (1) replicability, (2) logic, (3) adherence to recognized methodologies, (4) construct validity (i.e., how well data analysis ‘fits’ into preexisting theory), (5) adherence to proper statistical sampling and statistical procedures for data analysis, (6) avoidance of bias, and (7) qualifications of the researcher.”).
82. Fradella, supra note 79, at 412.
83. Wood, supra note 81, at 1401.
84. Id. at 1402 (citing Evidence of “Acute Grief Syndrome” Cannot Be Used as Expert Testimony, 207 N.Y. L.J. 26, 27 (1992)).
85. Id.
86. See Veronica B. Daher et al., Judicial Application of Daubert to Psychological Syndrome
scholar noted that "the testability or falsifiability and potential error rate factors for appraising [social science evidence] will rarely be sufficiently present to meet the Daubert standard."87 Another stated, "the Court's opinion read literally would dictate the end of the receipt of psychiatric and psychological testimony in federal courts."88 Even as late as 2004, scholars noted that "syndromes can never satisfy Daubert because they are not testable. Courts that choose to rely on evidence stemming from a theory about this or that syndrome embrace what is in reality not a scientific theory at all."89

E. The Increasing Importance of the "Generally Accepted" Factor

Any veracity in these predictions and descriptions of Daubert's stringency has been undermined by the fact that judges in Daubert jurisdictions apparently treat psychological testimony the same way Frye jurisdictions and pre-Daubert courts generally have treated them, in part because both standards share the same "general acceptance" factor. In 1996, one scholar noted that Daubert courts "have sometimes sought refuge in Frye-like principles in order to bring some order out of what appears to be a chaotic situation of there appearing to be a new syndrome developed every month."90 Based on the results of a survey filled out by 325 state judges before 1999, one scholar concluded that "Daubert's impact on the admissibility of psychological syndrome and profile evidence [is]


90. Id. at 15 n.99 (citing James T. Richardson, Dramatic Changes in American Expert Evidence Law, 2 JUD. REV. 13, 23 (1996)); see also William M. Grove & R. Christopher Barden, Protecting the Integrity of the Legal System: The Admissibility of Testimony from Mental Health Experts Under Daubert/Kumho Analyses, 5 PSYCHOL. PUB. POL'Y & L. 224, 238 (1999) ("Following Daubert/Kumho, federal judges are now on notice by the U.S. Supreme Court that they bear an affirmative duty to actively exclude junk science testimony.").
negligible" and suggested that:

[J]udges [may not be] concerned with the two more technical factors of falsifiability and error rate because (a) they assume general acceptance and peer review and publication are proxies for scientific reliability and are sufficient factors for determining scientific validity, and (b) because they do not understand how to apply them.

A more recent study notes that Daubert courts end up relying heavily on Daubert’s “general acceptance” prong. This also appears to be the case in medical cases generally, as one legal scholar noted in 2005: “[T]he admissibility of expert medical testimony in civil and criminal litigation after Daubert looks much like that before Daubert.”

Certain psychological testimonies are regularly admitted regardless of jurisdiction. Psychological testimony with regard to the existence of false confessions; competency to stand trial; an individual’s mens rea; personality disorders; and the causes, types, and problems of emotional distress are generally accepted. Testimonies on Post-Traumatic Stress Disorder (PTSD), Battered Child Syndrome, and a child’s tendency to delay reporting sexual abuse are

91. Dahir, supra note 86, at 78.
92. Id. at 77.
93. See Fradella, supra note 79, at 443-44 (“Finally, although courts pay lip service to Daubert, it appears the Frye test is alive and well. Cases in which methods and/or conclusions were being offered that conformed to those that are ‘generally accepted in the relevant scientific community’ are the ones in which testimony is deemed admissible. In contrast, when an expert varies from that which is generally accepted, courts are quick to exclude the testimony citing the very same factors that were relevant under Frye.”).
95. Fradella, supra note 79, at 441-42.
97. United States v. Boise, 916 F.2d 497, 503-04 (9th Cir. 1990) (applying Frye and recognizing that several circuit and state courts have recognized that Battered Child Syndrome is an accepted medical diagnosis); State v. Heath, 957 P.2d 449, 464 (Kan. 1998) (applying Frye in admitting testimony concerning general acceptance of Battered Child Syndrome).
also accepted. Parental Alienation Syndrome (PAS), “the systematic denigration by one parent by the other with the intent of alienating the child against the other parent,” has gained acceptance over the past decade. One scholar in 2003 expressed fears that while Frye jurisdictions would accept testimonies on Battered Woman Syndrome, Daubert jurisdictions would reject them due to their strict scientific standards. However, this has not been the case, as Daubert jurisdictions have also accepted them.

While other psychological testimonies are more controversial, the controversy over whether to accept a certain testimony does not split along Daubert and Frye lines. For instance, prior to 2000, psychological testimonies on the profiles of sex offenders were rejected in both Daubert and Frye jurisdictions. In 2000, a new assessment tool called the Abel Assessment for abuse victim . . . ”); State v. Marrington, 73 P.3d 911, 917 (Or. 2003) (remanding case to admit testimony in accordance with proper standards).


103. See, e.g., United States v. Young, 316 F.3d 649, 657 (7th Cir. 2002); Harris v. State, 84 P.3d 731, 747 n.13 (Okla. Crim. App. 2004); State v. Weaver, 648 N.W.2d 355, 363-64 (S.D. 2002).

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Sexual Interest had started to gain steam in the psychological community. Since then, the profiling tool has met a mixed response independent of Daubert or Frye. 105 Similarly, testimonies based on repressed memories have been accepted 106 and rejected 107 in both Daubert and Frye jurisdictions. 108 Lastly, Child Sexual Abuse Accommodation Syndrome (CSAAS), where a child covers for the parent who is sexually abusing her, has also met with a mixed reaction independent of jurisdiction. 109


106. Some Daubert-jurisdiction cases accept testimony. E.g., Hoult v. Hoult, 57 F.3d 1, 3-4 (1st Cir. 1995) (affirming trial court’s application of Daubert); Isely v. Capuchin Province, 877 F. Supp. 1055, 1066 (E.D. Mich. 1995) (“In this case, Dr. Hartman knowledgeablely testified about several studies which have validated the theory of repressed memory.”); see also Fradella, supra note 79, at 442 (“[Repressed memory retrieval] has been generally accepted by the scientific community [as of April 2003] and is, therefore, generally accepted under Daubert.”). There is at least one Frye-jurisdiction case which accepts testimony. Wilson v. Phillips, 86 Cal. Rptr. 2d 204, 208 (Cal. Ct. App. 1999) (holding that repressed memory theory is not “scientific” and therefore no Frye hearing necessary).

107. Some Daubert-jurisdiction cases reject testimony. E.g., Gier v. Educ. Serv. Unit No. 16, 845 F. Supp. 1342, 1353 (D. Neb. 1994) (“Plaintiffs have failed to demonstrate by a preponderance of the evidence that their experts’ methodologies for evaluating the plaintiffs in this particular case are reliable.”); State v. Cressey, 628 A.2d 696, 699 (N.H. 1993) (“[T]he evaluation of a [sexually abused] child is partly a science and partly an art form.”); People v. Murphy, 654 N.Y.S.2d 187, 190 (App. Div. 1997) (accepting repressed memory testimony only if independently corroborated); State v. Quattrocchi III, No. P92-3759, 1999 WL 284882, at *10 (R.I. Apr. 26, 1999) (“As the testimony at the preliminary hearing indicates, the experts are deeply divided on the reliability or accuracy of recovered memories.”); Hunter v. Brown, No. 03A01-9504-CV-00127, 1996 WL 57944, at *6 (Tenn. Ct. App. Feb. 13, 1996) (Franks, J., concurring) (“Daubert requires the trial judge to ‘ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.’ I believe it is well documented that the current state of scientific knowledge about repressed memory is too contradictory and inconclusive to be a reliable basis for expert testimony at this stage.”). At least one Frye-jurisdiction case rejects testimony. E.g., Hearndon v. Graham, 767 So. 2d 1179, 1182 (Fla. 2000) (“We recognize that the acceptance of theories supporting memory loss of childhood sexual abuse is a disputed area of psychological study.”).


109. Some Daubert-jurisdiction cases reject CSAAS theory. E.g., Steward v. State, 652 N.E.2d 490, 493-94 (Ind. 1995) (limiting CSAAS testimony to impeachment of child’s testimony);
F. Other Factors for Rejecting Testimonies

Whether a psychological testimony is accepted does not appear dependent upon whether the jurisdiction is a Daubert or Frye jurisdiction. Nonetheless, there are some consistent reasons why psychological testimonies are rejected. As stated before, lack of “general acceptance” is a common reason for rejection.

Psychological testimonies concerning issues common to the experience of mankind or easily understood by the lay juror have consistently been rejected. For instance, in Commonwealth v. Francis, a psychologist testified that “memories fade over time, that people under severe stress do not acquire information as well as alert persons not under stress, and that people tend unconsciously to resolve apparent inconsistencies between their memories and after-acquired facts.” Because the jurors had a “general understanding” of such principles, the expert testimony was excluded. And in State v. Roquemore, a
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rape case required jurors to determine whether an element of rape existed: whether the defendant's actions were violent. The state called upon an expert to testify that the crime scene photos, police reports, and pathological reports fit known patterns of violent behavior. Noting that if "the subject of the testimony is within the understanding of the jury, the expert testimony is inadmissible,"114 the court rejected the testimony, because the "jury is perfectly capable of making the analysis and factual determinations without opinion testimony."115

When proffered evidence is more prejudicial than probative, trial courts must bar admission, an evidentiary rule commonly used to exclude psychological testimony.116 For instance, in Pennell v. State,117 psychological testimony concerning the profile or general characteristics of a serial murderer as compared with the defendant was rejected. "Such evidence is of little probative value and extremely prejudicial to the defendant since he is, in a sense, being accused by a witness who was not present at any of the crimes."118 CSAAS testimonies are also sometimes rejected on this basis.119

Other reasons for rejecting expert testimony include an inappropriate reliance upon a review of the literature and not on the expert’s own experiences or expertise,120 lack of expert qualification, lack of relevance or applicability,121 or inappropriate interference with witness credibility.122 However, these factors will not be as salient to reparative therapy. First, this Note assumes that the testifying psychologist is not merely reviewing and summarizing the literature of

114. Id. at 114.
115. Id.
116. FED. R. EVID. 403.
118. Id. at 55; see also State v. Floray, 715 A.2d 855, 859 (Del. Super. Ct. 1997) (rejecting testimony regarding the profile of a sex offender because it was more prejudicial than probative).
119. Rosemary L. Flint, Child Sexual Abuse Accommodation Syndrome: Admissibility Requirements, 23 AM. J. CRIM. L. 171, 173 (1995) ("However, some courts prohibit testimony concerning CSAAS, arguing that its probative value is outweighed by its prejudicial impact and that it is unreliable.").
120. United States v. Paul, 175 F.3d 906, 912 (11th Cir. 1999) (rejecting testimony by law professor concerning handwriting analysis, because "[h]is skill, experience, training and education as a lawyer did not make him any more qualified to testify as an expert on handwriting analysis than a lay person who read the same articles"); Carroll v. Litton Sys., Inc., No. B-C-88-253, 1990 WL 312969, at *50 (W.D.N.C. Oct. 29, 1990) ("The mere recitation of a list of studies is not a magical incantation paving the way to the witness stand unless it is accompanied by reasoned and scientifically accepted analysis.").
121. Dahir, supra note 86, at 71.
122. Smithburn, supra note 89, at 22 ("Some courts reject traits evidence for its improper bolstering of the credibility of the alleged victim and thereby invading the province of the jury.").
reparative therapy. Second, this Note also assumes that psychological testimony is given by a qualified expert. Third, the testimony of psychologists regarding the psychological harm of reparative therapy is especially relevant and applicable, since child abuse cases commonly rely upon expert testimony and reparative therapy only consists of psychoanalysis with no "physical" effects. Finally, testimony rejected due to undue interference with witness credibility mostly involves psychological theories concerning a certain individual’s propensity to lie under various circumstances, so this factor is irrelevant here. Expert testimony that children suffer psychological harm from reparative therapy is required to show that the therapy constitutes emotional child abuse. This Part has demonstrated that whether the jurisdiction is under Daubert or Frye, such testimony's admissibility depends primarily on the following factors: general acceptance, whether the testimony concerns a subject common to the experience of mankind, and whether the testimony will be more prejudicial than probative.

