ARTICLES

INVERTS, PERVERTS, AND CONVERTS: SEXUAL ORIENTATION CONVERSION THERAPY AND LIABILITY

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Homosexuality distorts the natural bond of friendship that would naturally unite persons of the same sex. It works against society's essential male/female design and family unit. Yet today children from kindergarten through college are being taught in school that homosexuality is nothing but a normal, healthy option. It is our policy as psychoanalytically-informed individuals to dispel the misinformation that surrounds the subject of homosexuality. Our task is to discuss issues misrepresented by social-activist groups who have portrayed sexual deviancy as a normal way of life. We seek to further the research and treatment of this disorder, while protecting the patient's right to treatment.[1]

I. INTRODUCTION

While the above text reads as though it were resurrected from psychiatry's antediluvian days, it is actually excerpted from the current literature of NARTH,[2] National Association for Research and Therapy of Homosexuality ("NARTH"). NARTH, founded in 1992, is a California-based organization that holds itself out as a "Non-Profit Psychoanalytic, Educational Organization Dedicated to Research, Therapy and Prevention of Homosexuality."[3]

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[1] Excerpted from the National Association for Research and Therapy of Homosexuality (NARTH), *Statement of Policy* (visited Mar. 20, 1997) <http://www.narth.com/menus/statement.html.> [hereinafter NARTH].

The terms "invert" and "pervert" served as popular labels for gays and lesbians during the late nineteenth and early twentieth centuries. *See, e.g.*, JONATHAN N. KATZ, GAY AMERICAN HISTORY: LESBIANS AND GAY MEN IN THE U.S.A. 138 (ed. rev. 1992) (presenting excerpts from scientific writings from 1895: "[w]e can hardly cure the inverts" and from 1899: "[t]he sexual perversions that have been modified [include] unnatural passion for persons of the same sex"). *Id.* at 145. *See also* LILLIAN FADERMAN, ODD GIRLS AND TWILIGHT LOVERS: A HISTORY OF LESBIAN LIFE IN TWENTIETH-CENTURY AMERICA 59 (1991) ("Already by 1890 some female 'inverts' had joined the sexual underworld."). The term "convert" refers to the gay or lesbian who claims to have been changed to heterosexuality through conversion therapy.

[2] *See id.*

[3] *Id.*

The type of therapy to which NARTH refers is variously known as "conversion,"[4] "reorientation,"[5] or "reparative"[6] therapy. Its well-settled goal is "to change a person from a homosexual orientation to a heterosexual orientation."[7] Moreover, it is commonplace to refer to a gay man or lesbian's changing his or her sexuality to heterosexuality as "curing" it.[8] While perhaps one of the more vocal champions of conversion therapy, NARTH represents only one such force involved in modern-day efforts to change gays and lesbians to heterosexuals. Indeed, conversion therapy is currently practiced by psychiatrists, psychologists, and pastoral counselors.[9]

This Article will proceed from the position that conversion therapy is the consummate embodiment of anti-gay sentiment because its implicit primary goal is to eradicate homosexuality.[10] This Article considers ways to hold conversion therapists liable for their actions until such therapy is completely prohibited.[11] It first discusses the background and nature of conversion therapy within psychotherapeutic and religious contexts, where it most frequently occurs. Second, it examines the legality of conversion therapy and analyzes several cases in which it has been in issue. It then evaluates possible causes of action under which a

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[4] *See generally* Douglas C. Haldeman, *Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination, in* HOMOSEXUALITY: RESEARCH IMPLICATIONS FOR PUBLIC POLICY 149 (John C. Gonsiorek & James D. Weinrich eds., 1991) [hereinafter RESEARCH IMPLICATIONS] (using term "conversion therapy").

[5] *See* KATZ, *supra* note 1, at 129 (using term "reorientation therapy").

[6] *See, e.g.*, American Psychiatric Association, *Gay & Lesbian Issues: American Psychiatric Association Fact Sheet* (1994) (using term "reparative therapy") [hereinafter *APA Fact Sheet*]. *See also* NARTH, *Reparative Therapy of Male Homosexuality* (visited Mar. 20, 1997) <http://www.leaderu.com/orgs/narth/docs/repair.html> (using term "reparative therapy"). This article will use the term "conversion therapy" unless otherwise noted, because the term "reparative" implies that such therapy is both necessary and curative, neither of which has been proven to be true. By contrast, the term "conversion" merely indicates that a change from one state to another is contemplated and is thus free from presumptions as to the need for, or efficacy of, such change.

[7] *APA Fact Sheet*, *supra* note 6, at 1.

[8] *See generally* MARTIN DUBERMAN, CURES: A GAY MAN'S ODYSSEY 9 (1991) (discussing the possibility of being cured of his homosexuality).

[9] *See* Haldeman, *supra* note 4, at 149 (" [E]fforts by both mental health professionals and paraprofessionals, e.g., pastoral care providers, to convert lesbians and gay men to heterosexuality have persisted."). *See also* KATZ, *supra* note 1, at 129 ("Lesbians and Gay men have long been subjected to a varied, often horrifying list of 'cures' at the hands of psychiatric-psychological professionals.").

[10] *See* KATZ, *supra* note 1, at 129 ("The treatment of Lesbians and Gay men by psychiatrists and psychologists constitutes one of the more lethal forms of homosexual oppression."). *See also infra* text accompanying notes 60-62 (discussing negative aspects of conversion therapy).

[11] Organizations such as the American Psychological Association and the American Psychiatric Association would seem to have the most power to ban conversion therapy although currently, both organizations sanction its use. *See, e.g., APA Fact Sheet, supra* note 6, at 1.

patient with a homosexual orientation might sue a psychotherapist who has tried to convert her to heterosexuality,[12] such as negligent malpractice and intentional infliction of emotional distress. This Article then proposes a third cause of action under which to sue a conversion therapist that incorporates the elements of the intentional infliction of emotional distress claim, but bases liability on a lower threshold of proof. This Article concludes by reiterating the need to hold conversion therapists liable for their actions until such therapy is completely prohibited.

II. IF IT AIN'T BROKE', FIX IT ANYWAY: THE CONVERSION THERAPY CREDO

Homosexuality was first thought of as a mental or medical illness during the nineteenth century.[13] One scholar wrote that "[t]his conceptualization is itself a fairly recent invention: European discussion of homosexuality as a medical phenomenon dates to the early 1800s."[14] Similarly, another scholar stated that "[h]istorians have documented the medical community's promotion, beginning in the late nineteenth century, of a concept of homosexuality as pathological and abnormal."[15] Efforts to change the sexual orientation of gay men and lesbians have been linked to the conceptualization of homosexuality as a medical disease. An expert on gay and lesbian history noted that "[t]he treatment of homosexuality by medical practitioners is of relatively recent origin, and is closely tied to the conceptualization of homosexuality as a medical-psychological phenomenon, a 'mental illness.'"[16]

The psychiatric profession in the United States continued to regard homosexuality as a disease well into the twentieth century. Indeed, this tendency was evidenced perhaps most conspicuously by the classification of homosexuality as a disorder in the second edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, DSM-II — a classification

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[12] *See* Lili Wright, *The Straight Truth: No One Knows if Gays Can Change*, SALT LAKE TRIB., May 12, 1996, at A1 (stating that conversion therapy is most frequently conducted through "conventional" therapy, i.e., psychotherapy).

[13] *See* John C. Gonsiorek, *The Empirical Basis for the Demise of the Illness Model of Homosexuality, in* RESEARCH IMPLICATIONS, *supra* note 4, at 116 ("From a historical perspective, homosexuality first evolved into a medical 'illness' in the late 19th century or early 20th century depending on the country."). *Accord* MICHEL FOUCAULT, THE HISTORY OF SEXUALITY 101 (Robert Hurley trans., 1978) ("There is no question that the appearance in nineteenth-century psychiatry, jurisprudence, and literature of a whole series of discourses on the species and subspecies of homosexuality, inversion, pederasty, and 'psychic hermaphrodism' made possible a strong advance of social controls into this area of 'perversity.'").

[14] KATZ, *supra* note 1, at 130.

[15] Erin G. Carlston, *"A Finer Differentiation": Female Homosexuality and the American Medical Community, 1926-1940 in* SCIENCE AND HOMOSEXUALITIES 177 (Vernon A. Rosario ed., 1997).

[16] KATZ, *supra* note 1, at 129.

that lasted through the final months of 1973.[17] However, in December 1973, the American Psychiatric Association finally abandoned their official position on homosexuality, resulting in the long-awaited removal of homosexuality from its list of disorders.[18] Groups such as the American Psychological Association, the American Anthropological Association, and the American Sociological Association have since joined the trend departing from the homosexuality-as-illness model.[19]

In spite of what appeared to be unanimous professional support for the depathologization of homosexuality, psychiatrists, psychologists, and others in the mental health field persisted in regarding it as an illness.[20] This stubborn re-

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[17] Charles Silverstein, *Psychological and Medical Treatments of Homosexuality, in* RESEARCH IMPLICATIONS, *supra* note 4, at 101. The diagnosis for homosexuality read as follows: "This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances . . . ." AMERICAN PSYCHIATRIC ASSOCIATION, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 44 (2d ed. 1968).

[18] *See* Silverstein, *supra* note 17, at 101. The decision to remove homosexuality from the list of disorders seems to have been greatly influenced by political forces and "the new social values" of the day. It "came during a period of egalitarianism in our society, as gay liberation followed on the heels of the black civil rights movement and the women's liberation movement." *Id.* at 105. However, one commentator has stressed the importance of recognizing that there was also an empirical basis for the removal of homosexuality as a disorder, not merely a political one: "the political pressure placed on the American Psychiatric Association in the early 1970s was a necessary but not sufficient condition for the depathologizing of homosexuality. The other condition that was also necessary but not sufficient was an empirical basis for discarding the illness model of homosexuality." Gonsiorek, *supra* note 13, at 115.

[19] *See* Gerald C. Davison, *Constructionism and Morality in Therapy, in* RESEARCH IMPLICATIONS, *supra* note 4, at 138. Moreover, the "ego-dystonic homosexuality" category that succeeded the DSM-II's classification of homosexuality in the DSM-III in 1980 was itself removed from the manual in 1987. Gonsiorek, *supra* note 13, at 116. Specifically, "Ego-dystonic homosexuality" was a "diagnoses to be applied when a person was troubled by his or her homosexual inclination . . . ." Davison, at 138. The precise diagnostic entry read as follows: "The essential features are a desire to acquire or increase heterosexual arousal, so that heterosexual relationships can be initiated or maintained . . . ." AMERICAN PSYCHIATRIC ASSOCIATION, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 281 (3d ed. 1980). This diagnostic entry was omitted in 1987 in the DSM-III-R and replaced with one that was "non-specific with respect to the gender of the person one is sexually attracted to . . . defined by the presence of 'persistent and marked distress about one's sexual orientation . . . .'" Davison, at 138.

