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Conversion Therapy: An evidence assessment and qualitative study

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Executive Summary

Executive summary

Background

The UK Government has committed to exploring legislative and non-legislative options for ending so called 'conversion therapy'. In this report the term 'conversion therapy' is used to refer to any efforts to change, modify or supress a person's sexual orientation or gender identity irrespective of whether it takes place in healthcare, religious or other settings.

The aim of this research was to improve understanding of the practice and to address the following four research questions:

1. What forms does conversion therapy take?
2. Who experiences conversion therapy and why?
3. What are the outcomes of conversion therapy?
4. What measures have been taken to end conversion therapy around the world?

In order to answer Questions 1-3, a rapid evidence assessment was conducted examining research published from January 2000 to June 2020. Forty-six published studies were identified. Most of the evidence identified was specifically focused on conversion therapy aimed at changing sexual orientation, with only five articles that specifically addressed conversion therapy to change gender identity. A qualitative study was also conducted to gather evidence on the experiences of people in the UK who had undergone conversion therapy. Thirty individuals were interviewed (16 men, 12 women, 2 non-binary persons) who had experienced sexual orientation change efforts (24), gender identity change efforts (3) or both (3).

To answer Question 4, an additional search of the grey literature was conducted to identify measures taken around the world to end conversion therapy.

Key Findings

1. What forms does conversion therapy take?

- Evidence suggests that modern forms of conversion therapy are commonly based on a belief that same-sex sexual orientations and transgender identities are developmental disorders, addictions and/or a spiritual problem.
- The most common methods identified involved a combination of spiritual (e.g. prayer 'healing'/exorcisms, pastoral counselling) and psychological methods (e.g. talking therapies). The boundaries between religious and psychological approaches are often unclear with many combining the two in a way that could be described as pseudo-scientific.
- Conversion therapy appears to most commonly be delivered in religious settings by religious individuals or organisations but may also be delivered by mental health professionals or family members. In some cases, secular mental health professionals may

treat minority gender identities (e.g. non-binary) or minority sexual orientations (e.g. asexual) as symptoms of existing mental health conditions; it is unclear how often this is a deliberate attempt at conversion therapy.

- There is less evidence relating to gender identity change efforts but what evidence there is suggests that conversion therapy with transgender people can take a very similar form to that aimed at changing sexual orientation.

2. Who experiences conversion therapy and why?

- There is no representative data on the number of lesbian, gay, bisexual and transgender (LGBT) people who have undergone conversion therapy in the UK, however some evidence appears to suggest that transgender people may be more likely to be offered or receive conversion therapy than cisgender lesbian, gay or bisexual people.
- There is consistent evidence that exposure to conversion therapy is associated with having certain conservative religious beliefs.
- Common reasons given for seeking out conversion therapy are:
    - a perceived irreconcilability between one's religious values and one's sexual orientation or gender identity
    - a desire to belong and feel 'normal' within a community
    - external pressure or coercion by family members or people from one's faith community
- Some people report that while they underwent conversion therapy voluntarily, they feel these 'choices' were shaped by powerful influences in their social environment and under guidance from authority figures.

3. What are the outcomes of conversion therapy?

- There is no robust evidence to support claims that conversion therapy is effective at changing sexual orientation or gender identity. Some of the largest studies report little to no reported change in sexual orientation and reports of success are unpersuasive due to serious methodological limitations and sometimes major flaws in study designs. No studies examining the effectiveness of conversion therapy aimed at changing gender identity were identified within the search period (2000 – 2020).
- Evidence of harm associated with conversion therapy outweighs reports of some benefits such as social support and a sense of belonging. Furthermore, the reported benefits are common to most forms of talking therapy or support groups and could be provided by other, more affirmative, approaches that mitigate risks of harm.
- There is a growing body of quantitative evidence that exposure to conversion therapy is statistically associated with poor mental health outcomes including suicidal thoughts and suicide attempts. This body of evidence is larger for sexual orientation change efforts; however, one recent study has also found that gender identity change efforts are associated with similar negative health outcomes. Although care needs to be taken when

making causal inferences, qualitative studies have found that those who have undergone conversion therapy attribute such feelings to the conversion therapy. The majority of those interviewed in this study described experiencing conversion therapy as harmful, including reports of self-harm and suicidal thoughts. Plausible explanations for such harms include that conversion therapy exacerbates internal conflicts rather than resolves them and reinforces stigma associated with minority sexual orientations or gender identities.