III. SORTING OUT THE EVIDENCE ON REPARATIVE THERAPY

Although Hicks marshals a substantial amount of data, consisting primarily of surveys and anecdotes, to support her claim that a reasonably prudent parent would know of reparative therapy’s harmfulness, much of the data would either be inadmissible in court or ineffective even if admitted. Gans’s and Yoshino’s critiques of reparative therapy, as well as critiques of reparative therapy generally, also contain data that would face similar evidentiary problems if proffered as evidence.

This Part discusses several categories of data that have been presented by legal scholars and shows how each category of data is either inadmissible in court or ineffective in showing that reparative therapy constitutes child abuse. The categories of data include: sexual orientation’s link to nature as opposed to nurture, the influence of homophobia, preexisting psychological problems in homosexual youth, anecdotal evidence, the inability of reparative therapy to change sexual orientation, and homosexuality’s status as a mental illness.

After considering each of these categories of data relied upon by legal scholars, this Part discusses the most critical piece of data that these scholars have failed to produce that would actually be admissible and effective in showing that reparative therapy constitutes child abuse: evidence of reparative therapy’s harmfulness.

A fine distinction should be made, however. In a child abuse case involving reparative therapy, while the state may not be able to find evidence that reparative therapy is per se harmful, it is entirely plausible for the state to find an expert witness who would testify that reparative therapy in the individual child’s
case was harmful to that child. Such testimony would probably be countered by the parent’s expert testifying that the alleged harm to the child was not a result of the reparative therapy, but other factors; a jury would then have to decide whom to believe. It is generally difficult for either side to prove their case under this scenario, because in many emotional harm child abuse cases, “[d]epression, antisocial behavior, and other behaviors may be evidence of emotional maltreatment, but they could just as well [sic] be attributed to other causes.” In any case, this Note does not speculate on the existence or effectiveness of such testimony, since that fully depends on the facts of each individual case. Rather, this Note focuses on Hicks’s assertion that reparative therapy should constitute per se child abuse.

A. Sexual Orientation Is a Product of Nature

Some have rightly noted that pro-gay activists and intellectuals often focus unnecessarily and unhelpfully on whether sexual orientation is a product of nature or nurture. Fortunately, Hicks does not make the mistake of relying on a nature/nurture argument to show how reparative therapy would be child abuse.

123. As will be discussed infra, many proponents of reparative therapy believe that if someone with homosexual attractions is suffering from psychological malaise such as depression, the depression is a result of his homosexuality, not any form of reparative therapy.

124. Some states may permit a psychologist to testify as to her opinion about whether the child in question has suffered harm from the reparative therapy, based on her specialized experience; this is known as “pure opinion testimony.” See Hadden v. State, 690 So. 2d 573, 579-80 (Fla. 1997) (“While an expert’s pure opinion testimony comes cloaked with the expert’s credibility, the jury can evaluate this testimony in the same way that it evaluates other opinion or factual testimony.”).


126. See generally Janet E. Halley, Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability, 46 Stan. L. Rev. 503 (1994); see also Devon W. Carbado, Straight Out of the Closet, 15 Berkeley Women’s L.J. 76, 109 n.205 (2000) (“[T]he treatment of homosexuality in antiracist discourse should not hinge on whether it is attributable to ‘nature’ or ‘nurture,’ nor should it hinge on the question of ‘choice.’ What is almost always true about efforts to locate the ‘cause’ of homosexuality is that such efforts are buttressed by the idea that homosexuality is deviant.”); Nancy J. Knauer, Law and Sexuality: A Review of Lesbian, Gay, Bisexual and Transgender Legal Issues, 12 L. & Sexuality 1, 5 (2003) (“By premising their rights claims and related appeals to equality principles on assertions of immutable status, pro-gay advocates have entrusted the success of a major social and political movement to the reliability of a few inconclusive studies concerning, inter alia, the size of the hypothalamus in the cadavers of gay men and the inner ears of lesbians.”).
However, the subject is still being discussed enough in reparative therapy debate to warrant a brief mention here.

While scientific evidence can be marshaled to support both the argument that sexual orientation is a result of nature and the argument that sexual orientation is a result of nurture,\(^{127}\) reparative therapy proponents make the claim that sexual orientation is a product of nurture and therefore changeable.\(^{128}\) In response to this charge, some gay rights advocates, perhaps recognizing that the nature versus nurture debate is both futile and unhelpful to their cause, do not rely on the proposition that sexual orientation is biological, but instead attack reparative therapy itself.\(^{129}\) In the midst of this debate, no professional association asserts that sexual orientation is an innate trait, suggesting a growing recognition of the distinction’s moral irrelevance.

Hicks rightly notes that whether sexual orientation is a product of nature or nurture is not relevant to whether reparative therapy is harmful.\(^{130}\) Therefore, psychological testimony that sexual orientation is innate would be rejected due to its clear lack of general acceptance, and psychological testimony that sexual orientation is changeable by the environment is irrelevant as to whether reparative therapy is harmful. Hicks properly frames the issue in terms of whether reparative therapy is harmful when she says that “regardless of the ‘correct’ answer, ‘reparative’ therapy is psychologically damaging and should not be administered on gay, lesbian, bisexual and transgender people, and

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127. Hicks, supra note 5, at 511-13 (reviewing scientific data); see also A. Dean Byrd, Nat’l Ass’n for Research & Therapy, The Innate-Immutable Argument Finds No Basis in Science, http://www.narth.com/docs/innate.html (last visited Apr. 1, 2005) ("[A]lthough the issue is enormously complex and simply cannot be reduced to a matter of nature vs. nature [sic]—the answer to that debate is probably ‘yes’—it is likely that homosexual attraction, like many other strong attractions, includes both biological and environmental influences."); Cohan, supra note 12, at 73 ("The question over whether gay, lesbian, bisexual, and transgender people are born into their sexual orientation remains inconclusive. I believe that sexual orientation is at least partially determined genetically.").


130. Hicks, supra note 5, at 512-13.
especially not on children." 131 As the remainder of this Part shows, Hicks's data may support her assertion in the court of public opinion, but it would not be able to support her assertion in the courtroom.

B. The Strengthening of Internalized Homophobia

Another attack mounted against reparative therapy is that it strengthens a child's internalized homophobia. The idea is that a child naturally adopts homophobic attitudes from the society around her (societal homophobia), and when the child becomes aware of her own homosexual attractions, the child then turns her preexisting homophobic attitudes toward herself, resulting in shame, guilt, and self-hatred. 132 These resulting feelings are known as "internalized homophobia." Given this backdrop, the introduction of reparative therapy into the child's life further reinforces the child's internalized homophobia. Therefore, opponents of reparative therapy argue, a parent who subjects her child to reparative therapy subjects her child to increased feelings of shame, guilt, and self-hatred, resulting in emotional child abuse. Hicks alludes to this process when she states, "Parents of gay, lesbian, bisexual, and transgender children should also be aware of hardships that their children face as a result of societal homophobia." 133

This argument initially appears to be admissible, because the idea of internalized homophobia as a psychologically harmful phenomenon would likely be considered "generally accepted" among licensed psychologists. One study endorsed by the American Psychological Association (APA) showed that "gay men scoring high on a measure of internalized homophobia were significantly more likely than less homophobic gay men to experience sexual dysfunction and relationship instability, and to blame themselves for anti-gay victimization." 134 Another professional argues that clinicians "who offer or even consider

131. Hicks, supra note 5, at 513.
132. See Cohan, supra note 12, at 72-73 ("Many gay and lesbian individuals who are raised in a society like ours that disapproves of homosexuality will internalize those negative attitudes and values. Every time such a person feels sexual desire for someone of the same sex, he will experience shame, guilt and self-hatred without necessarily understanding why, because these feelings often operate on an unconscious level.").
133. Hicks, supra note 5, at 524-25; see also id. at 524 n.100.
conversion therapy for their clients are ignoring the sociopolitical context that perpetuates both external and internal homophobia.”\(^{135}\) Although it is somewhat problematic that there is no “official” definition of homophobia,\(^{136}\) there is also no “official” definition of racism, which is generally accepted to be psychologically harmful.\(^{137}\) Moreover, even if reparative therapists do not agree with the conceptual validity of homophobia, “general acceptance” does not require unanimity.\(^{138}\)

However, there are two interrelated problems with the admissibility of these data. First, the testimony would have to be extremely careful not to link homophobia with reparative therapy in a way that may be more prejudicial than probative, especially given the fact that the context behind reparative therapy is usually a type of conservative Christianity. The obvious religious context might make a judge more sensitive as to whether testimony concerning homophobia is more prejudicial than probative. In *Valentin v. New York City*,\(^{139}\) a case involving a sexual harassment claim against a police department, the plaintiff sought to submit a qualified expert’s testimony concerning “institutionalized sexism and homophobia” within “police culture.”\(^{140}\) The court rejected such testimony. Because the expert had no knowledge of the plaintiff’s particular work environment and was “not present when the specific incidents allegedly occurred,” such evidence would have been more prejudicial than probative.\(^{141}\) Similarly, in *State v. Haynes*,\(^{142}\) expert testimony concerning whether the


\(^{136}\) Lester W. Wright, Jr. et al., *Development and Validation of the Homophobia Scale*, 21 J. PSYCHOPATHOLOGY & BEHAV. ASSESSMENT 337, 338-46 (1999), available at http://www.springerlink.com/media/f83ebu4qmh1jvi9twe2l/contributions/t/7/3/1/t73103hp41744507.pdf (noting the discrepancies between different studies of homophobia and that “there is no universally accepted definition of homophobia”).


\(^{139}\) No. 94 CV 3911 (CLP), 1997 WL 33323099 (E.D.N.Y. Sept. 9, 1997).

\(^{140}\) *Id.* at *19.

\(^{141}\) *Id.*

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defendant’s killing was motivated by homophobia was rejected partly because "the prejudicial impact outweighed probative value, as it tended to 'sensationalize' the facts and issues."\(^{143}\)

The second problem is that while homosexual attraction may not be common to the experience of mankind, homophobia arguably is. In seeking to bar admission, the parent may object that just as a professional psychologist would not be required to testify about the existence and harmful effects of racism due to widespread knowledge and experience of the phenomenon, a professional psychologist would not be required to testify about the existence and harmful effects of homophobia. For instance, in *Haynes*, the expert testimony sought to analyze whether the defendant’s act of killing was a "homophobic murder," defined by the expert as a murder resulting from "a panic that ensued after an unwanted homosexual encounter."\(^{144}\) This expert testimony was rejected, because it was "well within the understanding of the average juror."\(^{145}\) Similarly, if the prosecution wished to advance its basic argument that when a reparative therapist tells a child that the child should overcome deep seated attractions, the child will become emotionally harmed to a degree constituting child abuse, it would not require a psychologist to explain the term "internalized homophobia" to further advance its argument. Bereft of the backing of expert testimony, the strength of that argument must then depend on other evidence, the possibilities of which will be explored *infra*. This section simply shows that the prosecution cannot rely on the "internalized homophobia" argument that Hicks employs.\(^{146}\)

C. Preexisting Psychological Problems in Homosexual Youth

One of the more scientific arguments against reparative therapy is an extension of the homophobia argument. It is undisputed that homosexual, bisexual and transgender youths suffer from depression at significantly higher rates than heterosexual youths. For example, one study cited by Hicks noted that 28.1% of gay males and only 4.2% of heterosexual males attempt suicide.\(^{147}\) She also notes that homosexual youths are more likely to be victims of assault, which

\(^{143}\) *Id.* at *4.*

\(^{144}\) *Id.*

\(^{145}\) *Id.*

\(^{146}\) However, there is nothing preventing the prosecution from employing the phrase "internalized homophobia" in its opening or closing argument, as long as it does not claim expert backing.