[20] *See* Gonsiorek, *supra* note 13, at 116 ("[S]ome psychoanalytic theorists . . . continue to develop increasingly complex and arcane theoretical structures to 'prove' the inherent psychopathology of homosexuality, again ignoring the evidence against such an illness perspective."). *Id. See also* KATZ, *supra* note 1, at 130 ("[P]sychiatrists and psychologists are among the major ideologues of homosexual oppression.").

fusal to adopt the prevailing opinion that homosexuality is not an illness has carried over into the present day. The current practice of conversion therapy attests to the antiquated belief that homosexuality is a disease.[21]

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,"[22] and surgically removing the ovaries and clitoris.[23] Additionally, patients were lobotomized and subjected to "aversive conditioning" and "covert sensitization."[24] Specifically, aversive conditioning involved administering electric shock or inducing vomiting while simultaneously showing the patient homoerotic stimuli. The homoerotic stimuli would then be removed and replaced with heterosexual erotic visual stimuli. The goal of the conditioning was to "strengthen heterosexual feelings in the sexual response hierarchy."[25] Similarly, covert sensitization therapy relied on the "use of noxious stimuli paired with same-sex erotic imagery"[26] but asked patients merely to imagine the shocks and vomiting experienced by patients subjected to aversive conditioning.

A. *Psychotherapy 101: Change Their Minds, The Rest Will Follow*

In addition to using therapy that tried to change gays and lesbians by altering them physically, psychiatrists also employed techniques specifically targeting the mind.[27] An historian wrote that "[o]ften homosexuals have been the subjects of Freudian psychoanalysis and other varieties of individual and group psychotherapy."[28] Like their earlier counterparts, therapists today who attempt to convert

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[21] Although there do not appear to be any official statistics as to the numbers of therapists conducting such therapy today, the literature of one organization practicing the therapy suggests that at least "200 psychologists and therapists" are doing so. National Association for Research and Therapy of Homosexuality, Press Release, *New Study Confirms Homosexuality Can Be Overcome* [hereinafter NARTH Release]. Moreover, with respect to the numbers of people attempting to be converted to heterosexuality, the media has reported that one religious organization has boasted having "more than 6,000 people in therapy at its 90 ministries across the country." Rick Weiss, *Psychologists Reconsider Gay 'Conversion' Therapy; Group's Proposal Seeks to Curb Such Treatment*, WASH. POST, Aug. 14, 1997, at A8.

[22] KATZ, *supra* note 1, at 130.

[23] *See id.*

[24] Haldeman, *supra* note 4, at 152.

[25] *Id.*

[26] KATZ, *supra* note 1, at 129.

[27] Even though the body was the primary target of therapists, they were obviously attempting to change the mind and ways of thinking and feeling. *See, e.g.*, Silverstein, *supra* note 17, at 111.

[28] KATZ, *supra* note 1, at 129. *See also* Silverstein, *supra* note 17, at 111 ("Psychologists and psychiatrists attempted to cure homosexuals of their sexual affliction by various means."). Psychoanalysis is a method for treating mental illness, developed by Sigmund Freud in the early twentieth century. It "aims to help the patient understand his or her emotional development and to help the person make appropriate adjustment in particular

gays and lesbians to heterosexuality rely most often on treatments that focus on their patients' psyches as a way of affecting the desired transformation. Psychotherapy appears to be one of the more popular therapeutic formats through which to carry out conversion attempts.[29]

While there may be a tendency in our society to downplay the effects of psychotherapy or "talk therapy,"[30] sufficient evidence suggests that it can greatly affect those persons upon whom it is practiced. A recent work detailing the scientific underpinnings of psychotherapy asserts that "we now know that psychotherapy directly affects the brain" and that "[p]sychotherapy works because it produces long-lasting changes in the neurons that make up your mind."[31] Another expert aptly described the patient-psychotherapist relationship as one that "commonly has a tremendous impact on a patient's life."[32]

Psychotherapy 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."[33] Instead, it is a "treatment of mental and emotional problems by psychological methods."[34] A more comprehensive definition of psychotherapy posits that it is

> [a] form of treatment for mental illness and behavioral disturbances in which a trained person establishes a professional contract with the patient and through definite therapeutic communication, both verbal and nonverbal,

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situations." AMERICAN MEDICAL ASSOCIATION, ENCYCLOPEDIA OF MEDICINE 832 (Charles B. Clayman ed., 1989) [hereinafter *AMA*]; MORTON HUNT, THE STORY OF PSYCHOLOGY 177 (1993) (describing the "basic elements" of psychoanalysis).

[29] *See* Wright, *supra* note 12, at A1 (discussing use of psychotherapy as a means of conducting conversion therapy). However, a recent case, Pitcherskaia v. Immigration and Naturalization Service, 118 F.3d 641 (9th Cir. 1997), makes it clear that methods such as drug therapy and electroshock therapy are still being used in conversion therapy attempts. *See infra* text accompanying notes 72-78 (presenting Pitcherskaia case as one of few in which conversion therapy has been addressed by the courts).

[30] *See* JEFFREY D. ROBERTSON, PSYCHIATRIC MALPRACTICE: LIABILITY OF MENTAL HEALTH PROFESSIONALS 428 (1988) (indicating that "talk-therapy" is synonymous with psychotherapy). For general discussion of how psychotherapy is regarded in popular culture, *see* HUNT, *supra* note 28, at 562 ("Although psychotherapy has thus grown vastly in influence and acceptability . . . it has long been assailed both by those who regard psychology as a spurious science and those who regard psychotherapy as a spurious healing art."). *Id.*

[31] SUSAN C. VAUGHAN, THE TALKING CURE: THE SCIENCE BEHIND PSYCHOTHERAPY xiii-xiv (1997). The power of psychotherapy can be inferred from another scholar's description: "the psychotherapeutic relationship . . . is a special union founded on an implied understanding of confidentiality, trust, and fiduciary care . . . that enables a patient to share feelings, thoughts, experiences, and fantasies never disclosed before in an atmosphere of unconditional acceptance, empathy, and trust." JOSEPH T. SMITH, MEDICAL MALPRACTICE: PSYCHIATRIC CARE 85-86 (1986).

[32] SMITH, *supra* note 31, at 86.

[33] *Id.* at 84.

[34] *AMA*, *supra* note 28, at 833.

> attempts to alleviate the emotional disturbance, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.[35]

The statistics on psychotherapy alone underscore the tremendous influence it has had on contemporary society. By one account, "each year some fifteen million Americans make 120 million visits to psychotherapists"[36] and "[c]umulatively, nearly one out of three persons – eighty million or so – have had some experience with psychotherapy."[37] Moreover, psychotherapy has been shown to have a significant negative impact on patients. There is "reasonable evidence that psychotherapy, improperly applied, may have an injurious impact on a patient, and that the injury may be quite severe. Therefore, it may be assumed that a person could sustain some degree of harm or injury from involvement in psychotherapy."[38]

B. *Religious Groups Help Save the Gay*

In addition to attempts made by psychologists and others in the mental health field to convert gays and lesbians, various forces in the religious sector have made similar attempts.[39] Sometimes referred to as "change ministries" or "ex-gay"[40] groups, it has been reported that such organizations number in the hundreds throughout the country.[41] Next to "the scientific community, the primary

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[35] ROBERTSON, *supra* note 30, at 428 (quoting COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 3352 (H. Kaplan & B. Sadock eds., 1985). "Basically, psychotherapy, regardless of the theoretical school or techniques applied, is a means by which a trained professional . . . strive[s] to explore the various levels of the client's character, lifestyle, and manner of being. The basic purpose of counseling and psychotherapy is to assist the client to develop a more effective and fulfilling means of experiencing and interacting with the world.").

[36] HUNT, *supra* note 28, at 560. Moreover, "[a]bout a third of these treatments are provided by psychologists, another third by psychiatrists, and the rest by clinical social workers, clinical mental health counselors, and pastoral counselors. All these professionals, despite their dissimilar backgrounds and allegiances, practice therapies that are psychological, as distinguished from such other approaches to mental illness as the physiological, the social, and the religious (although psychiatrists may also dispense medication)." *Id.*

[37] *Id.*

[38] SMITH, *supra* note 31, at 85.

[39] The religious conversion movement has been underway since at least the 1970s. Don Lattin, *"Change Ministers" Try to Convert Gays*, PHOENIX GAZETTE, Jan. 19, 1991, at A12. One such group, Exodus International, for instance, has been in existence since 1976. *See* Holly Morris, *Ex-gay Groups Offer Religious Counseling to Help Ease the Transition When Homosexuals Convert*, ATLANTA J. & CONST., May 16, 1992, at E6. This article will look only at conversion attempts made by those in the secular realm.

[40] Religious groups and ministries practicing conversion therapy and/or that counsel gays and lesbians who have already "converted" are referred to as "ex-gay" groups. Morris, *supra* note 39, at E6.

[41] *See* Tracy Everbach, *Conversion Formula: Ministry Aims to Counsel Gays Away*

proponents of sexual orientation change have been pastors and religiously-oriented lay persons."[42]

Many of the religious conversion groups try to change their gay and lesbian clients' sexuality by simultaneously attempting to change them spiritually.[43] 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."[44] Some of the other techniques reportedly used include a "14-step recovery program"[45] and the playing of team sports, such as baseball and basketball.[46] Such religious proponents of conversion therapy justify the use of conversion programs on moral grounds. The leader of one group stated that "God has condemned homosexual behavior and has made the power to change available to those who desire it."[47] Similarly, a former ex-gay ministry employee said that "[they] feel that God has made it clear that homosexuality . . . is a form of sin."[48]

C. *If At First You Don't Succeed . . .*

Both religious and secular practitioners of conversion therapy have boasted about their success in changing people from homosexuality to heterosexuality. One organization, for instance, has painted an optimistic picture of the potential to "overcome" homosexuality[49] while another leading "ex-gay" group claims a conversion success rate of thirty percent.[50] Despite its proponents' spirited support for the use of conversion therapy, the consensus among the majority of scientists and mental health professionals knowledgeable on the subject suggests that sexuality cannot be changed.[51]

From Homosexuality, DALLAS MORNING NEWS, July 30, 1996, at 15A.

[42] Haldeman, *supra* note 4, at 156.

[43] *See* Morris, *supra* note 39, at E6.