4. What measures have been taken to end conversion therapy around the world?

- Most interventions employed by states to combat conversion therapy appear to apply to both sexual orientation and gender identity change efforts. Some apply to sexual orientation change efforts only.
- A range of legal and regulatory interventions have been introduced internationally to restrict conversion therapy. These vary in scope and have targeted a variety of sectors either individually or in combination (e.g. healthcare contexts, religious contexts, advertising).
- There have been several legal challenges to bans in the USA; however, no judicial decision to date has overturned a ban on conversion therapy.
- A conversion therapy ban has been successfully applied to sanction a life coach offering conversion therapy in Madrid, which has one of the world's most comprehensive laws on conversion therapy.

Conclusions

Modern forms of conversion therapy appear to largely take the form of talking therapies and spiritual interventions. There is evidence that these forms of conversion therapy can be harmful but there is no robust evidence that identifies whether certain techniques or practices used by conversion therapists are more or less harmful than others. The evidence base is larger for sexual orientation change efforts than for gender identity change efforts.

A growing number of legal jurisdictions are legislating to restrict conversion therapy. The scope of such laws varies and due to many legislative measures being relatively recent there is little evidence on what are the most effective policies for ending conversion therapy.

Introduction

1. Introduction

1.1 Policy context

The National LGBT Survey 2017 found that, of the 108,000 people who responded to the survey, 2% had previously undergone conversion therapy in an attempt to 'cure' them of being LGBT, and a further 5% had been offered it (Government Equalities Office, 2018). Transgender respondents were more likely to have reported having undergone or been offered conversion therapy (13%) than cisgender respondents (7%). In addition to these findings, there is a growing body of evidence which suggests that attempts to change a person's sexual orientation or gender identity can cause serious harm.

From an international perspective, a number of states - including Canada, Germany, Malta, Republic of Ireland, Australia and various US states have passed legislation or are bringing forward legislative and other measures to combat conversion therapy. The United Nations Independent Expert on protection against violence and discrimination based on Sexual Orientation and Gender Identity has considered the human rights implications of conversion therapies and called for such practices to be banned across the globe (IESOGI, 2020).

In 2018, Government committed to exploring legislative and non-legislative options for ending so-called 'conversion therapy' in the UK. The Government Equalities Office (GEO) commissioned this research to inform policy development on the legislative and non-legislative options for ending conversion therapy in the UK.

1.2 Background

'Conversion therapy' is commonly used as an umbrella term to refer to efforts to modify a person's sexual orientation or gender identity. It goes by many other names including 'reparative therapy', 'sexual reorientation therapy' and 'ex-gay therapy'. The word 'therapy' may not accurately reflect the nature of conversion efforts which may take the form of religious practices rather than using 'therapeutic' approaches. Within the scientific literature, the terms 'Sexual Orientation Change Efforts' (SOCE) and 'Gender Identity Change Efforts' (GICE) are used to refer to all conversion efforts including medical, psychological or religious approaches (see Appendix 1 for a glossary of terms used in this report).

So-called 'conversion therapy' was originally conceived in the early to mid-twentieth century at a time when homosexuality and (what was then referred to as) 'transsexualism' were considered mental disorders. Such therapies were administered by mental health professionals, sometimes by court-mandate (e.g. Alan Turing), and included methods such as aversive behavioural techniques (e.g. using electric shocks or chemically induced nausea), hormone therapy (e.g. 'chemical castration'), hypnosis and psychotherapy (King & Bartlett, 1999).