\(^{147}\) Hicks, *supra* note 5, at 518 n.57 (citing Gary Remafedi, *The Relationship Between Suicide Risk and Sexual Orientation: Results of a Population-Based Study*, 88 AM. J. PUB. HEALTH 57, 57-60 (1998)).

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has an undeniable psychological impact.\textsuperscript{148} The APA also recognizes that “[r]esearch has shown that gay men are at risk for mental health problems and emotional distress.”\textsuperscript{149}

These facts nonetheless have no bearing on whether reparative therapy is harmful, because preexisting depression only speaks to the state of the youth prior to the reparative therapy. Even reparative therapy proponents do not dispute these facts. In fact, they often rely on these facts to argue for reparative therapy,\textsuperscript{150} claiming that reparative therapy is required to bring such youths out of depression. The debate between proponents and opponents of reparative therapy does not center around whether homosexuals are in fact more depressed but on the causes of the depression. Therefore, psychological testimony regarding the increased likelihood of depression in homosexual youths would be rejected. Whether reparative therapy actually increases or decreases depression in homosexual youths is a separate inquiry that Section G of this Part discusses.

D. Anecdotal Evidence

Anecdotal evidence is a powerful tool in the marketplace of ideas, and as such it is heavily relied upon by both sides of the reparative therapy debate.\textsuperscript{151} For example, Yoshino introduces his discussion of reparative therapy with a powerful and horrific anecdote from an individual undergoing electroshock therapy.\textsuperscript{152} More significant to the child abuse analysis, the vast majority of Hicks's evidence for the harmfulness of reparative therapy includes both comical

\textsuperscript{148} Id. at 518 n.56 ("Fifty-nine percent of gay men and twenty-one percent of lesbians report victimization in high school, and fifty percent and twelve percent, respectively, report victimization in junior high school.") (quoting Anthony R. D’Augelli, Lesbian, Gay, and Bisexual Development During Adolecence and Young Adulthood, in TEXTBOOK OF HOMOSEXUALITY AND MENTAL HEALTH 279 (1996)); see also id. at 518 n.58 ("[L]esbian, gay, and bisexual youths are at risk for psychological problems.") (quoting Anthony R. D’Augelli & Scott Hershberger, Lesbian, Gay, and Bisexual Youth in Community Settings: Personal Challenges and Mental Health Problems, 21 AM. J. COMMUNITY PSYCHOL., 421, 443-44 (1993)).

\textsuperscript{149} AM. PSYCHOLOGICAL ASS’N, supra note 134.

\textsuperscript{150} Dale O'Leary, Nat'l Ass’n for Research & Therapy, Recent Studies on Homosexuality and Mental Health, http://www.narth.com/docs/recent.html (last visited Nov. 18, 2005) ("[S]ome social conservatives will attribute the findings [that homosexuals are more likely to be depressed] to the inevitable consequences of the choice of a homosexual lifestyle.").

\textsuperscript{151} For testimonials from people with self-reported negative experiences with conversion therapy, see HUMAN RIGHTS CAMPAIGN, supra note 49, at 7. For testimonials from people with self-reported positive experiences with conversion therapy, see Nat'l Ass'n for Research & Therapy, Interviews/Testimonials, http://www.narth.com/menus/interviews.html (last visited Nov. 18, 2005).

\textsuperscript{152} Yoshino, supra note 31, at 784-85; see also Cruz, supra note 19, at 1352-53 (citing anecdotes).
and horrific anecdotes, such as exorcisms, physical restraints, and kidnappings.

The use of anecdotes is not only practically persuasive, but also plays a significant role in the field of psychology. Because psychological theories do not have the same kind of validity as other scientific theories, psychologists “can at best offer only ‘anecdota’: information obtained through experience in dealing with psychological problems, reading about case studies, and extrapolation from the theoretical speculations of others.”

The 1999 Supreme Court case of *Kumho Tire Co. v. Carmichael* suggests that anecdotal testimony is permissible, provided it is based on the psychologist’s own experiences: “An expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.” Therefore, a psychologist might testify to her experiences with her clients who have undergone reparative therapy and are seeking to recover from its harmful effects. For instance, one psychologist documents his own experiences with post-reparative therapy clients, noting “chronic depression, low self-esteem, difficulty sustaining relationships, and sexual dysfunction.” On the other hand, testimony recounting the stories of people a psychologist has never met who have undergone reparative therapy will not be admitted, as it would constitute a mere review of the literature that any lay person could perform.

Sometimes, a state court may permit personal experience testimony from a psychologist by considering such testimony not “scientific,” thereby circumventing the *Daubert* or *Frye* test. “Testimony that is based solely on the expert’s own clinical observation and experience is not subject to *Frye.*”

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153. Discussing all of Hicks’s anecdotal evidence would be impractical. Anecdotes are found at Hicks, *supra* note 5, at 515-20 nn.39-53 & 60, 524-25 nn.100-01, 103-04, 106, & 108.
154. *Id.* at 525 n.106.
155. *Id.* at 515 n.40, 516 n.46.
156. *Id.* at 516 n.45; see also Cohan, *supra* note 12, at 82 n.66.
158. *Id.* at 922.
160. *Id.* at 152.
161. Haldeman, *supra* note 46, at 261. Haldeman also notes that the severity of the psychological harms resulting from reparative therapy depends on the therapy involved and the person’s natural resilience.
However, this is only the case in states that have not imported the *Kumho* holding that eliminates the need to distinguish between “scientific” and “technical” or “other specialized” knowledge. And such experience-based testimony may ultimately be subject to the same *Daubert*-esque factors in order to test for reliability.\(^{163}\)

While anecdotal testimony may be permitted if the anecdotes derive from the psychologist’s own experiences, it is important to remember that emotionally powerful anecdotes can come from both sides. In fact, it is precisely because of this result, with one side pitting its poster children against the other’s, that a judge may bar such anecdotal testimonies altogether for their inflammatory, and therefore prejudicial, effect. Even if the judge does not bar such testimony, anecdotal evidence should not be the primary legal weapon in the arsenal of reparative therapy opponents because it is easily countered.

**E. Reparative Therapy Does Not Work**

A major locus of the debate over reparative therapy is whether it can truly change homosexuals into heterosexuals, and this argument often complements the argument that reparative therapy is a manifestation of societal homophobia. This has taken on increased significance as the debate has shifted away from whether sexual orientation is a product of nature or nurture. Citing the APA, Hicks notes that “scientific evidence does not show that ‘reparative’ or conversion therapy works.”\(^{164}\) Quoting the American Psychiatric Association, Gans also notes that “[t]here is no evidence that any treatment can change a homosexual person’s deep-seated sexual feelings for others of the same sex.”\(^{165}\) There is copious evidence demonstrating the low success rate of reparative therapy,\(^{166}\) and evidence of “success” is often discredited, legitimately or not, by

\(^{163}\) Logerquist v. McVey, 1 P.3d 113, 131 (Ariz. 2000) (“[S]ome of *Daubert*’s questions can help to evaluate the reliability even of experience-based testimony. In certain cases, it will be appropriate for the trial judge to ask, for example, how often an engineering expert’s experience-based methodology has produced erroneous results, or whether such a method is generally accepted in the relevant engineering community. Likewise, it will at times be useful to ask even of a witness whose expertise is based purely on experience, say, a perfume tester able to distinguish among 140 odors at a sniff, whether his preparation is of a kind that others in the field would recognize as acceptable.”) (citing *Kumho Tire Co.* v. Carmichael, 526 U.S. 137, 151 (1999)).

\(^{164}\) Hicks, *supra* note 5, at 513-14, 514 n.36.

\(^{165}\) Gans, *supra* note 18, at 227; see also id. at 227 nn.52-55.

\(^{166}\) Hicks, *supra* note 5, at 518 nn.59-60 (citing studies indicating three percent success rate and ten percent success rate). Hicks also suggests that the leaders of the reparative therapy movement are predominantly heterosexual. *Id.; see also Cruz, supra* note 19, at 1378-81 (citing evidence of failures).
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claiming that “‘success’ stories are really stories of bisexuals who are responding to heteroerotic inclinations that were already present.”¹⁶⁷ Proponents of reparative therapy, in response, tend to rely on the flexible nature of sexual orientation or the possibility of change, presumably because it is easier to hedge by arguing that change is “possible” rather than to declare outright that reparative therapy “works.” Arguing that change is “possible” needs only be supported by one “success” story, whereas arguing that reparative therapy “works” requires a greater burden that proponents may know they cannot meet. To support the claim that change is possible, proponents often cite case studies of self-reporting individuals who have “changed.”¹⁶⁹

The latest manifestation of this debate revolved around a study published in 2003 by Dr. Robert Spitzer, who was instrumental in eliminating homosexuality from the American Psychiatric Association’s recognized list of mental diseases in 1973. Dr. Spitzer studied 200 cases of individuals who had undergone reparative therapy and reported some measure of change.¹⁷⁰ In response, professional associations remained relatively silent while individual psychologists have challenged the methodology and reliability of the study.¹⁷¹ Some legal scholars


¹⁶⁸. See Benjamin Kaufman, Why NARTH? The American Psychiatric Association’s Destructive and Blind Pursuit of Political Correctness, 14 REGENT U. L. REV. 423, 430 n.35 (2001-2002) (citing studies of reparative therapy’s “success”). It is subtle but significant that the title of Kaufman’s section documenting such studies is “Change is Possible.” Id.

¹⁶⁹. See New Direction for Life Ministries, Summary of Evidence Found by the Homosexuality and the Possibility of Change Project, http://www.newdirection.ca/research/evidence.htm (last visited Nov. 3, 2005) (containing links to studies showing a total of 86 persons with a change in sexual orientation behavior, 287 persons with partial sexual orientation shift, and 45 persons with total sexual orientation shift). But see Yarhouse & Throckmorton, supra note 167, at 73 (“Critics are right to point out that many studies cited to support the effectiveness of professional change therapies and religion-based ministries suffer from poor methodologies, including small sample sizes, lack of clear definitions and consistency in measures of change or success, and use of therapist report and self-report of change. However, poor methodologies do not disprove success; what is needed are prospective, longitudinal studies of those entering such change programs and greater consistency as to what constitutes ‘success.’”).