[44] *Id.* One former employee of an ex-gay group stated that "through a relationship with Jesus Christ, change – not just of behavior, but internally – can be brought about." *Id.*

[45] Wright, *supra* note 12, at A1.

[46] *See id.* The director of one gay male conversion group sees sports as helping to build 'masculine self-esteem' and helping men see one another as 'pals, companions, buds' instead of as sex partners." *Id.*

[47] A. Damien Martin, *The Emperor's New Clothes: Modern Attempts to Change Sexual Orientation, in* INNOVATIONS IN PSYCHOTHERAPY WITH HOMOSEXUALS 28 (Emery S. Hetrick, M.D., and Terry S. Stein, M.D., eds., 1984).

[48] Morris, *supra* note 39, at E6.

[49] A recent study on the outcome of conversion therapy attempts on gay men and lesbians claims that "[a]mong the study's significant findings is a documented shift . . . in the frequency and intensity of their [the subjects'] homosexual thoughts and actions" and goes on to explain the basis for such an assertion. NARTH Release, *supra* note 21.

[50] *See* Wright, *supra* note 12, at A1.

[51] *See* Haldeman, *supra* note 4, at 149. Generally speaking, if anything has changed in terms of one's sexuality, it is generally thought to be the person's behavior, not his or her actual orientation. *Id.* at 152. Conversion methodologies "do not shift sexual orientation

The American Psychological Association, one of the leading organizations in the mental health field, stated that " '[n]o scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change sexual orientation.'"[52] Similarly, the American Psychiatric Association echoed this position by stating 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."[53] Studies that claim to demonstrate that changes to sexual orientation have occurred have been criticized as "inadequate and misleading scientific practice"[54] as well as "consistently flawed by poor or nonexistent follow-up data, improper classifications of subjects . . . and confusion of heterosexual competence with sexual orientation shift."[55]

Furthermore, just as the most stringent opponents of conversion therapy find it objectionable for its scientific inefficacy, they also object to it on moral and ethical grounds.[56] One opponent posited that "change-of-orientation therapy programs are ethically improper and should be eliminated. Their availability only confirms professional and societal biases against homosexuality . . . ."[57] Another commentator has argued that if "we attempt to conjure a 'cure' for homosexuality, we only reinforce bigotry."[58] Such opponents of the therapy advocate focusing "instead on healing and educating an intolerant social context."[59]

While those opposed to the use of conversion therapy obviously support its abolishment, most likely abolishment will not occur any time soon. The power of the religious community, for instance, insures that homosexuality will continue to be viewed as something that requires a cure. The fact that neither the American Psychiatric Association nor the American SH Psychological Association has condemned the use of conversion therapy on the ground that it is unethical also supports its continued practice. Although the American Psychiatric As-

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at all. Rather, they instruct or coerce heterosexual activity in a minority of subjects which is not the same as reversing sexual orientation." *Id.* at 151-52.

[52] *Id.* at 160.

[53] *APA Fact Sheet*, *supra* note 6, at 1. Moreover, one critic of conversion therapy has forcefully denounced it as an "idea whose time has come and gone" and has also asserted that at "no point has there been empirical support for the idea of conversion." Haldeman, *supra* note 4, at 159.

[54] *APA Fact Sheet*, *supra* note 6, at 1. *See also* Haldeman, *supra* note 4, at 115, 150-59 (giving a comprehensive look at research data on conversion therapy studies).

[55] Haldeman, *supra* note 4, at 155. For instance, the Masters and Johnson Institute's conversion therapy study showed a success rate of under thirty percent. *Id.* One commentator has said of the Masters and Johnson study that "[t]his supposedly scientific study has left unclear who is being measured, what is being measured, and how it is being measured." *Id.*

[56] *See id.* at 159 ("Psychological ethics mandate that mental health professionals subscribe to methods that support human dignity and are effective in their stated purpose. Conversion therapy qualifies as neither.").

[57] Davison, *supra* note 19, at 148.

[58] Haldeman, *supra* note 4, at 160.

[59] *Id.* at 159-60.

sociation made it clear that it does not regard homosexuality as an illness and that it found no evidence supporting the efficacy of conversion therapy,[60] it nevertheless has not condemned outright the use of conversion therapy.[61] Similarly, although the American Psychological Association passed a resolution calling for "therapists to obtain informed consent from homosexual or sexually uncertain clients before embarking on so-called 'conversion' or 'reparative' therapy,"[62] it has failed to condemn the use of such therapy. The failure to call for the demise of conversion therapy by groups such as the American Psychological Association has the practical effect of condoning its use.

III. LEGAL REMEDIES FOR THE HARM INFLICTED BY CONVERSION THERAPY

A. *The Courts and the Conversion Therapist*

The deep-seated animus felt toward gays and lesbians in our culture facilitates, if not actually compels, the practice of conversion therapy. Given the absence of any genuine professional or social opposition to its use, one possible forum in which to challenge conversion therapy is a court of law.[63] Judging from the paucity of case law on the use of conversion therapy, however, it may be difficult to test the hypothesis that courts may provide a forum in which to seek relief. Only a handful of cases exist in which the use of conversion therapy has figured even remotely.

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[60] *See APA Fact Sheet, supra* note 6, at 1.

[61] *See id.*

[62] *Id.* SMITH, *supra* note 31, at 160. In medical cases, informed consent is a legal theory that gives the patient a "cause of action for not being adequately informed as to the nature and consequences of a particular medical procedure, process, or treatment prior to giving consent to the initiation of that treatment." Specifically, where the physician has actively misrepresented to the patient the possible risks involved in the procedure, courts have invalidated the patient's consent. The doctor's actions in such cases have been held to make out the intentional tort of battery. By contrast, the majority of cases involve the physician's failure to disclose risks of treatment and have thus been regarded as negligent malpractice cases. *See id.* at 165. The physician's duty of care "includes making reasonable disclosure of all significant facts, including the nature of the treatment and some of the more probable risks and consequences inherent in the proposed procedure." *Id.* at 165. Hence, "a doctor who fails to exercise this duty is likely to be held liable for medical malpractice." *Id.* In such cases, consent is not an affirmative defense raised by the defendant; instead, it must be pleaded and proved as part of the plaintiff's prima facie case. Unless the plaintiff can prove that she did not consent to the invasion or conduct, the defendant may be absolved of all liability. *Id.*

[63] *See* ROBERTSON, *supra* note 30, at 426 (discussing the fact that courts are the only place to seek redress when injured by a therapy not regulated by the profession or other controls). Generally speaking, there are five basic regulatory methods for therapists: a codified set of standards known as Standards for Providers of Psychological Services; the professional code of ethics; Professional Standards Review Committees (sponsored by state associations, used to arbitrate complaints); the federal government (using various plans such as Medicare and Medicaid); and state licensing and certification boards. *See id.* at 430.

In *Roy v. Hartogs*,[64] a lesbian patient who sought psychiatric help for sexual problems was "induced to have sexual intercourse"[65] by her male, heterosexual psychiatrist "under the guise of medical therapy to cure his patient's lesbianism."[66] While both the supreme and appellate courts found that the use of sexual intercourse as a means by which to treat a patient constituted malpractice, neither court directly addressed the attempt to convert the patient to heterosexuality. Each opinion addressed the issue of homosexuality as if it were a disease and somehow treatable, albeit not through sexual intercourse initiated by a mental health professional. The judge in the first case opined: "In this case where the plaintiff consulted the defendant for sexual problems, the treatment prescribed was not palpably unreasonable on its face. A jury might find that a plaintiff, in her mental state, could reasonably have submitted to the 'treatment' in the hope that her condition would thereby improve."[67]

In spite of the ruling against the psychiatrist, one is left feeling that his attempt to convert the plaintiff would have been acceptable had he chosen a means less flagrantly a violation of professional standards. Moreover, one is left to infer that the plaintiff's "condition" was lesbianism because the court never explicitly stated what it was. Not until the psychiatrist sued his insurance company did a court reveal that the plaintiff was a lesbian.[68]

Likewise, the appellate court, in reversing plaintiff Roy's award of punitive damages, held that "the weight of the evidence did not justify the jury's finding that defendant's conduct, while inexcusable, was so wanton or reckless as to permit an award for punitive damages."[69] Thus, the court's decision leads to the inescapable conclusion that the court did not view the doctor's use of conversion therapy as a serious offense. In sum, because none of the *Hartogs* decisions focused on the use of conversion therapy per se, none can be regarded as determinative on the issue of whether such therapy is actionable under a negligent malpractice theory. This lack of focus on the issue may indicate the type of treatment such issue would receive in a different courtroom.

The probability that a court would adequately address the issue of conversion therapy would be further diminished if a religious psychotherapist were the defendant. In *Amato v. Greenquist*,[70] although the issue of conversion therapy did

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[64] 366 N.Y.S.2d 297, 298 (1975).

[65] Roy v. Hartogs, 381 N.Y.S.2d 587, 588 (1976).

[66] Hartogs v. Employers Mut. Liab. Ins. Co. of Wis., 391 N.Y.S.2d 962, 963 (1977). In this action, initiated by psychiatrist Hartogs against his insurance company, the court declared that the therapist "admitted that he at all times knew that the therapy he was administering was a violation of professional ethics and not within acceptable medical standards." *Id.* at 963. However, the court also revealed that the therapist was primarily interested in fulfilling his own sexual needs. As a result, it may be inferred that converting the plaintiff was not his main goal. *See id.*

[67] *Hartogs*, 366 N.Y.S.2d at 301.

[68] *See Hartogs*, 391 N.Y.S.2d 962.

[69] *Hartogs*, 381 N.Y.S.2d 587, 589.

[70] 679 N.E.2d 446 (Ill. 1997).

not arise, the court's handling of a religious therapist's actions is nevertheless instructive as to how a court may treat such a therapist who has tried to convert his or her patients. Specifically, the appellate court of Illinois had to determine whether the plaintiff stated a claim for psychotherapeutic malpractice against a church pastor who had become sexually involved with the plaintiff's wife.

In holding that the plaintiff failed to state a claim for psychotherapeutic malpractice, the court stated that to the extent that it would have to "establish a standard of reasonable care for religious practitioners practicing their respective faiths," which would "involve[] the interpretation of [religious] doctrine," it would decline to do so.[71] The court would only allow lawsuits "alleging tortious conduct" by religious figures "so long as the resolution [did] not require interpretation of either religious doctrine or religious duties imposed on an individual by a particular church."[72] Thus, the *Greenquist* court's reluctance to entertain an action requiring interpretation of religious precepts may be an indication that courts will grant great latitude to the practice of religious conversion therapy.