Today, same-sex sexual orientations and transgender identities are considered a normal part of human variation and are not included as mental disorders within the latest edition of the World

Health Organization's International Classification of Diseases. Most evidence-based recommendations for working therapeutically with LGBT people in distress endorse psychological approaches that provide unconditional acceptance, identity exploration and social support to help them work through difficult emotions (American Psychological Association, 2009a, 2009b, 2012, 2015; British Psychological Society, 2019; King et al., 2007). Many UK psychotherapy, counselling and health professional bodies have signed a Memorandum of Understanding which sets out a joint position that conversion therapies are unethical and potentially harmful[1].

Over 60 health professional associations across more than 20 countries have adopted position statements against conversion therapies (ILGA World, 2020). Some religious institutions are beginning to adopt similar positions. In 2017 the Church of England's national assembly voted to endorse a memorandum against conversion therapy. A growing number of former leaders of 'ex-gay' organisations have also publicly rejected their effectiveness and warned about the harms produced by the methods they were involved in delivering (ILGA, 2020).

1.3 Aims of the report

The aim of this research is to improve understanding of the practice, experience and effect of conversion therapies. The research seeks to address the following four research questions:

1. What forms does conversion therapy take?
2. Who experiences conversion therapy and why?
3. What are the outcomes of conversion therapy?
4. What measures have been taken to end conversion therapy around the world?

[1] Memorandum of Understanding on Conversion Therapy in the UK Version 2 October 2017 (see also Drescher, 2002 for a discussion of ethical issues).

Method

2. Method

In order to answer the research questions, a rapid evidence assessment (REA) on the topic was conducted together with a qualitative study with individuals who had undergone conversion therapy in the UK. The approach taken is summarised in this chapter (for full details see Appendix 2).

2.1 Rapid Evidence Assessment and review of international practice

An REA was conducted based on guidance produced by the EPPI-Centre for Civil Service on Rapid Evidence Assessment (Civil Service, 2014). The search was limited to empirical papers published in academic journal articles, by professional organisations or government bodies that were available in English to answer the first three research questions (RQ1, RQ2, RQ3).

The search was time-limited to literature published from 1 January 2000 to 30 June 2020. Search terms were selected based on those used in previous reviews of conversion therapy in consultation with a specialist subject librarian and agreed with the Government Equalities Office (GEO) prior to running the search. Inclusion and exclusion criteria were applied resulting in 46 articles and reports being included in the review. Most of the evidence identified focused specifically on sexual orientation change efforts (SOCE) with only five articles specifically addressing gender identity change efforts (GICE) and one report that addressed both (see Table 1 for a summary of article characteristics).

Table 1: Summary of article characteristics

Characteristic	Sexual Orientation Change Efforts (SOCE) 40 articles	Gender Identity Change Efforts (GICE) 5 articles	Both SOCE and GICE 1 article
Geography	35 North America 2 South Africa 1 UK 1 Poland 1 China	4 North America 1 UK	1 UK
Design	19 Qualitative 19 Quantitative 2 Systematic reviews	1 Qualitative 3 Quantitative 1 Systematic review	1 Quantitative
Topic	6 Prevalence and characteristics of those who undergo SOCE 4 Associations between exposure to SOCE and harmful outcomes	1 Prevalence and characteristics of those who undergo GICE 1 Associations between exposure to GICE and harmful outcomes	1 Prevalence and characteristics of those who undergo conversion therapy

	6 Effectiveness at changing sexual orientation 2 Conversion therapists' views and framing of SOCE 2 Quality assessments of evidence 1 Health professionals' views on SOCE 18 Experiences of conversion therapy	1 Nature of conversion therapy practices 1 Conversion therapists' views and framing of GICE 1 Perceptions of different therapy responses among transgender participants	
Quality	Overall tended to be of average quality. Effectiveness studies tended to be lower quality due to design limitations.	Overall tended to be above average quality	Average quality

An additional search of the grey literature was conducted to answer RQ4 relating to measures taken around the world as none of the studies from the academic literature could adequately answer this question or provide up-to-date information.