¹⁷¹. See B.A. Robinson, Ont. Consultants on Religious Tolerance, Analysis of Dr. Spitzer’s Study of Reparative Therapy, http://www.religioustolerance.org/hom_spit.htm (Feb. 16, 2002). The APA cancelled a scheduled debate on the topic. See id. (“The doctors who were to debate on the topic decided there was not enough scientific information to have a proper debate. They felt that any debate would turn into a political debate and not a true scientific debate. While there is
rightly saw this as another round in the irrelevant nature/nurture debate.\textsuperscript{172} In any case, today, it is “generally accepted” in established professional associations that reparative therapy does not work. Even reparative therapy proponents do not make the bald assertion that reparative therapy indeed does “work.” Instead they merely assert that change is possible.\textsuperscript{173}

Nonetheless, psychological testimony regarding the ineffectiveness of reparative therapy in changing homosexuals into heterosexuals would be rejected on the basis of irrelevance, because arguing that something does not work does not mean such a thing is harmful—sugar pills may not cure a patient of the common cold, but they do not harm the patient.\textsuperscript{174} Similarly, whether reparative therapy works or not is irrelevant to whether reparative therapy is harmful. For instance, many therapies in general have questionable “success” rates when it comes to curing or alleviating widely recognized mental ailments. As Christopher Slobogin notes, “Even many symptoms—such as whether a person is ‘depressed,’ ‘anxious,’ or suffering from ‘low self-esteem’—are unverifiable in the same way a physical fact is because the terms themselves are so amorphous and subjective.”\textsuperscript{175} The questionable success rates of such non-controversial therapies do not therefore show that such therapies for alleviating depression and other disorders are harmful.\textsuperscript{176}

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\textsuperscript{172} Knauer, supra note 126, at 2-10 (discussing theoretical and political implications of Spitzer’s study).

\textsuperscript{173} Nat’l Ass’n for Research & Therapy of Homosexuality, Gay-to-Straight Research Published in APA Journal, http://www.narth.com/docs/throckarticle.html (last visted Nov. 18, 2005) (interviewing Warren Throckmorton, who stated, “[S]exual orientation, once thought to be an unchanging trait, is actually quite flexible for some people”). This assertion is very different from the claim that reparative therapy works.

\textsuperscript{174} The analogy is not perfect, since unlike the common cold, homosexuality is not considered an illness. A sugar pill may harm the patient by precluding more effective cures, but reparative therapy would not harm the patient because there is no illness, so it is not precluding any other effective treatments.

\textsuperscript{175} Slobogin, supra note 157, at 921.

\textsuperscript{176} It is this author’s opinion that the debate over whether reparative therapy “works” is as irrelevant as the debate over whether sexual orientation arises from nature or nurture, because the inquiry is just as complex. The inquiry itself depends on one’s definition of sexual orientation, relies on an unsound distinction between feeling and behavior, and requires breaking into the “black box” that is an individual’s sexuality, which is so fluid and socially constructed as to render the categories of sexual orientation meaningless. See Warren Throckmorton, Initial Empirical and Clinical Findings Concerning the Change Process for Ex-Gays, 33 Prof. Psychol.: Res. & Prac. 242, 243 (2002) (describing said conceptual problems underlying the attempt to answer the question, “Do ex-gay ministries help people change sexual orientation?”).
F. Homosexuality Is Not an Illness

A common refrain among opponents of reparative therapy is the fact that the American Psychiatric Association removed homosexuality from its Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973, followed by the renunciation of homosexuality as a mental illness by the APA.177

The psychological community itself, however, does not grant the DSM much reverence. William Grove, arguing that a listing in the DSM should not constitute “general acceptance,” notes the process of creating the DSM: “[S]pecialty subcommittee members were assigned to review aspects of the literature relating to certain categories, using subjective methods . . . . Analyses of existing data sets were sometimes undertaken . . . but [the procedure] is not completely explicit, repeatable, or tied to polling representative samples of scientists.”178 He also adds that the listings in the DSM are “labels, not theories. This is a critical distinction—some experts have misled courts to believe falsely that the existence of a diagnostic label in DSM-IV somehow proves general acceptance of the existence of the described disorder.”179 Slobogin also notes the lack of agreement among psychologists on DSM listings: “[F]ield research indicates that mental health professionals involved in everyday practice may disagree more than half the time even on major diagnostic categories such as schizophrenia and organic brain syndrome.”180 Of the reparative therapy legal scholars, Cruz is the only one who acknowledges the inherent ambiguity in the nature of “mental illness” and who questioned reliance on the DSM.181

Nonetheless, the DSM appears to be held in high regard in the courts. When psychological testimonies concern mental diseases that are listed in the DSM, they generally pass the Daubert or Frye test, despite the fact that many of the DSM listings are falsifiable and should therefore meet a higher standard in Daubert jurisdictions, which are supposed to consider falsifiability.182 Courts that

177. Kaufman, supra note 168, at 433 (“Those who insist that homosexuality is not an illness point to the APA’s 1973 decision to remove homosexuality from its DSM.”); see, e.g., Gans, supra note 18, at 221-22; Hicks, supra note 5, at 518 n.60; Yoshino, supra note 31, at 798-99. Tam Tran provides a good account of the history of the DSM. Tam B. Tran, Using DSM-IV To Diagnose Mental Illness in Asian Americans, 10 J. CONTEMP. LEGAL ISSUES 335, 336-38 (1999). Her review specifically focuses on the DSM-IV, where “IV” signifies that the edition is the fourth edition.

178. Grove, supra note 90, at 230.

179. Id.

180. Slobogin, supra note 157, at 920.

181. See Cruz, supra note 19, at 1313-34 (discussing the DSM and the sociological context of “mental illness”).

182. See Smithburn, supra note 89, at 15 n.101 (noting that Daubert’s falsifiability requirement may call the DSM into question) (citing James T. Richardson, Dramatic Changes in American
permit psychological testimony regarding “compulsive gambling disorder,” a DSM-IV listed disease, do not permit testimony on the “pathological gambling lifestyle” because it strays beyond the boundaries of the DSM-IV definition.\textsuperscript{183} In criminal defense cases, “whenever a mental disorder is raised as a defense, if it is not listed in the DSM, it is not given much credence.”\textsuperscript{184} Holding PTSD to be a legitimate disorder, \textit{State v. Alberico} states, “The existence of DSM III-R and its general acceptance in psychology indicate that PTSD has been exposed to objective scientific scrutiny and empirical verification.”\textsuperscript{185}

Nonetheless, although the practice of reparative therapy certainly traces its roots to the view of homosexuality as a mental illness,\textsuperscript{186} it is unclear to what

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\item Fradella, supra note 79, at 432 (citing United States v. Scholl, 166 F.3d 964 (9th Cir. 1999)); see also Comer v. Stewart, 230 F. Supp. 2d 1016, 1052 (D. Ariz. 2002) (excluding testimony based on Daubert, because it did not properly apply the standards of diagnosing PTSD in accordance with the definition of DSM-IV); United States v. Harris, No. S192 Cr.455(CSH), 1994 WL 683429, at *4 (S.D.N.Y. Dec. 6, 1994) (\textit{The New York Times}, in its April 19, 1994 issue, characterized The Diagnostic and Statistical Manual of Mental Disorders hereinafter (“DSM”) as “the psychiatric profession’s diagnostic Bible.”); Cassell v. Lancaster Mennonite Conference, 834 A.2d 1185, 1190 (Pa. Super. Ct. 2003) (reversing trial court decision to exclude expert testimony because expert testimony’s reliance on DSM meant it was “generally accepted” and passes Frye test). But see Mancuso v. Consol. Edison Co. of N.Y., 967 F. Supp. 1437, 1456 (S.D.N.Y. 1997) (“ConEd has cited no cases in which a qualified psychologist was excluded from testifying because she did not follow the DSM-IV.”).
\item 861 P.2d 192, 208 (N.M. 1993). Additional language from the opinion indicates the court’s deference toward the DSM. \textit{See id.} (“We hold that PTSD testimony is grounded in valid scientific principle. DSM III-R is specialized literature that specifically catalogues the symptoms of mental disorders and prescribes the method by which the psychological evaluation should take place. DSM III-R, according to the State’s experts, is widely used in courtrooms, not only for issues of sex abuse, but for issues concerning sanity and competency as well. PTSD is generally accepted by psychologists and psychiatrists as a valid technique for evaluating patients with mental disorders.”).
\item Gans, supra note 18, at 223 (“The current practice of conversion therapy attests to the
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extent reparative therapy as practiced today does in fact rely on that view. While Hicks asserts that ‘‘reparative’’ therapists and ‘ex-gay’ ministries continue to claim that homosexuality is a mental illness that can, and should, be changed,” Yoshino notes that organizations supporting reparative therapy are “relatively insulated from the depathologization of homosexuality, as they are less reliant on a literal disease model to justify their conversion practices.” Mark Yarhouse and Warren Throckmorton, proponents of reparative therapy, cite studies showing that not all reparative therapies rely on a pathology-based model of treatment. Another reparative therapist states that “those who embrace reparative therapy as an option would not necessarily need to believe that those who call themselves homosexuals demonstrate more pathology than those who are heterosexuals.”

While it is relatively clear that for cases in which the existence of a mental illness is relevant, expert testimony relying on the DSM would probably be admitted, it is unclear whether expert testimony concerning homosexuality’s absence from the DSM would be admitted in the reparative therapy scenario. The few cases considering the fact that homosexuality is not in the DSM include cases concerning sentencing that improperly factors the defendant’s homosexuality as a mental illness, an employment discrimination case, and a case involving the right to be a foster parent. Nonetheless, it is likely that the exclusion of homosexuality from the DSM would not be relevant to whether reparative therapy is harmful, because cases that rely on the DSM do so in order

antiquated belief that homosexuality is a disease.”).

187. Hicks, supra note 5, at 518.
188. Yoshino, supra note 31, at 801.
189. Yarhouse & Throckmorton, supra note 167, at 67. Another example is stress inoculation training for coping with stressors—this is a “well-established treatment directed at a population other than a DSM diagnostic category.” William C. Sanderson, The Importance of Empirically Supported Psychological Interventions in the New Healthcare Environment, in 15 INNOVATIONS IN CLINICAL PRACTICE: A SOURCE BOOK 387, 396 (Leon VandeCreek et al. eds., 1997).

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to determine whether something is in fact a mental illness. Because reparative therapy does not depend on whether homosexuality is a mental illness, such evidence would be irrelevant.

On the other hand, if a psychologist testifies that reparative therapy causes or exacerbates disorders that are listed in the DSM-IV, such as “generalized anxiety disorder” (GAD) (Code 300.02)194 or “major depressive disorder” (Code 296)195 (commonly known as and hereinafter depression), such testimony would certainly be relevant to the child abuse claim. Whether such testimony would be reliable is a different question and will be addressed next.

G. Reparative Therapy Causes or Exacerbates GAD or Depression

Herein lies the crux of the evidentiary problem. It is generally accepted that reparative therapy does not work, that homosexuality is not a mental illness, and that homosexuals are much more prone to have mental illnesses than heterosexuals, yet there appears to be scant evidence, apart from anecdotes,196 that reparative therapy is harmful. One psychologist in 1994 noted the scattered nature of the reparative therapy debate and its resulting lack of focus on this specific harm issue: “The research question, ‘What is being accomplished by conversion treatments?’ may well be replaced by, ‘What harm has been done in the name of sexual reorientation?’ At present, no data are extant.”197 Apparently, this lack of data persisted for another decade. In 1997, the APA stated, “Data that conclusively indicate harmfulness of conversion therapy do not exist.”198 Cruz notes in 1999 that despite the vast number of accounts of people who have suffered real harms through reparative therapy, there was a “lack of systematic

194. AllPsych Online, Generalized Anxiety Disorder (GAD), http://allpsych.com/disorders/anxiety/generalizedanxiety.html (last visited Apr. 2, 2005) (“GAD is evidenced by general feelings of anxiety such as mild heart palpitations, dizziness, and excessive worry. The symptoms are difficult to control for the individual and are not related to a specific event (such as in PSTD).”).