By contrast, in a case decided by the United States Court of Appeals for the Ninth Circuit, the court pointedly and thoughtfully addressed the issue of conversion therapy, albeit not within a malpractice context. *Pitcherskaia v. Immigration and Naturalization Service*[73] involved a Russian citizen's application to the United States for asylum after she had been apprehended by the Russian militia, registered at a clinic as a "suspected lesbian,"[74] and forced to undergo treatment for lesbianism, such as "sedative drugs" and hypnosis.[75] In ruling against her plea for asylum, the Board of Immigration Appeals (BIA) held that "although she had been subjected to involuntary psychiatric treatments, the militia and psychiatric institutions intended to 'cure' her, not punish her, and thus, their actions did not constitute 'persecution' within the meaning of the Immigration and Nationality Act.[76] In reversing the BIA's decision denying asylum and remanding the case for reconsideration, the Court of Appeals for the Ninth Circuit held that the conversion treatments to which Pitcherskaia had been subjected constituted mental and physical torture. The court rejected the BIA's argument that the treatments to which Pitcherskaia had been subjected did not constitute persecution because they had been intended to help her, not harm her.[77]

Specifically, the Ninth Circuit held that the "fact that a persecutor believes the harm he is inflicting is 'good for' his victim does not make it any less painful to the victim . . . ."[78] The court stated that "[h]uman rights laws cannot be sidestepped by simply couching actions that torture mentally or physically in be-

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[71] *Id.* at 450.

[72] *Id.*

[73] 118 F.3d 641 (9th Cir. 1997).

[74] *Id.*

[75] *See id.* at 645.

[76] *Id. See also* 8 U.S.C. § 1101(a)(42)(A) (1994).

[77] *See Pitcherskaia*, 118 F.3d at 647.

[78] *Id.* at 648.

nevolent terms such as 'curing' or 'treating' the victims."[79] The court not only strongly characterized the use of conversion therapy as mental and physical torture, but it refused to justify the use of such therapy on the ground that it was intended as a cure. The opinion appears to be of vital importance to opponents of conversion therapy because it echoes their position that conversion therapy is as damaging as it is unjustified.

Despite the discussion of conversion therapy in *Pitcherskaia*, there is a virtual absence of other case law on the subject of conversion therapy. This absence may be the result of several factors. First, the absence may stem from an historic reluctance of consumers of mental health services to sue their care givers.[80] This hesitancy has been attributed to several factors, such as the fear of being stigmatized for seeing a therapist, the fear of having one's personal life divulged in a public forum, and the desire not to breach the closeness that develops between patient and therapist.[81] The above fears and concerns would be magnified for some gays and lesbians who worry about revealing their homosexuality.[82] Another factor inhibiting the bringing of malpractice claims against mental health therapists arises from the difficulty associated with establishing the elements of such claims. The elements of causation and harm, for instance, are often difficult to prove given the intangible nature of psychological matters.[83] In the absence of adequate proof, the cause of action will fail.

Despite the lack of lawsuits brought against conversion therapists under a negligent malpractice theory, speculation as to how such a claim might play out is

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[79] *Id.*

[80] *See* ROBERTSON, *supra* note 30, at 3 ("Until recently, lawsuits against mental health professionals were virtually unheard of."). While statistics suggest that there has been a significant increase in the number of cases brought against practitioners, "[t]he incidence of claims against psychiatrists and psychologists is still low compared with other medical specialists and the majority of claims still result in favorable verdicts for the defendant." *Id.*

[81] *See* ROBERTSON, *supra* note 30, at 5.

> Probably the most powerful reason therapy-related injuries are not taken to court is the seemingly quieting effect the doctor-patient relationship has on a patient. The psychotherapeutic relationship, unlike almost any other doctor-patient or professional-client relationship, is a special union founded on an implied understanding of confidentiality, trust, and fiduciary care . . . This type of relationship commonly has a tremendous impact on a patient's life to the point that even if a harm is sustained, the patient's vulnerability, coupled with the psychotherapist's superior position of authority, tends to greatly enhance a general reluctance to initiate a lawsuit.

SMITH, *supra* note 31, at 85-86.

[82] This Article will not endeavor to prescribe the degree of openness gays and lesbians should exercise about their sexuality, but the success of helping to find conversion therapists liable for their action rests on plaintiffs' willingness to discuss their sexuality in a public forum.

[83] *See infra* note 96, (discussing difficulty associated with proving elements of negligent malpractice).

necessary given the increase in mental health malpractice suits in recent years.[84] If the number of mental health malpractice claims continues to increase, this Article may be useful to predict whether this cause of action can successfully hold conversion therapists liable for their actions.

B. *Negligent Malpractice: Prelude to a Claim Against Conversion Therapists*

Under civil tort law, the plaintiff in the case must establish the following elements by a preponderance of the evidence to establish a claim of ordinary negligence:[85]

> 1. A duty or obligation, recognized by the law, requiring the person to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
> 2. A failure on the person's part to conform to the standard required: a breach of duty . . .
> 3. A reasonably close causal relationship between the conduct and the resulting injury. This is what is commonly known as "legal cause," or "proximate cause," and which includes the notion of cause in fact.
> 4. Actual loss or damage resulting to the interests of another.[86]

In essence, to be liable for negligence, one must owe a duty of care to another that requires compliance with a certain standard, must fail to comply with such standard and must prove to be both the cause in fact and the legal or proximate cause of the other's resultant harm.

While the formula for ordinary negligence and the formula under which professionals[87] may be sued consist of essentially the same elements, the two diverge when it comes to the standard of care owed to another person. Courts hold professionals to a higher standard than they hold ordinary citizens, whom courts generally hold to the "reasonable man" standard.[88] Thus, courts will require a physician "not only to exercise reasonable care in what he or she does, but . . . to possess a minimum standard of special knowledge and ability."[89] One articulation of the medical standard of care reads as follows:

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[84] *See* Steven R. Smith, *Mental Health Malpractice in the 1990s*, 28 HOUS. L. REV. 209, 211 (1991) [hereinafter *Mental Health 1990s*] (discussing expansion of liability in recent years among mental health professionals).

[85] *See* SMITH, *supra* note 31, at 86 (discussing the standard of proof required in a negligence action).

[86] W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30 (5th ed. 1984) [hereinafter PROSSER & KEETON] (discussing the elements of a negligence claim).

[87] Professionals include surgeons and other doctors, dentists, pharmacists, psychiatrists, veterinarians, lawyers, architects, engineers, etc. *See* PROSSER & KEETON, *supra* note 86, § 32.

[88] RESTATEMENT (SECOND) OF TORTS § 285 (1977). The standard of care can be established by statute, administrative regulation, judicial decision, or by the trial judge or jury. *See id.*

[89] PROSSER & KEETON, *supra* note 86, § 32.

> In the absence of a special contract, a physician or surgeon is not required to exercise extraordinary skill and care or the highest degree of skill and care possible; but as a general rule he is only required to possess and exercise the degree of skill and learning ordinarily possessed and exercised, under similar circumstances, by the members of his profession in good standing, and to use ordinary and reasonable care and diligence, and his best judgment, in the application of his skill to the case.[90]

Therefore, assuming a practitioner-patient relationship has been established, if the practitioner falls below the requisite standard of care, the practitioner has breached a duty to the patient, and the patient may sue under a negligent malpractice theory.

The plaintiff must establish virtually the same elements to bring a claim of negligent malpractice against a medical doctor as against a mental health provider: "[c]ivil suits or tort actions against mental health professionals are based on the same legal principles that underlie traditional medical malpractice

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[90] ROBERTSON, *supra* note 30, at 7. However, "[t]he general standard of reasonable care, by definition and intent, is not meant to hold a physician or psychiatrist liable for an error in medical judgment or treatment as long as the requisite level of care has been exercised." SMITH, *supra* note 31, at 75. The level of skill referred to in the standard of care is sometimes considered that of the "average" member of the profession, which means those in good standing who possess the minimum of "common skill" in the field. *See* PROSSER & KEETON, *supra* note 86, § 32. Moreover, while the standard of conduct for the medical profession has generally been whatever is "customary and usual in the profession," there has been a recent trend away from such standard toward one that imposes a higher degree of care, that of the reasonably prudent physician. *See id.* The result is that proof of the medical custom becomes relevant to, but not conclusive of, the degree of care owed. *See id.*

On another level, under the "locality rule," the nature of the community in which the physician practiced has been taken into account in evaluating his or her duty of care owed. *Id.* In recent times, however, some jurisdictions have opted to treat the physician's location as just one factor to consider, while others have abandoned the locality rule altogether. *See id.* Additionally, in trying to establish the appropriate standard of care, expert witnesses are required to testify in the majority of cases in order for there to be a finding of negligence. *See id.* This is true given that "juries composed of laymen are normally incompetent to pass judgment on questions of medical science or technique . . . ." *Id. See also* SMITH, *supra* note 31, at 91.

However, when the "matter is regarded as within the common knowledge of laymen, as where the surgeon saws off the wrong leg, or there is injury to a part of the body not within the operative field, it is often held that the jury may infer negligence without the aid of any expert." PROSSER & KEETON, *supra* note 86, § 32. Traditionally, however, such experts have been reluctant to testify against their peers, which has made it difficult for the plaintiff to establish the prevailing standard of care. *See id.* Nevertheless, some physicians have "become more willing to testify for plaintiffs" in recent years. *Id.* However, if "the technique or therapy is innovative or incorporates elements of several different theoretical schools of thought, the difficulty in finding an expert familiar with the defendant's approach is great." SMITH, *supra* note 31, at 91.

claims."[91] Nevertheless, plaintiffs' claims against mental health professionals have proven to be much more difficult to establish than those against medical professionals.[92] This difficulty proves especially true with respect to psychotherapists: "the practitioner of psychotherapy is the least often sued of all medical practitioners."[93]

While patient-plaintiffs are generally successful in proving that the psychotherapist owed them a duty of care,[94] they have been less successful in establishing the attendant standard of care. One reason for this difficulty stems from the fact that the standard is not as clearly defined in the mental health field as it is in other areas of medicine.[95] The myriad schools of thought in the mental health field helps explain why the standard is less clearly defined.[96]

In a medical malpractice action, a court may account for differences in medical schools of thought and evaluate the physician according to the principles of the school to which he or she claims adherence.[97] The school of thought must be recognized "within definite principles, and it must be the line of thought of a respectable minority of the profession."[98] Therefore, because many schools of

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[91] BENJAMIN M. SCHUTZ, LEGAL LIABILITY IN PSYCHOTHERAPY 8 (1982). "This standard of care is often couched in language concerning the medical physician. However, it is applicable to mental health professionals as well." *Id.* Moreover, as "regards psychotherapists, it is only mental health professionals (i.e., duly qualified and licensed members of professions in the mental health field) who can be sued for malpractice . . . Quacks can, however, be sued for ordinary negligence." *Id.* at 39. Generally speaking, mental health professionals include psychiatrists, psychologists, social workers (both clinical and psychiatric), therapists, psychoanalysts, marriage and sex therapists, and members of the clergy, among others. ROBERTSON, *supra* note 30, at 428.