2.2 Qualitative interviews

For the qualitative study, 30 individuals with experience of conversion therapy in the UK were interviewed. Prior to data collection, ethical approval was granted through Coventry University's institutional ethics procedures. Interviews took place between April and July 2019. Interview questions were developed based on the study objectives and initial findings from the REA, in consultation with GEO.

Participants were recruited via a range of methods including social media, through contacting a wide range of stakeholder (e.g. LGBT, religious and healthcare) organisations and the use of fliers at several Pride festivals. Potential participants were directed to a screening survey to register their interest in taking part in the project where they were provided with full information about the research and links to sources of support.

Participants were screened for eligibility. To be eligible participants must have had first-hand experience of conversion therapy in the UK within the last twenty years. Of the 30 interviewees, 20 had experienced conversion therapy within the last 10 years, with the remaining having experienced conversion therapy between 10 and 20 years ago[2]. Two interviewees were

[2] Some interviewees had experienced conversion therapy more than once or over a prolonged period. None of the interviewees' experiences included historic forms of aversion therapy. No major differences were noted in the

undergoing conversion therapy at the time they were interviewed. Twenty-eight lived in England, one in Scotland and one in Northern Ireland. The majority of interviewees lived in urban areas (26). The sample was predominantly white (28) and Christian (22) despite attempts to reach out to people from ethnic minority backgrounds and from other faith groups. A summary of sample characteristics is provided in Table 2 below.

Table 2: Overview of interviewee characteristics

Sample characteristics	
Age	20 – 60 years (average 39 years)
Gender	16 Men 12 Women 2 Non-binary people
Gender identity	24 Cisgender 6 Transgender/non-binary
Sexual orientation	19 Lesbian/Gay 2 Bisexual 3 Heterosexual[3] 1 Pansexual 4 Asexual 1 Other ('same-sex attracted')
Ethnicity	28 White 1 Black 1 Mixed/multiple ethnic group
Religion	22 Christian 5 No religion 2 Agnostic 1 Gaian
Aim of conversion therapy	24 SOCE 3 GICE 3 Both

All interviewees were provided with relevant information and signposted to sources of professional support and helplines.

experiences of those who had undergone conversion therapy in the last 10 years compared to those who had experienced it 10-20 years ago. Several individuals were excluded from the study as part of the screening process as they did not fit our working definition of conversion therapy (e.g. the treatment they underwent did not aim to change their sexual orientation or gender identity).

[3] Of those who indicated that their sexual orientation was 'heterosexual' two had previously identified as gay while one was a heterosexual transgender interviewee.

2.3 Limitations / Interpreting this research

- The inclusion criteria for the REA was limited to research published in academic journals, by professional bodies and Government departments (see Appendix 2 for full inclusion criteria). Grey literature not captured in the REA such as undercover journalistic investigations (e.g. Brand, 2018; Strudwick, 2011) and surveys published by charities and other organisations (e.g. Bachmann & Gooch, 2018; Ozanne Foundation, 2019) may provide important sources of evidence regarding the forms that conversion therapy takes in the UK.
- No randomised control trials (RCTs) have been conducted in relation to the effectiveness or harmfulness of conversion therapy. The studies included in the REA therefore fall short of the 'gold standard' in clinical evidence for assessing effectiveness, primarily due to the following key methodological limitations (see Appendix 2 for an overview of each):
    - A lack of prospective, controlled study designs that can robustly examine causal relationships
    - A reliance on retrospective self-reporting
    - A reliance on self-selected and potentially biased samples
    - A lack of longitudinal studies that follow individuals over time
    - The use of different (and often unreliable) measures of 'success'
    - The inclusion of a wide variety of conversion therapy approaches