195. AllPsych Online, Major Depressive Disorder (Unipolar Depression), http://allpsych.com/disorders/mood/majordepression.html (last visited Apr. 2, 2005) (“Symptoms of depression include the following: depressed mood (such as feelings of sadness or emptiness), reduced interest in activities that used to be enjoyed, sleep disturbances (either not being able to sleep well or sleeping too much), loss of energy or a significant reduction in energy level, difficulty concentrating, holding a conversation, paying attention, or making decisions that used to be made fairly easily, [and] suicidal thoughts or intentions.”).

196. Haldeman notes that “subjects who have undergone failed attempts at conversion therapy often report increased guilt, anxiety, and low self-esteem,” but his statement is based on anecdotal evidence. Yarhouse & Throckmorton, supra note 167, at 70.

197. Id. (citing Douglas C. Haldeman, The Practice and Ethics of Sexual Orientation Conversion Therapy, 62 J. CONSULTING & CLINICAL PSYCHOL. 221, 221-27 (1994)).

198. Cruz, supra note 19, at 1351.
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information about the frequency of these harms." In 2002, Yarhouse and Throckmorton assert that “[a]ccording to the empirical evidence to date, the objective of sexual reorientation has not been demonstrated to be intrinsically harmful.”

Douglas Haldeman, who is not a proponent of reparative therapy, notes the methodological unreliability of anecdotal evidence: “The reports of harm done by conversion treatments, however, are subject to the same methodological limitations as those affecting studies purporting to show a positive treatment outcome.” As recently as February of 2003, B.A. Robinson, an opponent of reparative therapy, expressed his frustration at this lack of evidence.

The only published study close to empirically linking reparative therapy with psychological harm was completed by Ariel Shidlo and Michael Schroeder in 2002. Similar to Spitzer’s study, they interviewed 202 people who had undergone reparative therapy. Although Cruz looked forward to this study in 1999 as the first scientific basis for the real psychological harms of reparative therapy, the primary focus of the study was, unfortunately, yet again on the efficacy of reparative therapy. The psychologists did ask the participants for whom reparative therapy failed what types of psychological harms they suffered, and many reported increased distress, depression, or spiritual harms. However,

199. Yarhouse & Throckmorton, supra note 167, at 71.
200. Haldeman, supra note 46, at 261.
201. Robinson, supra note 171 (“I am personally enraged at the irresponsibility of the large professional mental health organizations. . . . Today, there are at least 1,000 therapists conducting reparative therapy. . . . Yet no statistically valid, peer-reviewed study in this field has ever been attempted. Mental health professionals know that these forms of therapy are dangerous and can induce suicide attempts. Yet the therapy’s safety and efficacy can only be guessed at.”).
202. See Ariel Shidlo & Michael Schroeder, Changing Sexual Orientation: A Consumers’ Report, 33 PROF. PSYCHOL.: RES. & PRAC. 249 (2002); see also Warren Throckmorton, May I Ask Your Evaluation of the Shidlo and Schroeder Study, Which Appears To Have Arrived at Conclusions So Directly Opposed to Spitzer’s Study?, http://www.drthrockmorton.com/article.asp?id=11 (last visited Dec. 2, 2005) (“Shidlo and Schroeder’s study is the only peer reviewed study I know about that systematically sought to examine those who say they tried reorientation counseling but were not happy with the results.”).
203. Cruz, supra note 19, at 1354 (“All of these harms are real and serious. However, there is a significant lack of information about their incidence. Psychologists Ariel Shidlo and Michael Schroeder are currently conducting research with people who have attempted sexual orientation conversion, but have yet to publish any results.”).
204. See Shidlo & Schroeder, supra note 202, at 251 (noting that the title of the project had to be changed from “Homophobic Therapies: Documenting the Damage” to “Changing Sexual Orientation: Does Counseling Work?”).
205. See Shidlo & Schroeder, supra note 202, at 254 (noting that their review of psychological harms were qualitative rather than quantitative); id. at 254-56 (recounting anecdotes of harm); see
some also reported psychological benefits such as an increased sense of hope, coping strategies, and social skill building.206

Unsurprisingly, reparative therapy opponents tout the Shidlo/Schroeder study and denigrate the methodology of the Spitzer study,207 while reparative therapy proponents do the exact opposite.208 In any case, both studies rely on non-random samples and self-reporting.209 As Haldeman notes in 2002, “It is nearly impossible to obtain a random sample of research participants who have been treated for their sexual orientation, and it is equally as difficult to assess outcomes in a way that does not contaminate the scientific process with social bias.”210 To overcome this barrier and produce more meaningful studies, Haldeman encourages a “systematic study of motivations of those who seek to change sexual orientation...”211

In sum, the idea that reparative therapy is psychologically harmful is not generally accepted in the psychological community, and psychologists are only starting to construct scientific studies to capture this principle. Although it is speculative at this stage, what will likely emerge are studies that attempt to catalogue various forms of reparative therapy, such as aversive treatments versus

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206. See Shidlo & Schroeder, supra note 202, at 256-57; see also New Direction for Life Ministries, supra note 205.

207. See, e.g., Attempts To Change Sexual Orientation, supra note 205 (devoting half of the webpage to criticizing Spitzer’s study while spending one paragraph discussing the Shidlo/Schroeder study); Barbara Dozetos, Gay.com, Researchers Clash Over ‘Ex-Gays,’ May 9, 2001, http://www.gay.com/content/tools/print.html?coll=news_articles&sernum=2001/05/09/2&navpath=channels/news (quoting numerous organizations and individuals criticizing Spitzer’s study, while noting that “[t]he methodology behind Shidlo and Schroeder’s study differed significantly from Spitzer’s”).

208. The most “balanced” comparison of the studies I could find was at a pro-reparative therapy site, New Direction for Life Ministries. See New Direction for Life Ministries, Comparison of the Research of Robert L. Spitzer with the Research of Ariel Shidlo and Michael Schroeder, http://www.newdirection.ca/research/compare.htm (last visited Apr. 10, 2005).

209. Id.


211. Id. at 262.
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psychotherapy,\textsuperscript{212} religion-integrated treatments versus secular ones, and treatments that focus on chastity versus those that focus on increasing attractions for the opposite sex.\textsuperscript{213} Such studies will probably also examine such treatments' effects on clients depending on the clients' own motivations, such as whether the client is a minor pressured by her parents\textsuperscript{214} or whether the client is religiously motivated.\textsuperscript{215}

IV. POSITION STATEMENTS, RESOLUTIONS, AND CODES, OH MY: CONFUSION OVER GUIDELINES IN PSYCHOLOGICAL PRACTICE

In addition to the aforementioned data and arguments raised by opponents of reparative therapy, much of the legal reparative therapy literature also cites various position statements and resolutions (hereinafter written guidelines) of the numerous professional psychological organizations. Many of these written guidelines contain explicit condemnations of reparative therapy. In Hicks's theory, since most professional psychological associations denounce reparative therapy, a "reasonably prudent parent" "would discover that 'reparative' therapy is not accepted in the mainstream medical community."\textsuperscript{216} Therefore, a parent who subjects her child to a psychological practice that is denounced by the psychology profession, indicating its harmfulness, would be guilty of child abuse.

Although Hicks's theory, based on New York law, may be read to imply that a parent must know that an action is harmful in order to be subject to prosecution for child abuse, it is important to emphasize that this mens rea element is not required for emotional child abuse cases in many states, which simply require the establishment of emotional harm and its causation.\textsuperscript{217}

\textsuperscript{212} See \textit{id}. at 261 (noting that in Haldeman's experience, clients who have undergone aversive procedures suffer significantly more than clients who have undergone less intrusive forms of therapy).

\textsuperscript{213} See Martin Koretzky, Nat'l Ass'n for Research & Therapy of Homosexuality, APA Symposium Seeks Common Ground, http://www.narth.com/docs/commonground.html (last visited Apr. 5, 2005) (reporting that Dr. Mark Yarhouse identified a "continuum of service options for clients who experience same-sex attractions, including reorientation/reparative therapy, chastity/celibacy, sexual-identity management, and gay-affirmative therapy").

\textsuperscript{214} This would be most useful for the type of reparative therapy discussed in Hicks's article.

\textsuperscript{215} See Cruz, supra note 19, at 1345-48 (noting difficulty of ascertaining whether a client's proffered religious reason is "truly" individual or derives from desire to conform).

\textsuperscript{216} Hicks, supra note 5, at 524.

The existence of emotional harm requires expert testimony, and the previous Part has demonstrated that several forms of testimony face evidentiary problems. However, if an expert could truthfully testify that it is generally accepted by the psychology profession that reparative therapy is harmful, such testimony would by definition pass the "general acceptance" test of Daubert or Frye, and it may therefore not even be necessary to have empirical evidence of reparative therapy's harmfulness. Not only would such testimony be admissible, it would be relatively dispositive in proving that reparative therapy is per se emotionally harmful, since the existence of emotional harm is itself determined by the psychology profession. The profession's condemnation of a practice is rooted in its belief that such a practice is harmful to the patient. Having established the emotional harm element of emotional child abuse, the parent would be guilty or liable for child abuse, regardless of whether the parent even knew that such a practice was harmful.

However, the reason why the argument outlined cannot work is because the written guidelines that are commonly cited by legal scholars are not even considered probative of whether a psychological practice is harmful in court. Instead, courts have consistently looked to psychological associations' codes of ethics to determine whether a psychologist has violated a standard of care, thereby exposing her to liability for harming her patient. While many written guidelines have "condemned" reparative therapy, codes of ethics, the only legally relevant guidelines, have been silent.

This Part reviews the legal literature's reliance upon written guidelines, asserts that the only relevant guideline for legal purposes is a code of ethics, and demonstrates that legal scholars and some psychologists fail to acknowledge this.

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218. This Part shows that it is codes of ethics that are relevant in determining whether a profession has condemned a practice, deeming it violative of the standard of care. Such practices are presumed to be harmful to the patient. It is true that some psychologists feel that codes of ethics have shifted focus from preventing harm to the patient to shielding psychologists from liability. See infra note 239. Still, the existence of liability implies the existence of harm, and the explicit purpose of codes of ethics is still to protect the patient from harm. See, e.g., AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT (2002), http://www.apa.org/ethics/code2002.pdf ("This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.").

219. See infra notes 240-254 and accompanying text.
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A. Legal Scholars' Reliance on Written Guidelines of Psychological Organizations

Hicks, Yoshino, and Cohan place an uncritical reliance on the written guidelines of professional psychological organizations, while Gilliam and Cruz ignore them.

Hicks relies on these written guidelines to bolster her argument that a reasonably prudent parent should know that reparative therapy is harmful. First, she cites a unanimous board decision made by the American Psychiatric Association in 1998 to oppose reparative therapy (hereinafter 1998 American Psychiatric Association Board Decision). Second, she notes:

At the 105th annual meeting in Chicago on August 14, 1997, the [APA] announced: 'The APA opposes all portrayals of lesbian, gay and bisexual people as mentally ill and in need of treatment due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance and unfounded beliefs about sexual orientation.

Third, she cites a policy statement from the American Academy of Pediatrics, published in 1993, stating that therapy "directed at specifically changing sexual orientation . . . can provoke guilt and anxiety while having little or no potential for achieving changes in orientation" (hereinafter 1993 Pediatrics Policy Statement). Finally, she notes that the president of the APA's Society for the Study of Lesbian, Gay, and Bisexual Issues accused reparative therapy of having an inappropriate bias.