[92] *See Mental Health 1990s*, *supra* note 84, at 213 ("Mental health malpractice claims traditionally have been low for a number of reasons: [among them] the elements of negligence – duty, causation, and injury – are often difficult to prove.").

[93] SMITH, *supra* note 31, at 85.

[94] *See id.* at 89 ("When a patient and doctor enter into an agreement for medical or psychotherapeutic services, the doctor-patient relationship is said to have been created. From this point until the termination of treatment, the doctor legally and ethically owes the patient a duty of ordinary and reasonable care.").

[95] *See Mental Health 1990s*, *supra* note 84, at 214. For example, while there is generally a clear standard in the medical establishment for a treatment for appendicitis, there is no clear standard for the treatment of schizophrenia in the mental health establishment. *See id.*

[96] *See generally* PROSSER & KEETON, *supra* note 86, § 32 (defining concept of school of thought as it relates to establishing the standard of care in negligent malpractice case: "[w]here there are different schools of medical thought, and alternative methods of acceptable treatment, it is held that the dispute cannot be settled by the law, and the doctor is entitled to be judged according to the tenets of the school the doctor professes to follow.").

[97] *See id.*

[98] *Id.* However, Prosser points out that belonging to a respectable minority "does not mean . . . that any quack, charlatan or crackpot can set himself up as a 'school,' and so apply his individual ideas without liability." *Id.* In addition, anyone holding him or her-

thought exist in psychotherapy, this wide variety in treatment approaches makes it difficult to settle on one standard.[99] Indeed, with "more than 200 types of therapy having been identified and innovations and experimentation a common requisite to treating certain complex and particularly difficult patients, the courts have been restrained in declaring negligence simply because treatment methods differ from mainstream psychotherapy practice."[100] If the standard of care cannot be established with certainty, the plaintiff will have a much more difficult time proving the therapist breached it.

The plaintiff bringing a mental health malpractice suit may have similar difficulty establishing the next element of the negligence claim, proximate or legal cause. Here, the plaintiff must show that "something the psychotherapist did or failed to do proximately caused the emotional injury."[101] Proximate cause[102] generally concerns the determination of "whether the defendant should be legally responsible for the injury" to the plaintiff.[103] One interpretation of proximate cause states that it is "merely the limitation which the courts have placed upon the actor's responsibility for the consequences of the actor's conduct."[104] Further definitions discuss proximate cause in terms of whether the defendant could have foreseen that his or her conduct would cause the plaintiff's harm.[105]

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self out as "competent to treat human ailments" must possess minimum requirements of skill and knowledge, and such physician must exercise reasonable care in "ascertaining the operational facts upon which his diagnosis is based. *Id.* He or she must also know the limits of his or her abilities and refer patients to other physicians as necessary. *See id.*

[99] *See* SCHUTZ, *supra* note 91, at 3.

[100] ROBERTSON, *supra* note 30, at 417.

[101] SMITH, *supra* note 31, at 89.

[102] *See generally* PROSSER & KEETON, *supra* note 86, § 32.

[103] *Id., supra* note 80, § 42. Before a court will consider proximate cause, factual, or "but-for" causation, must be established. Generally a question for the jury to decide, " 'cause in fact' embraces all things which have so far contributed to the result that without them it would not have occurred." *Id.* § 41.

[104] *Id.* Moreover, "the legal limitation on the scope of liability is associated with policy . . . ." *Id.*

[105] Specifically, proximate cause has been defined as "the primary or moving cause, or that which, in a natural and continuous sequence, unbroken by any efficient intervening cause produces the injury and without which the accident could not have happened, if the injury be one which might be reasonably anticipated or foreseen as a natural consequence of the wrongful act." BLACK'S LAW DICTIONARY 1225 (6TH ED. 1990). Intervening cause is a concept that intends to assess the "extent of the defendant's original obligation." PROSSER & KEETON, *supra* note 86, § 41. It is a force that "comes into active operation in producing the result *after* the negligence of the defendant." *Id.* The defendant will be held liable for it only if it was " 'foreseeable.' " *Id. See also id.* § 44 (discussing concept of superseding cause, which is a force that will preclude the defendant's liability). "Foreseeable" is a term used to describe intervening causes that are "closely and reasonably related with the immediate consequences of the defendant's act, and form a normal part of its aftermath; and to that extent they are not foreign to the scope of the risk created by the original negligence." PROSSER & KEETON, *supra* note 85, § 42.

As for mental health providers, even if a patient establishes that the therapist's conduct fell below the standard of care, the patient may find it hard to prove that this breach caused the injury.[106] The injuries generally associated with claims in the psychotherapy context are of a "nonphysical or intangible nature."[107] Moreover, "the patient-plaintiff is faced with the arduous task of clearly connecting any alleged emotional harm occurring as a result of psychotherapy to some specific act or omission committed by the therapist."[108] The plaintiff's task of proving that the therapist caused the complained of harm is "arduous" because psychotherapy historically has not involved a lot of "directives,"[109] but instead, has relied on "talking"[110] between patient and therapist. Under this therapeutic paradigm, the therapist would respond to the patient merely through "nods, uh-huhs, or interpretations [of the patient's thoughts]."[111] As a result, it could be "almost impossible" for a court to link these seemingly vague responses to the patient's alleged injury.[112]

By contrast, a patient may be able to prove proximate cause more easily today because therapists may be more inclined to "give directives for concrete action."[113] If so, it is easier "for a court to perceive the links between the therapist's action and injury."[114] The concrete action referred to may involve a therapist's directive to "a father to forcibly carry a recalcitrant adolescent to his room wherever he misbehaves" in order to "reestablish proper hierarchies of authority in a family."[115] Any injury sustained by the father in the process of carrying out the therapist's directives, such as injury caused by his son in retaliation for the father's actions, could be traced back to the therapist more easily than if the therapist had merely responded to the father in a vague, non-directive way.[116]

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[106] *See Mental Health 1990s*, *supra* note 84, at 214.

[107] SMITH, *supra* note 31, at 87.

[108] *Id.* at 89. Causation is possible to prove if, based on the defendant therapist's acts of omission or commission, an expert witness could testify that the standard of care had not been met. *See id.*

[109] SCHUTZ, *supra* note 91, at 6.

[110] *See supra* notes 30-39 and accompanying text (discussing psychotherapy).

[111] SCHUTZ, *supra* note 91, at 6.

[112] *Id.*

[113] *Id.*

[114] *Id. See generally* Edwards v. Tardif, 692 A.2d 1266 (Conn. 1997) (finding defendant practitioner's negligent conduct to be proximate cause of plaintiff's suicide because such suicide was a foreseeable risk to the patient given her medical history and condition).

[115] SCHUTZ, *supra* note 91, at 6.

[116] *See id.* Proving proximate cause may be greatly facilitated if the acts of commission or omission of the psychotherapist are such that an expert psychiatric witness could testify that the psychotherapist had not met the requisite standard of care. This would enhance a plaintiff's allegations that the therapist was negligent and that negligence in some manner caused or aided the patient in sustaining harm or injury. *See* SMITH, *supra* note 31, at 89.

Causation may elude proof for an additional reason. Specifically, because a patient who seeks therapy most likely has mental or emotional problems at the outset, the patient will have a difficult time establishing that the injury occurred because of therapy and not because of the patient's pre-existing condition.[117] Even if the therapist actually caused the plaintiff's injury, this fact may remain obscured "because the symptoms [of the plaintiff's injury] are not often dramatic but limited to the patient's general malaise."[118]

In addition, the patient-plaintiff faces a formidable task in proving that an injury has occurred.[119] Emotional injuries are generally intangible and therefore make it harder for the plaintiff to impress their existence upon a jury.[120] One commentator observed that "'[a] mangled limb or scarred body presents to a jury dramatic evidence of injury; a mangled psyche is much less evident.'"[121] Moreover, the law traditionally has been reluctant to recognize emotional or psychological injuries, unless they are also attended by some manifestation of physical harm.[122] For example, if one suffered mental distress in the wake of a trau-

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[117] *See Mental Health 1990s*, *supra* note 84, at 215. Proximate cause is "easier to prove if the acts in question and the injury "are closely related in time." SCHUTZ, *supra* note 91, at 8.

[118] ROBERTSON, *supra* note 30, at 418.

[119] The following injuries are among those that might be claimed by a mental health patient: exacerbation of presenting symptoms, appearance of new symptoms, patient misuse or abuse of therapy, patients overextending themselves in taking on tasks before they can adequately achieve them, disillusionment with therapy, leading to feelings of hopelessness in getting help from any relationship. *See* SCHUTZ, *supra* note 91, at 6.

[120] *See Mental Health 1990s*, *supra* note 84, at 215.

[121] *Id. See also* SMITH, *supra* note 31, at 87 ("Since psychotherapy primarily involves verbal interaction between a patient and psychotherapist, there is no telltale sign of injury as in the case of a physically related treatment. Therefore, an injury or harm received by a patient as a result of psychotherapy will be emotional or intrapsychic in nature.").

[122] *See Mental Health 1990s*, *supra* note 84, at 215. Under a claim of negligent infliction of emotional distress, the plaintiff attempts to recover damages for mental injury caused by the defendant's negligent conduct. *See* PROSSER & KEETON, *supra* note 86, § 54. While courts historically have awarded damages for emotional harm that resulted in addition to some physical impact or injury initially sustained by the plaintiff, they traditionally exhibited a "reluctance to redress mental injuries" that occurred without a physical cause. *Id.* Hence, the physical injury served as a "peg upon which to hang the mental damages," where such damages were thus appropriately labeled "parasitic." *Id.* In establishing this "impact" rule, courts attempted to secure a "guarantee that the mental disturbance [was] genuine" since "in the absence . . . of genuineness provided by resulting bodily harm, such emotional disturbance may be too easily feigned." RESTATEMENT (SECOND) OF TORTS § 436(a) cmt. b. As such, it was believed that "too wide a door" would be opened to "false claimants who have suffered no real harm at all." *Id.* Moreover, courts balked at allowing recovery for emotional distress alone since the absence of physical manifestations suggested that such distress was "trivial" and thus not deserving of the law's attention. Additionally, because the courts believed that since the mental distress was unattended by physical injury and since it arose purely from the defendant's negligence, there was no compulsion to impose liability upon such defendant. *See id. See*

matic event, such as a car accident, but was otherwise not physically injured, courts would not award damages for mental distress without evidence of physical injury as well.[123] Therefore, unlike a typical medical malpractice claim in which the plaintiff will likely exhibit some physical damage, injury in a mental health claim will be more difficult to establish where no such obvious injury exists.