  However, it should be noted that it would be practically and ethically difficult to conduct RCTs on forms of conversion therapy. It is therefore unlikely that there will ever be 'gold standard' evidence upon which to base policy and this report is based on the best available evidence.
- There is relatively little published evidence available regarding gender identity change efforts and only a small number of those interviewed for this study had undergone gender identity change efforts.
- As people who have undergone conversion therapy are a hidden population, the interview study necessarily relied on a self-selecting sample and recruitment strategies used may have introduced sampling biases; this is unavoidable. It is also based on a relatively small sample. It is not possible to determine how representative the findings are to the wider population of those who have undergone conversion therapy. In addition to the limited number of transgender participants, a lack of ethnic minority interviewees also limits the generalisability of the findings.
- The qualitative findings are based on retrospective self-reporting. Such accounts may not always be entirely accurate due to the vagaries of memory. It is possible that the providers of the so-called 'conversion therapy' may recollect a different version of events. In 10 cases, their experience of conversion therapy was between 10-20 years prior to the study and so their memory of these episodes may become distorted over time or their experiences may not represent current practices.
- Quotes from interviewees have been used in this report to illustrate key findings and to provide specific examples of the experiences of people in the UK. Quotes have been

labelled to indicate their sex registered at birth and self-reported gender (e.g. cisgender man, transgender woman), their self-reported sexual orientation (e.g. lesbian, gay, bisexual), their age range (e.g. 20s, 30s) and whether they had undergone sexual orientation change efforts (SOCE) or gender identity change efforts (GICE).

What forms does conversion therapy take?

3. What forms does conversion therapy take?

This chapter outlines common beliefs among those who provide conversion therapy, the frameworks and techniques used, as well as different settings and providers of conversion therapy. Findings from the published literature are presented followed by evidence from interviews conducted for this report to illustrate what forms conversion therapies take in the UK.

3.1 Overview

- Conversion therapists typically conceptualise same-sex sexual orientations and transgender identities as:
    - Spiritual problems (e.g. caused by sin or demonic forces)
    - Developmental disorders (e.g. caused by childhood trauma)
- Conversion therapy methods commonly take the following forms:
    - Spiritual techniques (e.g. prayer/exorcism, pastoral counselling)
    - Psychological techniques (e.g. talking or behavioural therapies)
    - Often the above are combined in pseudo-scientific forms of religious counselling
- Conversion therapy occurs in a range of settings, typically by religious individuals or organisations.
- There is evidence that in mental health settings there are some (potentially rare) cases of minority sexual orientations (asexual) and gender identities (transgender and non-binary) being misinterpreted as symptoms of a mental disorder.
- Qualitative evidence gathered for this report suggests conversion therapy occurs in much the same way in the UK as in the USA.

3.2 What conversion therapists believe

3.2.1 Findings from REA

This section draws on a heterogeneous body of evidence including a survey of conversion therapists (Nicolosi, Byrd & Potts, 2000a), studies analysing reparative therapy websites and materials (Arthur, McGill & Essary, 2013; Mikulak, 2020; Robinson & Spivey, 2019) and qualitative studies with people who have undergone conversion therapy (Beckstead, 2002; Beckstead & Morrow 2004; Fjelstrom, 2013; Flentje, Heck & Cochran, 2013; Flentje, Heck & Cochran, 2014; Johnston & Jenkins, 2006; Mikulak, 2020; Schroeder & Shidlo, 2002; Shidlo & Schroeder, 2002; Van Zyl, Nel & Govender, 2017; Van Zyl, Nel & Govender, 2018). Most of this research originates from North America and may not reflect how conversion therapy operates in all parts of the world today.