Yoshino, carefully cataloguing the history of reparative therapy, states that "the mental health profession has generally marginalized the practice. None of the major mental health associations . . . currently endorses conversion therapy." To back up his claim, he cites a position statement passed by the American Medical Association, a position statement passed by the Board of Trustees of the American Psychiatric Association supplementing the 1998

220. Gilliam's article was a legislative advocacy piece, and the main focus of his piece was not on reparative therapy, so his disregard of such written guidelines is understandable.
221. Hicks, supra note 5, at 513 n.34.
222. Id. at 513 & n.35 (citing Am. Psychological Ass'n Council of Representatives, Resolution on Appropriate Therapeutic Responses to Sexual Orientation (1997) [hereinafter 1997 APA Resolution]).
223. Id. at 514.
224. Id.
225. Yoshino, supra note 31, at 800.
American Psychiatric Association Board Decision, the 1997 APA Resolution, and a position statement passed by the National Association of Social Workers in 2000.

Cohen, arguing for the minor’s right to refuse reparative therapy, cites the 1998 American Psychiatric Association Board Decision, the 1993 Pediatrics Policy Statement, and a condemnation of reparative therapy by the American Psychoanalytic Association.

B. The Missing Link: Codes of Ethics

Based on Hicks, Yoshino, and Cohen’s reliance on these written guidelines, it is tempting to assume that such universal condemnation of reparative therapy surely qualifies as relevant and reliable evidence in a reparative therapy child abuse case. However, this assumption is rightly questioned in Gans’s article, which provides the most nuanced analysis of the legal impact of these written guidelines. She makes this careful distinction: “The fact that neither the American Psychiatric Association nor the [APA] has condemned the use of conversion therapy on the ground that it is unethical also supports its continued practice.” Citing a “Fact Sheet” published by the American Psychiatric Association in 1994 and the 1997 APA Resolution, she specifically notes that none of those statements condemn reparative therapy outright. For that reason, she surmises that a negligent malpractice action against reparative therapy would be difficult. Cruz also briefly mentions this distinction.

226. Id. at 800 n.147.
228. Cohen, supra note 12, at 75 n.36.
229. Id. at 76 n.37.
230. Cohen cited this condemnation but did not provide a citation. See id. at 75 (claiming that the “American Psychoanalytic Association and th[e] American Psychiatric Association have expressed their opposition to ‘reparative’ therapy” but citing only the American Psychiatric Association condemnation in the subsequent footnote).
231. Gans, supra note 18, at 227.
232. Id. at 228 n.60.
233. Id. at 228.
234. See id. at 241 (noting that the fact that neither the APA nor the American Psychiatric Association have banned the use of reparative therapy serves as a defense for the therapist).
235. Cruz, supra note 19, at 1301 (“For more than twenty-five years some have argued that reorientation efforts are unethical and harmful and should not be countenanced. Both the [APA] and the American Psychiatric Association . . . have considered resolutions to such effect, although neither adopted the resolutions at issue.”).
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Gans was almost right. The problem is not that these associations have not condemned reparative therapy, but that they have not deemed reparative therapy to be unethical.236 Notably absent from the litany of written guidelines cited by other authors are these associations' codes of ethics. Unlike the standard of care used in medical malpractice actions, which "vary substantially in authorship, form, dissemination, and purpose,"237 psychological standards for legal purposes actually seem to rely greatly on the code of ethics. As some research psychologists note, "In this age of increasing accountability, the formal means by which we psychologists hold ourselves accountable for our behavior is the APA Ethics Committee."238 One psychologist laments the fact that codes of ethics had become a code of legal liability rather than a code to protect the patient's best interest.239

The discussions by psychologists over legal issues usually center on the code of ethics, since they realize that the code is often the bedrock of litigation. For instance, as a result of disagreeing codes of ethics concerning whether it is ethical for psychologists to have sexual relations with ex-clients,240 one legal scholar recognizes that it would result in ambiguity over liability.241 Another notes that the APA potentially misled psychologists when it published a set of guidelines for professionals in making child custody evaluations and states that the guidelines were not intended to be "mandatory or exhaustive."242 This was misleading, because the APA was "quick to point out that the new guidelines build upon the APA Ethical Principles of Psychologists and Code of Conduct."243 If such guidelines were based upon the code of ethics, the scholar notes, then the

236. Gans, supra note 18, at 227.
238. Kenneth S. Pope et al., Ethics of Practice: The Beliefs and Behaviors of Psychologists as Therapists, 42 AM. PSYCHOLOGIST 993, 1004 (1987).
239. Carolyn R. Payton, Implications of the 1992 Ethics Code for Diverse Groups, 25 PROF. PSYCHOL.: RES. & PRAC. 317, 320 (1994) ("Previous codes seemed to have been formulated from the perspective of offering protection to the consumers of our discipline . . . . The 1992 revision appears to be more concerned with offering protection to psychologists . . . . It reads as though the final draft was edited by lawyers in the employment of the APA.").
241. Id. at 548 (proposing solution to the ambiguity).
243. Id.
following statement would be more accurate: "As guidelines they are not intended to be either mandatory, unless already embodied in the APA Code of Ethics, or exhaustive." 244 Other scholars state that the APA code of ethics explicitly separates its aspirational section from the section that "creates enforceable standards of conduct, which are punishable by sanctions if not followed." 245 Legal scholars who have analyzed the ethical conflicts that may arise between lawyers and psychologists working with each other note the centrality of the code of ethics in the conflict. 246 Another psychologist highlights the important legal role of the code of ethics when noting that, because more psychologists believe in the possibility of rational suicide for the terminally ill, the "current APA code of ethics needs to be examined to see if it will allow for participation in assisted suicide." 247

Many states explicitly set their legal standards of care in accordance with the APA ethical guidelines. 248 And even if statutes do not codify the state’s dependence on private associations, state courts often rely upon them to define the standards for malpractice suits anyway. For example, one Georgia psychotherapy malpractice case admitted expert testimony that explicitly relies on the APA ethical standards as evidence for malpractice. 249 A North Carolina

244. Id.
246. Id. at 131-32 (recommending that psychologists notify lawyers of their obligations to the code of ethics).
247. Phillip M. Kleespies et al., Suicide in the Medically and Terminally Ill: Psychological and Ethical Considerations, 56 J. CLINICAL PSYCHOL. 1153, 1168 (2000).
248. See, e.g., IDAHO CODE ANN. § 54-2305 (2003) (including “current, and as future amended, ethical standards for psychologists of the American Psychological Association”); N.C. GEN. STAT. § 90-270.15(a)(10) (2003) (authorizing the Board to discipline licensees whose conduct violates either the statutorily-defined Code of Conduct, or the “then-current code of ethics of the American Psychological Association”); OKLA. STAT. ANN. tit. 59, § 1361 (West Supp. 2005) (“The State Board of Examiners of Psychologists shall publish a code of ethics. . . . In developing and revising this code, the Board. . . . may take into account the Ethical Principles of Psychologists and Code of Conduct promulgated by the American Psychological Association and the Code of Conduct promulgated by the Association of State and Provincial Psychology Boards.”); WIS. STAT. ANN. § 455.08 (West 1998) (“The [Wisconsin] examining board shall adopt such rules as are necessary under this chapter and shall, by rule, establish a reasonable code of ethics governing the professional conduct of psychologists, using as its model the ‘Ethical Standards of Psychologists,’ established by the American Psychological Association.”).
249. Bala v. Powers Ferry Psychological Assoc., 491 S.E.2d 380 (Ga. Ct. App. 1997) (admitting expert testimony, stating that “it is my opinion that Dr. Abby Friedman’s disclosure was a deviation from the standard of care of a psychologist as set forth by the Ethical Principles and Code of the American Psychological Association”).
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court affirmed the use of the APA standards as long as the sections relied upon are not so vague that a "reasonably intelligent member of the profession" would not understand what practices are forbidden. Lawsuits have been filed challenging the reliance on private associations as an unconstitutional grant of legislative authority, but courts have not been receptive to this challenge.

In the child abuse context, the touchstone of a court's inquiry is the harm resulting to the child, but among the indicia of this inquiry is the standard of care. Because codes of ethics weigh more heavily, if not exclusively, in court determinations of standard of care for psychotherapy, whether a code of ethics condemns reparative therapy is far more relevant and reliable than whether other


251. Farber v. N.C. Psychology Bd., 569 S.E.2d 287, 300 (N.C. Ct. App. 2002) ("We do not conclude that discretionary reference to the ethical code of the American Psychology Association for purposes of determining improper behavior by a licensee to be a delegation of legislative authority to the APA."); see also Lucas v. Me. Comm'n of Pharmacy, 472 A.2d 904, 909 (Me. 1984) ("[S]tatutes whose operation depends upon private action which is taken for purposes which are independent of the statute usually pass constitutional muster.") (quoting KENNETH C. DAVIS, ADMINISTRATIVE LAW TREATISE § 3:12 (2d ed. 1978)); Bd. of Trs. v. City of Baltimore, 562 A.2d 720, 731 (Md. Ct. Spec. App. 1989) (noting that "courts have sometimes upheld legislative adoption of private organizations' standards which are periodically subject to revision, in limited circumstances such as where the standards are issued by a well-recognized, independent authority, and provide guidance on technical and complex matters within the entity's area of expertise. These cases usually involve accreditation or similar programs by established professional organizations").

252. See, e.g., In re Phillip B., 156 Cal. Rptr. 48, 51 (Ct. App. 1979) ("Several relevant factors must be taken into consideration before a state insists upon medical treatment rejected by the parents. The state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; the evaluation for the treatment by the medical profession; the risks involved in medically treating the child; and the expressed preferences of the child. Of course, the underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment."); in the analogous Christian Scientist context, where parents refuse to submit their ill children to medical treatment, courts will take standard of care into account in addition to evidence of harm. See Newmark v. Williams, 588 A.2d 1108, 1117 (Del. 1991) ("There are two basic inquiries when a dispute involves chemotherapy treatment over parents' religious objections. The court must first consider the effectiveness of the treatment and determine the child's chances of survival with and without medical care."); id. at 1117-18 (surveying different states' approaches); Custody of a Minor, 379 N.E.2d 1053, 1064 (Mass. 1978) (removing parents' legal custody because they refused to use chemotherapy when chemotherapy "has come to be viewed as the ordinary, medically indicated treatment for acute lymphocytic leukemia in children. Moreover, according to the undisputed medical evidence, chemotherapy is the only existing form of treatment which can claim such status"); and where parents used dietary program when "uncontradicted expert testimony revealed that the dietary program suggested by the parents had no value in the treatment of acute lymphocytic leukemia").

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written guidelines do the same.\textsuperscript{253}

C. Is Reparative Therapy Ethical?

The fact that greater legal weight is placed with codes of ethics raises the question why private psychological associations, which have not had any compunctions condemning reparative therapy via resolutions, policy statements, and board decisions, have nonetheless refrained from labeling the practice unethical. Some speculative reasons may be the aforementioned lack of concrete evidence of its direct harms or the fear of a religious backlash. Perhaps opponents of reparative therapy do not wish to use the force of law to stop the practices of their reparative therapist colleagues. In any case, votes to amend codes of ethics to make the practice unethical failed in 1994 and 1995.\textsuperscript{254} The proposal also failed in 2003, apparently due to last-minute maneuvering by reparative therapists.\textsuperscript{255}

This schizophrenia between condemning reparative therapy on one hand and not condemning it on the other has led to confusion and careless usage of the word "unethical" in legal scholarship describing reparative therapy. For instance, William Eskridge notes that "[t]he professional organizations in psychiatry and psychology have disavowed reparative therapy as . . . unethical in its asserted manipulation of patients."\textsuperscript{256} Hicks cites a news article apparently reporting that

\textsuperscript{253} Written guidelines are indeed used in some cases (usually equal protection civil rights cases). See, e.g., High Tech Gays v. Defense Indus. Sec. Clearance Office, 895 F.2d 563, 578 (9th Cir. 1990) (holding that same APA resolution not enough to overcome DOD’s proffered reason for employing expanded security clearance for homosexual applicants); Jantz v. Muci, 759 F. Supp. 1543, 1548 (D. Kan. 1991) (relying partly on APA resolution stating that homosexual orientation has no effect on job performance in an equal protection employment discrimination case to show that summary judgment is precluded); Baker v. Wade, 106 F.R.D. 526, 536 (N.D. Tex. 1985) (referring to the use of APA, American Psychiatric Association, and AMA resolutions in case challenging sodomy statute). But they are not used in cases requiring a party to establish that some treatment is harmful according to science or standard of care, as noted previously. See supra Section IV.B.