C. *Contributory Negligence and Other Ways to Elude Liability*

In addition to the aforementioned difficulties, a plaintiff may have to defeat various defenses asserted by the defendant-therapist. Defendants accused of harming plaintiffs through negligent behavior commonly assert contributory negligence and assumption of risk in their defense. Mental health practitioners in malpractice actions frequently rely on contributory negligence.[124]

If successfully raised, contributory negligence will bar the plaintiff from recovering damages in an action for negligence.[125] The defendant must plead and

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also PROSSER & KEETON, *supra* note 86, § 54 (stating three main policy reasons for courts' reluctance to award damages for emotional disturbance alone).

However, "the great majority of courts" have rejected the impact rule and instead allow recovery for mental distress where such distress can be "certified by some physical injury, illness or other objective physical manifestation." *Id.* Under this view, although it is not necessary to prove that physical injury or impact caused the emotional harm, some physical manifestation of the emotional harm must be shown to exist. PROSSER & KEETON, *supra* note 86, § 54. *See, e.g.*, Ellington v. Coca-Cola Bottling Co. of Tulsa, Inc., 717 P.2d 109 (Okla. 1986) (holding plaintiff's vomiting after finding an object resembling a worm in her bottle of soda was sufficient physical manifestation of mental anguish to recover for emotional damages). Confusion still exists as to what "conditions or symptoms should be deemed to qualify as the requisite injury." PROSSER & KEETON, supra note 86, § 54. In recent years, a minority of jurisdictions have allowed recovery for emotional disturbance alone. *See id.* The Restatement expressly bars recovery for mental injury alone, though the trend is moving away from this rigid rule. *See* RESTATEMENT (SECOND) OF TORTS § 436(a). This trend represents a dramatic departure for courts, which previously allowed recovery for emotional injury alone in cases where messages were negligently transmitted and corpses were mishandled. *See* PROSSER & KEETON, *supra* note 86, § 54. *See, e.g.*, Rowe v. Bennett, 514 A.2d 802 (Me. 1986) (holding that a showing of physical harm was not necessary for the plaintiff to collect damages for negligent infliction of emotional distress). *Accord* Molien v. Kaiser, 616 P.2d 813 (Cal. 1980) (holding that plaintiff could recover for emotional distress alone).

[123] *See generally* PROSSER & KEETON, *supra* note 86, § 54 (explaining that "where defendant's negligence alone causes only mental disturbance, without accompanying physical injury, illness or other physical consequences, and in the absence of some other independent basis for tort liability, the great majority of courts still hold that in the ordinary case there can be no recovery").

[124] *See* SCHUTZ, *supra* note 91, at 7 (discussing legal liability in psychotherapy).

[125] *See* RESTATEMENT (SECOND) OF TORTS § 467 (discussing plaintiff's bar from recovery under contributory negligence defense). Today, most states work under a comparative negligence system whereby the plaintiff and defendant share the liability according to

prove that the plaintiff was the factual and legal cause of the harm because plaintiff fell below the standard of reasonable care to which plaintiff should have "conform[ed] for his own protection."[126] The standard within the psychotherapist-patient context is the same because the defendant therapist must prove that the "patient's acts fell below the level of self care that the average person would have exercised under the same or similar circumstances."[127]

In *Cobo v. Raba*,[128] a patient, treated by a psychiatrist for depression, sued the psychiatrist for medical malpractice for misdiagnosis and negligent treatment. The court held that there was sufficient evidence regarding plaintiff's behavior to remand the case to submit to the jury the question of plaintiff's contributory negligence.[129] The court noted that plaintiff had refused to take medication as prescribed and precluded the therapist from taking notes during their therapy sessions.[130] The court found that this behavior constituted "substantial evidence that these actions . . . occurred simultaneously with defendant's negligent treatment and diagnosis to cause [plaintiff's] injuries."[131]

In addition tocontributory negligence, practitioners may defend their actions by establishing that the plaintiff's injury stems from plaintiff's initial condition, not the therapist's actions.[132]

> Because the natural pathological development and prognosis of mental disease is not well known, it is frequently difficult to state to a reasonable degree of medical certainty whether the application or omission of a particular procedure at a specified time caused mental injury to the patient. Thus, it is often difficult for the plaintiff to prove the element of causation.[133]

Finally, therapists may invoke the respectable minority rule to justify the use of a therapeutic technique that might otherwise be considered below the proper

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their respective degrees of fault. For a full discussion, *see* PROSSER & KEETON, *supra* note 86, § 67.

[126] RESTATEMENT (SECOND) OF TORTS § 463. The standard does not apply to children or the insane. *See id.* § 464. The defendant carries the burden of pleading and proving the contributory negligence defense. *See* PROSSER & KEETON, *supra* note 86, § 67. Causation principles governing the causal relationship between defendant's negligent conduct and resulting harm also apply to plaintiff's negligence and resultant harm. *See* RESTATEMENT (SECOND) OF TORTS § 465.

[127] SCHUTZ, *supra* note 91, at 7.

[128] 481 S.E.2d 101, 104 (N.C. 1997). Although psychiatrists treat the body as well as the mind and thus may have more tangible proof with which to defend themselves, the case is nevertheless relevant to situations involving purely psychological treatments because it shows how the defense generally operates. *See supra* notes 30-39 and accompanying text (discussing differences between psychiatry and psychology) and notes 109-18 and accompanying text (discussing problems of proof associated with claims brought against psychologists).

[129] *See id.*

[130] *See id.*

[131] *Id.* at 105.

[132] *See Mental Health 1990s*, *supra* note 84, at 215.

[133] SMITH, *supra* note 31, at 89.

standard of care.[134] By arguing that a respectable minority of therapists practice the technique, a defendant-therapist may be able to obscure the fact that he breached the standard of care and escape liability.[135]

D. *The Uphill Climb: Suing the Conversion Therapist for Negligent Malpractice*

A patient harmed by a negligent psychotherapist faces many obstacles that may prevent the patient from receiving relief for his or her injuries. Gay or lesbian patients may face even more difficulties when they seek such relief. The following fact pattern exemplifies how a gay or lesbian plaintiff who elects to sue a conversion therapist may attempt to overcome these obstacles.

The plaintiff, Jane, is a twenty-one year old college student who attends a major university in the South. She has known from the time she was a small child that she was a lesbian. Jane has never questioned her sexuality and is quite vocal about lesbian rights on her campus.

A couple years ago, Jane experienced acute anxiety due to school and economic pressures. She decided to meet with the campus therapist. The therapist used a form of talk therapy[136] as his primary therapeutic format. During her first session, Jane told him she was a lesbian and made it clear that her anxiety did not stem from her sexuality. She expressly stated that she did not wish to discuss her sexuality during therapy. Although the therapist appeared to accept Jane's explanation, after a few months and numerous sessions, he began to suggest that Jane re-evaluate her sexuality and consider that her lesbianism was the cause of her anxiety. The therapist never attempted to isolate any other cause or causes to explain her anxiety.

Over the next ten sessions, the psychotherapist continued to tell Jane to date men, wear make-up, and spend more time with heterosexual friends. He discussed the possibility that Jane convert to heterosexuality in spite of her repeated complaints that this discussion greatly upset her. Finally, Jane stopped seeing the therapist because she had become extremely depressed. For a year afterwards, Jane experienced acute depression. She lost weight, suffered from insomnia, and periodically contemplated committing suicide.[137] After speaking with an attorney, Jane decided to sue the therapist for the emotional injuries sustained during therapy.

Jane's attorney will sue the therapist for negligent infliction of emotional distress under the broader theory of negligent malpractice.[138] First, her attorney must prove that the therapist owed Jane a duty of care. This will not be in dis-

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[134] *See supra* notes 98-101 and accompanying text (discussing medical schools of thought and respectable minority rule).

[135] *See id.*

[136] *See supra* note 30 (stating that talk therapy is synonymous with psychotherapy).

[137] This represents the kind of information an expert witness would present on behalf of the plaintiff at trial. *See supra* note 90 (discussing expert witnesses).

[138] *See supra* note 122 (discussing negligent infliction of emotional distress).

pute because they entered into an agreement for psychotherapeutic services.[139] Second, the attorney must establish that the therapist fell below the proper standard of care for therapists who treat patients suffering from acute anxiety. An expert witness could help establish that the therapist's practice of conversion therapy fell below the proper standard of care for treating anxiety.[140]

The therapist may rebut this argument by establishing that he belonged to a respectable minority of practitioners who use conversion therapy to treat gay and lesbian patients suffering from anxiety.[141] The therapist would argue that his actions should be evaluated according to the principles of the school of thought to which he adhered.[142] Assuming that the therapist could establish that his school was recognized under "definite principles"[143] and was a "respectable minority,"[144] the therapist could convince the court that he did not act negligently. Even though his treatment did not comport with the school of thought recognized by Jane's attorney, the therapist did not breach the standard of care because he followed the standard set by his particular school of thought. Provided he was not a "quack or a charlatan,"[145] the therapist could successfully defend his actions, especially in light of the mental health profession's flexibility in setting standards of care.[146]

The therapist may further justify his use of conversion therapy on several grounds. First, he might argue that neither the American Psychological Association nor the American Psychiatric Association has banned the use of conversion therapy, suggesting that both organizations approve its use. He would argue that conversion therapy remains a legitimate practice despite the American Psychological Association's resolution requiring conversion therapists to obtain patients' informed consent and the American Psychological Association's statement that conversion therapy is not necessarily efficacious. Furthermore, the therapist could assert that society sanctions the use of conversion therapy as evidenced by the enactment of sodomy statutes throughout the country, the Supreme Court's view that homosexuality is not a fundamental right, and the prevailing religious views which generally reject the gay/lesbian lifestyle.[147] By establishing homo-

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[139] *See supra* note 94 (discussing circumstances under which a psychotherapist will owe a patient a duty of care).

[140] The precise mode of treatment for anxiety is beyond the scope of this Article and the relevant premise here is that it would not entail changing the patient's sexual orientation. *See supra* notes 88-90 and accompanying text (defining standard of care).

[141] *See supra* notes 97-100 and accompanying text (discussing medical schools of thought and respectable minority rule). The use of conversion therapy to treat a presenting condition of anxiety in a gay or lesbian patient is not necessarily one of its known applications. It is merely hypothesized to facilitate the relevant discussion.

[142] *See id.* (discussing schools of thought and respectable minority rule).