What all forms of conversion therapy have in common is the goal of 'helping' people attempt to resist, minimise or change their same-sex or transgender behaviours, thoughts or feelings (Nicolosi, Byrd & Potts, 2000a). Relatively little research has been conducted directly on the beliefs of conversion therapists, although this can be gathered to some degree from literature published by conversion therapists themselves and reports from those who have undergone conversion therapy. Common themes that runs through this literature are that many conversion therapists **believe that being lesbian/gay/bisexual or transgender is a mental disorder and can be altered or 'healed'.** Many also have religious **beliefs that God intends for everyone to be heterosexual and cisgender**[4]**.** One US-based survey of 206 conversion therapists' beliefs, conducted by prominent conversion therapy advocates, found that (Nicolosi, Byrd & Potts, 2000a):

- 97% 'strongly' or 'mostly' agreed that a homosexual client may be capable of change to a heterosexual orientation
- 93% 'strongly' or 'mostly' agreed that homosexuality was a developmental disorder
- 90% 'strongly' or 'mostly' agreed that the American Psychiatric Association's decision to declassify homosexuality as a mental disorder in 1973 was politically motivated
- 63% believed it can be helpful to bring prayer into the therapeutic setting

The authors noted that many of the conversion therapists also viewed same-sex sexual behaviour as 'an addiction'. Although, this was based on a self-selected sample and published in 2000, these findings are in line with what we know from literature written by influential conversion therapists, including one of the study's authors[5].

These findings are also consistent with published qualitative evidence in which those who have undergone conversion therapy report being told by therapists that homosexuality is a developmental disorder, a symptom of sexual addiction or is otherwise intrinsically disordered (e.g. Fjelstrom, 2013; Schroeder & Shidlo, 2002).

The survey by Nicolosi, Bryd and Potts (2000a) also found that 82% of conversion therapists strongly or mostly agreed that homosexuality is a 'gender identity problem'. This is consistent with studies examining gender identity change efforts which find that many **conversion therapists routinely conflate issues of sexual orientation and gender identity**, viewing them as different manifestations of 'gender identification deficits' and drawing on similar causal theories (Robinson & Spivey, 2019; Wright, Candy & King, 2018)[6]. As with same-sex sexual orientations, conversion therapists tend to view transgender identities as arising from impaired development, deficient caregiver role models or childhood trauma (Wright, Candy & King, 2018).

[4] Most of the evidence has examined conversion therapy in Christian or Jewish contexts, although such beliefs may also be a feature of other religions.

[5] For instance, the term 'reparative therapy' (developed by Joseph Nicolosi) conveys the idea held by conversion therapists that same-sex sexual orientations are caused by an unconscious attempt to 'repair' unmet needs and gender identification deficits (Nicolosi, 1991; Nicolosi, 2001).

[6] For example, the British theologian Elizabeth Moberly (1983), whose work influenced reparative therapists such as Joseph Nicolosi, stated that "transsexualism in both sexes has the same psychodynamic structure as homosexuality. The difference is essentially one of degree, not of kind" (p. 12-13).

3.2.2 Findings from qualitative research

These general beliefs were also reported within interviews with people in the UK gathered for this report. Interviewees commonly reported that the person delivering it **believed that their sexual orientation or gender identity was a problem of childhood development or trauma**. Interviewees reported that the person performing the conversion efforts **used the term 'brokenness'** to describe their sexual orientation or gender identity and the term 'healing' was often used when referring to changing their sexual orientation or gender identity. They also reported conversion therapists **attributed feelings of unhappiness to a 'homosexual lifestyle'** rather than as a result of their internal conflict and internalised stigma. Interviewees reported that changing their sexual orientation or gender identity was not always explicitly the aim (the focus was sometimes more on modifying sexual behaviour) but that the person providing the conversion therapy believed change was a possibility. Some interviewees who experienced conversion therapy in religious settings also said that providers **attributed same-sex sexual orientations to demonic forces** or sins of previous generations. And in some cases, religious providers would draw on a combination of pseudo-psychological and spiritual explanations as illustrated below.