\textsuperscript{254} In 1994, a resolution condemning conversion therapy as unethical was rejected by the American Psychiatric Association. A similar resolution was proposed but rejected by the APA in 1995. B.A. Robinson, Ont. Consultants on Religious Tolerance, Statements by Professional Associations and Their Leaders, http://www.religioustolerance.org/hom_expr.htm (last visited Nov. 18, 2003); see also Kaufman, supra note 168, at 424 (documenting American Psychiatric Association discussions to label reparative therapy as unethical in 1993).


\textsuperscript{256} William N. Eskridge, Jr., No Promo Homo: The Sedimentation of Antigay Discourse and
“both the [APA] and the American Psychiatric Association have denounced ‘reparative’ therapy as unethical.”257 Sherry Colb asserts that “the entire enterprise of ‘reparative therapy’ is ethically questionable and independently troubling,”258 citing Hicks’s article and conflating reparative therapy with the apparently unethical practice of core gender identity conversion.259 Harris Miller also suggests that reparative therapy is unethical.260 Although many individual psychologists certainly believe reparative therapy to be unethical, it is dangerous to conflate that with a practice being “unethical” from a legal perspective.

This confusion does not solely exist in the legal realm, but even among some psychologists themselves. In a study conducted in 1987, 55.7% of 456 psychologists believed that considering homosexuality to be per se pathological was unethical.261 In another study conducted in 1992, despite the fact that no association had declared reparative therapy unethical, one psychologist presumably practicing reparative therapy noted, “My professional association, the APA, has said that my religious beliefs (e.g., that homosexual acts are wrong) are unethical. Therefore, should I quit the APA or my religion?”262 In an audio documentary sponsored by National Public Radio, Alix Spiegel, the granddaughter of one of the psychologists who was instrumental in removing homophobia from the DSM, stated in 2002, “It’s now considered unethical to treat homosexuality, and any psychiatrist who attempts to change the sexual orientation of his patient can face professional censure.”263

In sum, given the legal deference granted to codes of ethics to determine the standard of care, it is unlikely that courts will admit testimony on the psychology

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257. Hicks, supra note 5, at 513 n.34.
259. Id. at 78 n.32.
261. Pope et al., supra note 238. Although the question on ethics was meant to obtain the individual psychologist’s view of whether an activity was ethical, it is unclear whether the psychologist responded in terms of whether the practice was objectively ethical, i.e., permitted by the code, or subjectively ethical.
profession’s rejection of reparative therapy as long as codes of ethics are silent on the issue. Consequently, prosecutors cannot hold parents who subject their children to reparative therapy liable for child abuse under this theory.

V. THE EMPIRICALLY VALIDATED TREATMENTS MOVEMENT

A recent movement in the field of psychology, known as the empirically validated treatments ("EVT") movement, could potentially pave the way for Hicks’s theory even if no evidence of reparative therapy’s harm were to surface and even if professional associations do not explicitly condemn reparative therapy in their codes of ethics.

A. What Is the EVT Movement?

Traditionally, the effectiveness of psychotherapy was not tested with empirical studies. As long as the treatment was working for the patient, that was good enough. Because of the seemingly subjective nature of psychotherapy and the fact that “[c]hoices of treatment depend heavily on the philosophical [as opposed to scientific] basis of the particular form of psychotherapy at issue,” empirical data supporting psychotherapeutic methods were largely lacking.

However, over the past decade there has been a movement within the psychology profession to push for an increased reliance (and for some, an exclusive reliance) on empirically validated treatments. “Generally, [EVTs] are defined as therapies that have been found to be successful in treating psychological disorders in controlled research studies with delineated populations.” This movement is largely seen as having been caused by the rise of managed care organizations, whose interests in cost-cutting are threatened by seemingly endless psychotherapy with highly uncertain and subjective results. Ultimately, “managed care organizations [are] interested in clinicians providing the optimal intervention: the least extensive, intensive, intrusive and costly intervention capable of successfully addressing the presenting problem.” As Geoffrey Marcyk and Ellen Wertheimer note, “For the first time, those who offer psychotherapy need to show results, and not just to the patient. The

265. Id. at 78.
266. Sanderson, supra note 189, at 388 ("However, in response to the increased costs of psychotherapy, and in particular to the perceived 'endless' nature of psychotherapy, managed care organizations are pressuring clinicians . . . .").
267. Id. (citations and quotations omitted).
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therapist-patient relationship has acquired a third member: the Health Maintenance Organization (HMO)." Even some psychologists who initially may be loath to support the EVT movement do so out of recognition that if they do not, HMOs will dictate the standards of care for their practices. As the current president of the APA warned in 2005, "If we do not take on this task [of focusing on empirical support], the challenge will not magically disappear. Rather, someone else will dictate what treatments are acceptable and what types of evidence are privileged." While the EVT movement appears to be sparked by HMO pressure, it has taken on a life of its own, having direct implications for the standard of care. The pressure on psychology to support its treatments with empirical data for the sake of satisfying HMOs gives rise to the implication that if some treatments have more empirical support than others, it may be "negligent for a therapist to fail to offer that treatment . . . . This empirically supported treatment may thus become the standard of care, with the therapist negligent for offering anything else." Although codes of ethics do not explicitly adopt the position that only EVT's are ethical, the influence of the EVT movement is increasingly felt in private associations' codes of ethics. Moreover, the EVT movement is seen as a practical defense against critics of psychotherapy who believe that psychotherapy is simply not on par with conventional medicine. Although

268. Marczyk & Wertheimer, supra note 264, at 33.
269. Sanderson, supra note 189, at 394 ("The question is not whether or not we should develop treatment guidelines whenever possible, but instead, have we already missed the boat?").
271. Id. ("Some APA members have asked me why I have chosen to sponsor an APA Presidential Initiative on Evidence-Based Practice (EBP) in Psychology, expressing fears that the results might be used against psychologists by . . . malpractice lawyers.").
272. Marczyk & Wertheimer, supra note 264, at 36-37.
273. Instead, the APA ethics code states that "'[p]sychologists work to develop a valid and reliable body of scientific knowledge based on research.' Similarly, the APA Ethical Guidelines note that psychologists 'maintain knowledge of relevant scientific and professional information related to the services they render . . . and make appropriate use of scientific . . . resources.'" Id. at 83-84.
274. See id. at 77-82 (describing the APA's history with EVT's); Sanderson, supra note 189, at 389 (citing a conference in 1991 determining the treatment consensus statement for panic disorders on the basis of the most convincing empirical data).
275. See, e.g., Hjelt, supra note 52, at 39 ("Psychotherapy, as a treatment for an emotional condition, is analogous to a drug or medication prescribed to treat a medical condition."); Sanderson, supra note 189, at 390 ("[P]sychological interventions seem to be taking a backseat to pharmacological approaches . . . . Unlike pharmaceutical companies that spend a significant amount of money promoting the use of their treatments to consumers and providers, no such profit-
courts appear unaware of the EVT movement, and opposition to it in the psychological community remains sizeable, the EVT movement shows no signs of slowing.

B. Evidence That Reparative Therapy Does Not Work Would Now Be Admissible

If the EVT movement were to take hold in the practice of psychology and then in courts, Hicks's theory would become more plausible. Testimony presenting already existing evidence that reparative therapy does not work, previously inadmissible due to its irrelevance, could then be admitted. The central tenet of the EVT movement is that all treatments that do not work carry too much risk of harm to the patient. Therefore, the fact that reparative therapy does not work means that it is "generally accepted" that reparative therapy carries too much risk of harm to the patient. Such testimony would be probative of reparative therapy's emotionally harmful effects, strengthening the case for characterizing reparative therapy as child abuse.

It is important to note that the EVT movement could have the side effect of making the Daubert factors—testability (or falsifiability), rate of error, and peer review—more relevant to psychological testimony, in contrast to current court practice, which leans heavily on the "general acceptance" prong held over from the Frye test. As Stephen Pappas noted in 2005:

Parallel to the evolution of the judicial approach to expert testimony in the decade following Daubert, a more critical and objective evidence-based assessment of medical science has evolved. . . . Evaluating the admissibility of expert medical testimony within the objective framework of evidence-based medicine and its focus on reliability and relevance will move the evaluation motivated organization exists for psychotherapeutic interventions.

276. A search for "empirically validated treatment" in Westlaw of all federal and state cases revealed no results. This is not to suggest that courts do not consider the role of empiricism in admitting psychological evidence, only that they appear unaware of this significant controversy.

277. See generally Marczek & Wertheimer, supra note 264 (opposing the EVT movement). Sanderson notes that EVT opponents argue that empirical studies fail to accurately mirror what occurs in actual practice, fail to take into account therapist and patient variability, and fail to recognize that all psychotherapies are equally effective. Furthermore, empiricism places undue reliance on the DSM. Sanderson, supra note 189, at 396; see also id. at 393 (quoting EVT opponent warning of "potential disastrous consequences . . . from such arrant foolishness").

278. See, e.g., supra note 270 (describing the reasons behind the creation of a 2005 Presidential Task Force on Evidence-Based Practice).

279. See supra Section III.E.
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closer to the reliability and relevancy standards envisaged by Daubert.280

Although Pappas refers to an analogous EVT movement in medicine, it applies equally to the psychological context.

However, even if the EVT movement causes Daubert courts to actually apply the other factors to psychological testimony, a prosecutor could still admit the empirical evidence that reparative therapy does not work. Such evidence has already been peer reviewed, and even proponents of reparative therapy have not been able to falsify these studies, nor do they even seriously contest them.281 Therefore, the Daubert hurdles would not prevent such testimony from being admitted, and the EVT movement will have deemed such testimony to be probative of a treatment’s undue risk of harm to the child.

VI. IMPLICATIONS AND RECOMMENDATIONS

Surveying the data and trends evolving concurrently in the psychology profession and the courts prompts several implications and recommendations. This Part first summarizes how this Note’s analysis affects Hicks’s theory of child abuse prosecution, then discusses how the analysis affects reparative therapy in the legal contexts that have been introduced by other legal scholars, and finally lists recommendations for how the legal and psychology professions should deal with reparative therapy as well as each other on a general level.

A. Implications for Child Abuse Prosecution

In sum, Hicks’s assertion that reparative therapy legally constitutes child abuse requires one of the following three conditions: (1) empirical evidence that reparative therapy results in psychological harm; (2) condemnation of reparative therapy in codes of ethics, thereby affirmatively establishing reparative therapy as a legal violation of the standard of care; or (3) a substantial increase in the influence of the EVT movement in psychology, thereby requiring reparative therapists to affirmatively and empirically show that reparative therapy works rather than rely defensively on the lack of evidence of its harms.

First, if empirical evidence that reparative therapy results in psychological harm were to surface, a child abuse prosecution would be plausible. Such robust evidence would quickly gain the “general acceptance” of the professional community, and expert testimony concerning the generally accepted notion that

280. Pappas, supra note 94, at 597.
281. Proponents instead assert the mere possibility of change. See supra note 168 and accompanying text.
reparative therapy is harmful would be admitted. This testimony would then establish actual emotional harm. Having established emotional harm by expert testimony and the fact that the parent subjected her child to such emotional harm by sending the child to reparative therapy, emotional child abuse could then be shown.