[143] *Id.*

[144] *Id.*

[145] *Id.*

[146] *See id.*

[147] Twenty-two states have sodomy statutes. These states are: Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Kansas, Louisiana, Maryland, Massachusetts, Michigan,

sexuality's disfavored status in society, the psychotherapist might lend further support to his respectable minority defense. Last, the therapist may find additional support for his school of thought and type of treatment by exploiting any biases the court or jury may have against gays and lesbians.

Nevertheless, if Jane's attorney proves the therapist fell below the requisite standard of care, the attorney will then have to prove proximate cause.[148] Just as Jane's lesbianism would complicate her attorney's ability to establish breach, it would similarly complicate the establishment of proximate cause.

In considering proximate cause, courts have traditionally analyzed several factors, such as whether it was foreseeable that harm would occur as a result of the conduct and whether any intervening or superseding causes preclude liability.[149] Jane's attorney must prove that the therapist foresaw or should have foreseen that using conversion therapy on Jane had a high probability of causing her harm. This argument is compelling for several reasons. First, most people who practice conversion therapy are likely to be aware of the controversy surrounding it, such as the belief that the therapy can emotionally and psychologically damage patients.[150] Thus, the therapist should have foreseen that Jane would become depressed or experience other adverse reactions. In addition, Jane expressly stated that she was comfortable with her sexuality and asked that they not discuss it in therapy. Jane's statement supports the contention that the therapist should have known that any attempt to discuss, no less alter, her sexuality could be met with a negative response. Nevertheless, any patient who attempts to sue a therapist for malpractice has a difficult time proving proximate cause.[151] Factor in Jane's homosexuality with such considerations and establishing proximate cause becomes even more difficult.

The therapist may use Jane's lesbianism in his defense. Under a ploy typically relied on by therapists to escape liability, the therapist may blame Jane's depression on her initial anxiety.[152] He may argue that Jane's depression resulted from internalized homophobia. Some social scientific literature suggests that gays and

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Minnesota, Mississippi, Missouri, Montana, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas, Utah, and Virginia. Thomas B. Stoddard, *Bleeding Heart: Reflections On Using the Law to Make Social Change*, 72 N.Y.U. L. REV. 967, 991 n.2 (1997). *See* Bowers v. Hardwick, 478 U.S. 186 (1986) (holding that there is no fundamental right to engage in sodomy). *See supra*, notes 40-49 and accompanying text (discussing religious views toward gays and lesbians and related attempts to convert them).

[148] *See supra* notes 101-18 (discussing proximate cause).

[149] *See supra* note 105 (discussing foreseeability).

[150] *See generally* Haldeman, *supra* note 5, at 153 (discussing possibility that conversion attempts may be harmful). *Accord* Richard A. Isay, *Psychoanalytic Theory and the Therapy of Gay Men*, *in* HOMOSEXUALITY/HETEROSEXUALITY: CONCEPTS OF SEXUAL ORIENTATION 285 (David P. McWhirter et al. eds., 1990) (discussing problems that arise in gay men who have undergone conversion therapy, including "severe anxiety, depression, and dysphoria").

[151] *See supra* notes 101-18 (discussing proximate cause).

[152] *See supra* text accompanying note 118 (discussing therapist's tactic whereby he or she blames plaintiff's alleged problems on plaintiff's mental problems).

lesbians internalize homophobia resulting in psychological and emotional disorders.[153] To rebut the foreseeability argument, the therapist might argue that Jane appeared to have a strong sense of self, thus he could not reasonably foresee that she would become depressed by his suggestions to convert.

If Jane's attorney establishes breach and causation, she must now prove that Jane actually sustained injury. Jane's complained of injury is depression, which is a "serious psychiatric illness."[154] Depression is an emotional injury; therefore, because it is intangible, Jane may have a difficult time proving its existence.[155] In light of the fact that many jurisdictions have abolished the rule previously requiring a physical injury before recognizing a mental injury,[156] Jane could most likely establish her injury. Moreover, because Jane exhibited physical manifestations of depression, such as sleeplessness and weight loss, she will have an easier time proving the emotional harm than if she had suffered from emotional injury alone. Jane's claim will be strengthened by social scientific and scientific data showing that conversion therapy psychologically and emotionally damages those upon whom it is used.[157]

In addition to the elements of the negligent malpractice claim, Jane's attorney must plead and prove that her client did not consent to the conversion therapy.[158] Literature on informed consent suggests that plaintiffs rarely win such claims in malpractice suits against psychotherapists. However, the American Psychological Association recently issued a resolution calling for therapists to obtain patients' informed consent prior to using conversion therapy.[159] This resolution provides support for a lawsuit based on the informed consent theory because the American Psychological Association, a powerful industry organization, publicly recognized the importance of giving consent prior to the use of such therapy.[160] Jane was subjected to attempts to change her sexuality without her consent; thus, she could present an argument based on the informed consent theory.

The facts suggest that the therapist proceeded to use conversion therapy even after Jane expressly stated that she did not want to discuss her sexuality and made it clear she was content with her sexuality. However, the issue moves beyond notions of the therapist misrepresenting the possible risks involved in the procedure or failing to represent certain risks associated with the procedure. Rather, the therapist did not disclose the fact that he was going to use this procedure, he merely began using conversion therapy. Therefore, this situation de-

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[153] *See generally*, Haldeman, *supra* note 4, at 150 (discussing idea of homophobia and its corrosive mental effects on gays and lesbians). *Accord,* Isay, *supra* note 149, at 285.

[154] *AMA, supra* note 28, at 344.

[155] *See supra* note 122 (discussing possibility of recovering for emotional injury alone).

[156] *See id.*

[157] *See supra* notes 56-59 and accompanying text (discussing negative aspects of conversion therapy). *Accord,* Isay, *supra* note 149, at 285.

[158] *See supra* note 63 (discussing informed consent).

[159] *See id.* and accompanying text (discussing informed consent).

[160] *See id.* (discussing need for therapist to obtain patient's informed consent prior to using conversion therapy).

fies analysis under the informed consent theory because the procedure itself, conversion therapy, was never discussed.

Despite the therapist's failure to inform Jane of his intent to convert her to heterosexuality, he may argue that he had her implied consent. Jane continued to seek therapy even after she realized that he was trying to convert her. The defendant is "entitled to rely upon what any reasonable man would understand from the plaintiff's conduct."[161] However, "silence does not operate as consent where no reasonable man would so interpret it."[162] Therefore, Jane's attorney would argue that Jane's unequivocal statement that she did not wish to discuss her sexuality made it impossible for any reasonable person to infer that she consented to his attempt to convert her. Her attorney would argue that Jane continued to see the therapist because she wanted to overcome her anxiety even after he began his conversion efforts. Jane could have been in a state of disbelief over what the therapist was trying to do to her because she had spent two months getting to know him before the conversion attempts began, during which time she began to trust and admire him. Jane's first impulse would not be to end therapy because patients in need of therapy are often afraid to second guess the actions of their therapist.[163] Moreover, Jane eventually did leave, which supports the assertion that she did not consent to the therapy.[164]

Even if the therapist shows that Jane inadvertently consented to the therapy, the question remains as to what weight, if any, the court should accord to such consent. Informed consent is based on the idea that "a consent, to be adequate as well as valid, must be given freely."[165] But "[w]hat is the real range of 'free choice' available to homosexually oriented people who are racked with guilt, self-hate, and discrimination[?]"[166] Indeed, how one can give informed consent when "[c]linical experience suggests that any person who seeks conversion therapy may be doing so because of social bias that has resulted in internalized homophobia."[167] Thus, Jane's attorney stands a good chance of proving that Jane

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[161] PROSSER & KEETON, *supra* note 86, § 18.

[162] *Id.*

[163] *See supra* notes 36-38 and accompanying text (discussing impact therapists have on their patients' lives).

[164] If the therapist did in fact succeed in arguing that Jane consented by implication, however, proceeding under a theory that he failed to disclose risks of such therapy, Jane could attempt to plead and prove that the therapist acted negligently under the informed consent theory. Hence, while depression may be a normal reaction to some therapies, if it were not disclosed as such, the therapist could be liable for falling below the standard of care. *See* PROSSER & KEETON, *supra* note 86, § 18. Several experts in the field of psychotherapeutic liability have cast doubt on the likelihood of success in cases alleging failure to obtain informed consent involving psychotherapists: it is "unlikely that significant liability exists for the failure of informed consent in most 'talk therapy,' " *Mental Health 1990s*, *supra* note 84, at 239, and "there have been no reported cases alleging a failure to fully inform with regard to psychotherapy." SMITH, *supra* note 31, at 165.

[165] SMITH, *supra* note 31, at 175.

[166] Davison, *supra* note 19, at 144.

[167] *APA Fact Sheet*, *supra* note 6, at 1.

did not consent to the conversion therapy.

One final concern, Jane must consider is the cost of divulging her private life were she to go to trial. While the facts of the hypothetical make it clear that she has not attempted to hide her sexuality, it may nevertheless deepen her depression to have to discuss the details of her private life in public, just as it would be for any plaintiff, gay or straight.[168] Jane must weigh the benefits of suing the therapist against these potentially negative factors.

In sum, for a plaintiff to successfully bring a claim of negligent malpractice against a psychotherapist is difficult at best. Although the plaintiff's arguments are relatively compelling, the defendant is able to match them with arguments of commensurate force. A plaintiff who wishes to hold a conversion therapist liable under a negligent malpractice theory faces the difficulties inherent in establishing mental health claims as well as those attendant to the disfavored status of homosexuality under the law and in society generally.

E. *Intending to Cause Severe Emotional Harm*

Potential plaintiffs need another means of holding a conversion therapist liable for his or her actions because assigning liability to a conversion therapist under a negligence theory is a formidable task. Plaintiffs should consider the intentional tort of intentional infliction of emotional distress ("IIED").

IIED represents the ideal paradigm under which to sue the conversion therapist. The very nature and substance of the therapy easily satisfies each element of the tort. The sole aim of conversion therapy is to eradicate homosexuality. Thus, it is hardly an understatement to allege that such conduct is "extreme and outrageous."[198] A plaintiff can similarly satisfy each of the remaining elements. Therefore, as long as the goal of conversion therapy remains the same, and as long as gays and lesbians require relief for harm caused by it, a new cause of action should be considered to facilitate such relief.

The cause of action should allow the aggrieved plaintiff to hold the conversion therapist liable under an IIED theory merely on a showing that such therapist engaged in the practice of the therapy, as opposed to requiring the plaintiff to prove each element of the tort.[170] The rationale behind such a claim is that once it has been established that conversion therapy constitutes IIED, it would be unnecessary to prove this fact over and over again. To the extent that the therapy retains its goal of eradicating homosexuality, it will perpetually amount to conduct that is extreme and outrageous, intentionally causing severe emotional distress.