> "[According to those providing conversion therapy] it was all because I had a poor relationship with my dad, and there was no affection in the relationship with my father, that was the constant theme that went through both the organisations that I was working with…And again that was linked to the relationship with my father, that allowed the demons to take hold."
>
> *Cisgender man, gay, 50s, SOCE*

3.3 Frameworks and techniques involved

3.3.1 Findings from REA

To identify conversion therapy techniques we drew on a diverse range of studies including a survey of conversion therapists (Nicolosi, Byrd & Potts, 2000a), qualitative studies (e.g. Fjelstrom, 2013; Flentje, Heck & Cochran, 2013; Johnston & Jenkins, 2006; Mikulak, 2020; Schroeder & Shidlo, 2002; Throckmorton & Welton, 2005; Van Zyl, Nel & Govender, 2017), surveys with those who have undergone conversion therapy (e.g. Dehlin et al., 2015) and a wide ranging systematic review (APA, 2009a). The techniques documented in these studies can broadly be categorised as falling within one of three frameworks: **'spiritual', 'psychoanalytic' or 'cognitive/behavioural'[7].** See Table 3 for an overview.

[7] The academic literature disproportionately represents experiences from the global North and North America in particular. The grey literature suggests more extreme forms of conversion therapy including 'corrective rape', electric shock aversion therapy and medical interventions occur in other parts of the world including parts of Africa, Asia and the Middle East (Madrigal-Borloz, 2020; Outright Action International, 2019).

Table 3: Overview of conversion therapy frameworks

Framework	Features
Religious/Spiritual	**Premise:** Same-sex attractions and transgender identities are caused by evil spiritual forces, sins of previous generations or are a test from God. Same-sex sexual behaviour or cross-dressing are sinful/immoral. **Techniques include:** Prayer 'healing' (including exorcising spirits), confession and repentance, faith declarations, fasting, pilgrimages, Bible reading, attending religious courses. **Setting:** Within a religious community, in places of worship, at religious conferences and festivals, on religious conversion therapy courses. **Provider:** A religious leader (e.g. vicar/priest, youth pastor), other members of the church or faith community, a religious therapist.
Psychoanalytic	**Premise:** Same-sex attractions and transgender identities are developmental disorders resulting from a variety of familial (e.g. distant relationship with a parent), social (e.g. rejection by childhood same-sex peers) or traumatic (e.g. childhood sexual abuse) factors. **Techniques include:** Exploring 'causes' through a discussion of childhood trauma, psychodrama, emotional-release work, 'father-son style holding', altering gender-role behaviour. **Setting:** One-to-one or group therapy/pastoral counselling, conversion therapy weekend retreats or courses. **Provider:** A group or organisation (often religious), therapist, life coach or pastoral counsellor (with or without any formal training).
Cognitive/Behavioural	**Premise:** Same-sex attractions and transgender identities are a behavioural problem similar to an addiction or compulsive behaviour. **Techniques include:** Reframing desires, redirecting thoughts, avoiding 'triggers', abstaining from masturbation or masturbatory reconditioning, journaling, accountability buddies/groups, behaviour modelling, covert aversive methods (e.g. snapping a rubber band on the wrist). **Setting:** One-to-one/group therapy or pastoral counselling, weekend retreats or courses, AA-style mutual aid groups (sometimes alongside people who suffer from addictions and/or sexual problems). **Provider:** A therapist, life coach or pastoral counsellor (with or without any formal training) and/or a group or organisation.

We refer to these as 'frameworks' because different techniques are based on certain sets of assumptions about human behaviour and the causes of sexual orientation or gender identity. However, these do not represent three different 'types' of conversion therapy as **a combination of these are often found within a single form of conversion therapy** (e.g. religious and

psychoanalytic ideas)[8]. Psychological frameworks (psychoanalytic and cognitive behavioural) are based on historic efforts to alter sexual orientation and gender identity through psychoanalytic and behaviour therapy (Drescher, 1998). These 'psychological' theories in relation to sexual orientation and gender identity have been rejected by numerous professional associations including the British Psychological Society (BPS), the British Psychoanalytic Council (BPC) and British Association of Behavioural and Cognitive Psychotherapies (BABCP)[9]. **Conversion therapies are often also only loosely based on these psychological theories in ways that could be described as pseudo-scientific.**