Second, condemnation of reparative therapy in codes of ethics would also permit prosecution for child abuse. Currently, when courts evaluate psychological malpractice liability, they look to the profession’s code of ethics. If the code of ethics condemn a practice, then such a practice violates the standard of care, which means that such a practice is harmful to the patient. If the code of ethics condemns reparative therapy, an expert could testify that it is generally accepted that the profession considers reparative therapy to be emotionally harmful. Having established actual emotional harm by expert testimony, emotional child abuse could then be shown.

Third, a substantial increase in the influence of the EVT movement in psychology would also permit prosecution for child abuse. The EVT movement’s central tenet is that psychotherapists should only employ practices that have been empirically validated because only such practices are effective, and all other practices are therefore unjustified and carry too much risk of harm to patients. If this movement caught hold, all psychotherapeutic practices that could not empirically demonstrate their effectiveness would be deemed unsafe and unethical. Assuming that reparative therapy continues to lack empirical support that it works, reparative therapy would then be among such practices that the EVT movement would reject. An expert could then testify that since reparative therapy does not work, it presumptively carries too high of a risk of harm. Having established actual emotional harm by expert testimony, emotional child abuse could then be shown.

B. Implications for Reparative Therapy in Other Legal Contexts

Applying these three conditions can also augment the analyses of the other legal articles already addressing reparative therapy. For instance, Gans’s proposed intentional infliction of emotional harm cause of action against reparative therapists depends on the existence of “extreme and outrageous conduct.” To show that the conduct is extreme and outrageous, Gans relies on the fact that “studies have proven the harmful effects conversion therapy can have on patients.” However, this phrase is misleading, as it is quite easy to prove that something can happen; one instance of harm proves that fact.

282. Gans, supra note 18, at 246.
283. Id. at 247.
Moreover, in any case, her assertion relies on claims by psychologists that reparative therapy perpetuates homophobia,\(^{284}\) testimony that faces problematic evidentiary hurdles, as discussed previously.\(^{285}\) She also relies on the fact that reparative therapists “are undoubtedly aware of the volatile controversy surrounding their actions,”\(^{286}\) but an action’s controversial character hardly gives rise to its being extreme or outrageous. However, if any of the three aforementioned conditions were satisfied, the “extreme and outrageous” claim would be substantially strengthened and Gans’s intentional infliction of emotional harm theory would likewise be more plausible.

The same analysis applies to Cruz’s proposal, which advocates for less deference to a client’s claim that she really wants reparative therapy. Although a full discussion of the complex doctrine of informed consent is beyond the scope of this Note,\(^{287}\) it is sufficient to assert that each condition would have a significant impact on the informed consent analysis. If evidence of the harms of reparative therapy surfaced, a reparative therapist would be required to inform the patient of these harms. If any of the latter two conditions occurred, thereby relegating reparative therapy to the position of being violative of the standard of care, the informed consent defense would drop out of the inquiry altogether, as the reparative therapist would simply not be allowed to perform such a practice.

Gilliam’s advocacy for protecting homosexual children from reparative therapy in foster care would gain significant credibility if any of the conditions were met. Homosexual juveniles would no longer be institutionalized by their caretakers for reparative therapy purposes, because Parham requires that a neutral fact-finder must make findings based on psychiatric standards that institutionalization is appropriate. If any of the conditions were satisfied, a neutral fact-finder would be obligated to find that institutionalized reparative therapy would be inappropriate.\(^{288}\) Lastly, child custody cases involving homosexual children would certainly be resolved in favor of the parent who chooses not to subject the child to reparative therapy, even if the pro-reparative

\(^{284}\) Id. at 248 n.185 (citing sources “discussing the reinforcement of homophobia through the use of conversion therapy”).

\(^{285}\) See supra Section III.B.

\(^{286}\) Gans, supra note 18, at 248.

\(^{287}\) See Hjelt, supra note 52, at 1 (“The amount written about the doctrine of informed consent in the last forty years truly threatens more than one old growth forest.”).

\(^{288}\) Arguably, it is already unconstitutional for a parent to commit her child to a mental institution for reparative therapy purposes. The fact that homosexuality is not an illness would remove any basis on which a neutral fact-finder would agree to commit a child. One observer stated in 2002 that it is “technically no longer . . . possible to have a child institutionalized for being homosexual.” Lehr, supra note 2, at 8. Regardless of whether this observation is true, the conditions would still strengthen the case that the institutionalization is unconstitutional.
therapy parent sought the therapy for religious reasons.\(^{289}\)

The only issue for which these conditions are probably irrelevant is the proposal by Cohan that adolescents should have the substantive due process right to refuse reparative therapy. *DeShaney v. Winnebago County Department of Social Services*\(^ {290}\) holds that “nothing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors.”\(^ {291}\) Therefore, whether reparative therapy is harmful or unethical has no bearing on the due process analysis, since the parent, not the state, would be causing the harm to the child.\(^ {292}\) It is worth noting, however, that some legal scholars are pushing for an adolescent’s right to make health care decisions,\(^ {293}\) and the conditions certainly bear on that debate.

**C. Recommendations**

Although this Note has focused on the issue of whether reparative therapy constitutes child abuse, the aforementioned implications in other legal contexts concerning reparative therapy warrant several broader recommendations. These recommendations generally address practical ways through which the law and psychology can address the controversial issue of reparative therapy.

First, the legal scholarship needs to take a more nuanced approach to the practice of reparative therapy, employing the science carefully and accurately. This is in contrast to framing the conflict in terms of right-wing fundamentalists versus gay rights activists, playing fast and loose with scientific data in order to shore up support for one side or the other\(^ {294}\) or carelessly conflating several studies (i.e., data that reparative therapy does not “work” and data on the

\(^{289}\) *In re* E.L.M.C., 100 P.3d 546, 563 (Colo. Ct. App. 2004) (“While courts are precluded by the free exercise of religion clause from weighing the comparative merits of the religious tenets of the various faiths or basing their custody decisions solely on religious considerations, the family is not beyond regulation in the public interest as against a claim of religious liberty, and neither the rights of religious nor rights of parenthood are beyond limitation. Thus, evidence of beliefs or practices which are reasonably likely to cause present or future harm to the child is admissible in a custody proceeding.”) (internal citation omitted).


\(^{291}\) *Id.* at 195.

\(^{292}\) This raises the question of whether psychologists licensed by the state are state actors. However, that question may be sidestepped; if reparative therapy is deemed unethical, then reparative therapists will not be able to obtain licenses. Therefore, the child would still be harmed by another private actor—the non-licensed reparative therapist.


\(^{294}\) See, e.g., *supra* notes 207-208 and accompanying text (discussing reporting on the Spitzer and the Shidlo/Schroeder studies by reparative therapy opponents and proponents).
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vulnerability of queer youths to depression). As Robert Bayer, a public health historian at Columbia University, states, "Both sides wrap themselves in the mantle of science and both sides charge that the other side is being unscientific." There is no excuse for legal scholarship to succumb to the same intellectual pitfalls of political activists.

Second, both the legal and psychological communities should join the chorus of those who have pressed for more reliable studies concerning the possible harms of reparative therapy. Relying solely on the rhetoric of resolutions, policy statements, or board decisions only highlights the awkward and embarrassing fact that no private association has condemned reparative therapy in its code of ethics—where it really matters.

Third, the controversy over EVT among psychologists should alert courts to the fact that, doctrinally, psychologists' ongoing debate about the role of empirical data differentiates psychology from other scientific disciplines. Some judges and scholars may certainly recognize this fact, but the Daubert and Frye doctrines are not clear as to how judges ought to consider psychological testimony. Psychological testimony should not face the same barriers as other scientific testimony for admissibility, as long as judges do not allow psychologists to conflate a variety of scientific assertions and make it clear to jurors that psychological testimony should not be considered as authoritative as other scientific testimony. However, if psychology eventually adopts the EVT approach to validating its practices, then courts may properly treat psychology in the same rigorous way it treats other traditional "sciences."

Fourth, private psychological associations need to develop a more structured mechanism or policy regarding their written guidelines. The ways in which legal scholars haphazardly and sometimes inaccurately rely on the plethora of written guidelines only highlights the present confusion. Furthermore, given the significant extent of private psychological associations’ political participation, these associations should be even more careful to explain which positions are rooted in science, to what degree, and whether a position means that a majority of its members agree with that position. With regard to codes of ethics, opponents of reparative therapy may not wish to sentence their proponent colleagues to jail

295. Spiegel, supra note 263, at 51:40. For more information on the latest battle over scientific data, see Robinson, supra note 171. See also Kaufman, supra note 168, at 426-33 (providing extensive overview of scientific evidence mounted by both sides as well as corresponding responses); Robinson, supra note 201; Yarhouse & Throckmorton, supra note 167, at 70-73 (providing relatively balanced but pro-reparative-therapy-leanig overview of scientific data).

or subject them to civil liability, but there may be a middle ground between rhetorical denunciations on the one hand and a rigidly draconian code of ethics on the other. Associations should consider such possibilities.

Fifth, private psychological associations should specifically condemn non-psychotherapeutic, physically invasive techniques of reparative therapy in their codes of ethics. Little suggests that reparative therapy proponents would put up much of a fight, since many of them likewise denounce physically invasive techniques. There is no reason that the practice of physically invasive reparative therapy should continue, and its elimination will better focus the debate on the practice of psychotherapy itself. Furthermore, opponents of reparative therapy have an incentive to push for this measure, since the conflation of physically invasive methods and psychotherapy only weakens their arguments. 297

CONCLUSION

Hicks never claims that reparative therapy would be held by all courts to be child abuse, astutely and implicitly recognizing that the legislatures, politics, and cultural attitudes of each state are significant factors in determining whether a court would adopt her theory. 298 However, she neglects to identify the critical evidentiary obstacles that must be surmounted before her theory could be realized.

One’s zeal against homophobia may be justified, especially given the sheer number of anecdotes attesting to the evils of reparative therapy, but zeal must be channeled in an effective manner. Courts that hear such child abuse cases are impervious to scattershot approaches to getting psychological testimony against reparative therapy admitted. Unless scientifically sound evidence as to reparative therapy’s harms emerges, private associations actually denounce reparative therapy in their codes of ethics, or the EVT movement takes significant hold in the psychological community, the testimony of psychologists on behalf of the child will neither be admitted nor effective.

This controversy also reveals significant holes in the way that courts and the practice of psychology interact. Both institutions need greater clarity and coherence with regard to how they view psychology, whether as a science, an art, or a mixture of both. Their policies should correspond accordingly. Opponents of reparative therapy have to face the reality that while a great deal of evidence and

297. See supra Section I.C. (discussing reasons for focusing on psychotherapeutic forms of reparative therapy).

298. See Hicks, supra note 5, at 543 (“Whether a court or legislature would ever extend protection to juveniles subjected to ‘reparative’ therapy may turn in part on the jurisdiction and community in which the juvenile resides.”).
popular professional opinion appears to be on their side, it does not excuse overreaching beyond what the evidence has established. Proponents of reparative therapy also need to concede that reparative therapy’s efficacy simply does not have scientific backing and move away from the tired and irrelevant nature/nurture debate.

Amidst this political furor, legal scholarship needs to develop a scientifically honest, context-sensitive framework for handling cases involving this controversial practice. The political environment is simply too volatile to risk staking out an overly rigid or principled position against reparative therapy as a whole—only a carefully nuanced system will best meet the concerns of all stakeholders and be insulated from shifting political winds as much as possible.