To allay fears that the proposed cause of action would invite frivolous claims given the relatively low quantum of proof required, several arguments may be

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[168] *See supra* notes 80-83 and accompanying text (discussing reasons patients are reluctant to sue therapists).

[169] *See infra* notes 169-82 and accompanying text (defining IIED).

[170] This manner of proceeding is predicated upon the assumption that an initial case has been brought in which each element of IIED has been satisfied.

advanced. First, because the population consists of a disproportionately smaller number of gays and lesbians than heterosexuals, the number of potential cases is minimized. Moreover, only a fraction of the already comparatively small gay/lesbian population may bring claims against conversion therapists, thus, it is not likely that the dockets will be flooded with claims. The proposed cause of action is more than justified because conversion therapists are free to practice the therapy with virtually no controls. In addition, because gays and lesbians have few, if any, protections under the law, justice mandates that the balance be weighed in favor of providing an efficient, accessible means by which gays and lesbians may protect themselves.

To make out a claim for IIED, the plaintiff must prove that the defendant engaged in (1) extreme and outrageous conduct (2) that intentionally or recklessly caused (3) severe emotional distress to another.[171] The Comment to the Restatement explains that extreme and outrageous conduct is that which goes "beyond all possible bounds of decency," is both "atrocious" and "utterly intolerable in a civilized community,"and would lead an average member of the community to exclaim, "Outrageous!", upon hearing the facts of the case. [172] Alternatively, courts have assessed whether a defendant's conduct has been "extreme and outrageous" by considering whether he or she knew that "the plaintiff [was] especially sensitive, susceptible and vulnerable to injury through mental distress at the particular conduct."[173] If so, the defendant's conduct would satisfy the extreme and outrageous element.

The plaintiff may meet the second element of the tort by proving that the defendant acted either intentionally or recklessly. First, the plaintiff may show that the defendant either "desire[d] to inflict severe emotional distress" on the plaintiff or that he or she had knowledge that emotional distress was "certain, or substantially certain, to result from [the] conduct."[174] Alternatively, the plaintiff may prove that the defendant acted recklessly, willfully or wantonly.[175] In order to do so, the plaintiff must demonstrate that the defendant knew there was a "high degree of probability that the mental distress will follow" from his or her actions but proceeded to act nevertheless.[176]

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[171] *See* RESTATEMENT (SECOND) OF TORTS § 46(1) (1965).

[172] *Id.* cmt. d.

[173] PROSSER & KEETON, *supra* note 86, § 12. *See, e.g.,* Nickerson v. Hodges, 84 So. 37 (La. 1920) (plaintiff allowed to recover for mental distress where defendants, knowing she had mental problems, led her to believe a pot filled with dirt was really a pot filled with gold, caused her to be publicly humiliated upon finding out the truth). Still a third way to test for the outrageousness of the defendant's conduct is to determine whether the defendant abused a position giving him actual or apparent power to harm an interest of the plaintiff. *See* RESTATEMENT (SECOND) OF TORTS § 46 cmt. e (1965).

[174] RESTATEMENT (SECOND) OF TORTS § 46 cmt. i (1965).

[175] *See* PROSSER & KEETON, *supra* note 86, § 12.

[176] *See, e.g.,* Blakely v. Shortal's Estate, 20 N.W.2d 28 (Iowa 1945) (plaintiff could recover for emotional distress after defendant cut his throat in plaintiff's kitchen in spite of the strong possibility that plaintiff would find his body).

To satisfy the final element, emotional harm, the "emotional distress must in fact exist, and it must be severe."[177] As such, "mere insults, indignities, threats, annoyances, petty oppressions, or other trivialities" will not constitute severe emotional distress.[178] In claims brought under an IIED cause of action, courts have been amenable to finding that severe emotional harm exists even where no physical signs of harm exist.[179] These courts rely on evidence of the extreme outrageousness of the act as a way of assuring that the complained of harm is in fact severe and genuine.[180] In addition to finding that the emotional harm was severe, courts also require that "reasonable person of 'ordinary sensibilities' " would suffer the type of mental distress the plaintiff has suffered as a result of the defendant's actions.[181] This standard does not apply in cases where the defendant possesses special knowledge of the plaintiff's susceptibility to injury.[182] Defendants accused of intentional infliction of emotional distress, such as conversion therapists sued by gay or lesbian plaintiffs, may defend themselves by arguing that they obtained the patient's informed consent.[183]

F. *"Outrageous!": The Case Against Conversion Therapy*

Using the same fact pattern, Jane's attorney must first show that the therapist's behavior constituted extreme and outrageous conduct. Given our generally homophobic society, the chance is slim that an average member of the community would exclaim, "Outrageous!", upon hearing that a therapist tried to turn a lesbian into a heterosexual. Thus, Jane's attorney should use a different approach. Jane's attorney would allege that the therapist had knowledge that Jane was "especially sensitive, susceptible and vulnerable to injury through mental distress at the particular conduct."[184]

An argument under this standard could proceed from allegations that because the therapist knew Jane was a lesbian, he knew she would be vulnerable to attempts to change her sexuality. Jane's attorney would assert that Jane's susceptibility to mental injury from the therapist's conduct was known to him since studies have proven the harmful effects conversion therapy can have on pa-

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[177] PROSSER & KEETON, *supra* note 86, § 12.

[178] *See* RESTATEMENT (SECOND) OF TORTS § 46 cmt. d (1965).

[179] This appears to be the trend among modern courts. *See* PROSSER & KEETON, *supra* note 86, § 12 (stating that there are numerous decisions in which courts have found the defendant liable for mental disturbance alone). The Restatement rejects any absolute necessity for physical manifestations of the harm. RESTATEMENT (SECOND) OF TORTS § 46 cmt. k. *See, e.g.*, State Rubbish Collectors Ass'n v. Silizinoff, 38 Cal. 2d 330 (1952) (defendant found to have sustained severe emotional harm where he was threatened with physical violence and the ruination of his business, though he suffered no physical harm).

[180] *See* RESTATEMENT (SECOND) OF TORTS § 46 cmt. k (discussing evidence of extreme outrage as way of assuring that the claim of harm is neither "feigned nor trivial").

[181] *See id.*

[182] *See id.*

[183] *See supra* note 62 and accompanying text.

[184] *See supra* note 172 and accompanying text.

tients.[185] Conversion therapists are undoubtedly aware of the volatile controversy surrounding their actions. The therapist would have known about such studies. Thus, he would have known the potential for Jane to suffer harm from his conduct.

Moreover, Jane's attorney would argue that because Jane had confided her lesbianism to the therapist and asked him not to discuss it during therapy, the therapist knew she would suffer mental distress at his attempts to convert her. The therapist obviously ignored Jane's wishes. Thus, the therapist would inflict harm because he tried to convert her against these wishes and against her express statement that she was content with her existing sexuality. He exploited her vulnerability and breached whatever trust might have existed between them. For these reasons, Jane's attorney could successfully argue that the therapist knew she was susceptible to mental harm through his conduct.

The therapist may argue that Jane consented to the therapy. However, this argument would not succeed even if he proved she gave her implied consent because he was negligent in failing to warn her of the treatment's side effects.[186] It is doubtful the therapist would even get this far because Jane obviously did not give her consent, as evidenced by her explicit statement that she did not wish to discuss her sexuality during therapy. In sum, it is a distinct possibility that Jane's attorney could prove that the conversion therapist's actions rose to the level of extreme and outrageous conduct.

To prove that the therapist "intentionally or recklessly caused harm" to the Jane, Jane's attorney would argue that he knew Jane's mental distress was "certain or substantially certain" to result from his conduct as opposed to arguing that he "desired to bring about the harm." It would be easier for Jane's attorney to prove the former standard because there is no evidence with which to prove the latter.[187] The attorney would use a similar line of reasoning to prove this element as she did to prove the first element.

Jane's attorney would argue that the therapist knew Jane was a lesbian, that she had come to him in a vulnerable state seeking professional help, that she had explicitly requested he not discuss her lesbianism, and that it was common knowledge that conversion therapy has caused emotional harm to gays and lesbians. Therefore, his attempt to change her sexuality would be certain to cause her great emotional distress. Perhaps the therapist's only defense would be to argue that Jane's continuing to engage in therapy after the conversion attempts began constituted implied consent. This argument would most likely fail. Thus, Jane's attorney would satisfy the second element.

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[185] *See supra* notes 57-59 (discussing the reinforcement of homophobia through the use conversion therapy).

[186] *See supra* note 62 and accompanying text (discussing informed consent).

[187] On a theoretical level, conversion therapy seeks to destroy and "harm" the concept of homosexuality; therefore, to the extent that gays and lesbians identify with homosexuality, it could be argued that conversion therapists intend to destroy, and thus, severely harm gays and lesbians.

Finally, to prove that Jane suffered severe harm, her attorney would rely on several arguments. First, Jane's complained of injury is depression, which is an emotional harm.[188] Second, even though not required under IIED, Jane's harm has physical manifestations, including sleeplessness and weight loss.[189] Thus, the seriousness of the depression could be attested to: concrete evidence exists to prove the last element.

The foregoing analysis provides an example of what a plaintiff may encounter in the courtroom were he or she to sue a conversion therapist under an IIED theory. Under the proposed cause of action, all future plaintiffs would be spared the burden of pleading and proving each element, assuming that a similarly-situated plaintiff were to successfully litigate an initial, paradigmatic case. Moreover, even if the circumstances in each subsequent case were to vary somewhat from those in the initial case, to the extent that each case centers on the plaintiff's effort to redress an injury resulting from attacks on his or her homosexuality, such differences would prove irrelevant. Thus, the need to prove anew that conversion therapy constitutes extreme and outrageous conduct resulting in severe harm would be rendered unnecessary.

IV. CONCLUSION

If not for the continued branding of gays and lesbians as suffering from an illness, there would be little reason to offer such persons a "cure." The need to hold conversion therapists liable for their actions arises out of the need to protect gays and lesbians from one more type of homophobic attack. Until organizations such as the American Psychiatric and Psychological Associations issue an unconditional ban on the practice of conversion therapy, the cause of action proposed herein serves as a possible mechanism by which to both thwart and redress such attacks. The well-documented attempts to change homosexuality are little more than thinly-veiled efforts to eliminate it by homophobic zealots who act under the shameless guise of beneficence and the flimsy aegis of professionalism. The law cannot tolerate this.

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[188] *See supra* note 152 (defining depression).

[189] *See supra* notes 176-80 and accompanying text (defining criteria by which harm may be found under IIED).