There is very limited evidence regarding the methods used to change gender identity. A systematic review by Wright, Candy and King (2018) found only four relevant studies but concluded that treatment **approaches for modifying gender identity appear to be similar to those employed in efforts to change sexual orientation** and that they adopt psychoanalytic and behavioural techniques. There is also evidence that some forms of gender identity change efforts are based in the same religious frameworks as sexual orientation change efforts (Robinson & Spivey, 2019)[10].

3.3.2 Findings from qualitative research

Although most of the available evidence is from North America, the qualitative data gathered from individuals in the UK for this report largely support these findings as outlined below.

Spiritual/Religious techniques

Many of the interviewees had undergone different types of conversion therapy (sometimes over a period of years) and there were no notable differences in the techniques used in cases where the individual had undergone conversion therapy in the last ten years compared to those who had undergone conversion therapy between 10-20 years ago. Most reported experiences of being offered **prayer healing or exorcisms** (called 'deliverance ministry') which sometimes involved laying hands on the body and shouting at the person believed to be possessed.

> "I think probably more than once I was delivered of a spirit, or a demon of homosexuality… And then I was told that if I did anything sinful based on the fact that I'd been delivered from these demons, that those demons would return, and they would bring seven other demons with them*."*
>
> *Cisgender man, gay, 40s, SOCE*

[8] The British theologian Elizabeth Moberly (1983) was influential in combining psychoanalytic and religious approaches. Her book *Homosexuality: a new Christian ethic* was a significant influence on the US clinical psychologist Joseph Nicolosi. She later claimed he had plagiarised her work and took credit for the development of 'reparative therapy' (Throckmorton, 2019).

[9] The organisations are all signatories of a Memorandum of Understanding on conversion therapy.

[10] Although some forms of gender identity change efforts appear to be associated with religious ex-gay organisations (Robinson & Spivey, 2019), the grey literature suggests that other forms of conversion therapy may be more specific to transgender people. For instance, there have been reports of people sharing lists online of therapists for parents of transgender children seeking non-affirming therapists (Greenesmith, 2020; ILGA, 2020) (see also Ashley, 2019).

Some reported being encouraged to engage in **confession and repentance** in front of others and repeat **statements of faith** such as "I'm not a lesbian, I'm created by God to be in a relationship and one day I will have a husband".

> "They said 'right you have to do repentance' so they said think of any thought you have had about the same sex that is sinful or ungodly and declare it in front of these people and talk about any kissing or sexual activity or anything you've done with the same sex. So obviously it was quite embarrassing."
>
> *Cisgender woman, lesbian, 30s, SOCE*

Forms of religious counselling sometimes referred to as **pastoral guidance/counselling** often involved not only faith-based discussions but commonly were based loosely on psychoanalytic ideas and techniques. Religious counselling was also often delivered in conjunction with various other activities such as religious support groups, workshops or conferences. Many reported being **encouraged to read ex-gay literature** that one interviewee described as "Christian anti-gay books mostly from America". No major differences were found between the lesbian/gay/bisexual and transgender interviewees' experiences of religious techniques. In fact, one transgender interviewee reported being given ex-gay literature on homosexuality by a priest and was told that it equally applied to issues of gender identity.

Other religious techniques referred to included studying the bible, fasting and spiritual pilgrimages. In one case, tithing (the practice of donating a tenth of earnings to the church) was proposed as a possible solution to unwanted same-sex attraction, including retrospectively tithing based on previous earnings.

Psychoanalytic techniques

Psychoanalytic techniques such as **looking for 'causes' by discussing childhood traumas and family relationships** were commonly referred to and interviewees reported therapists making suggestions as to the cause of their sexual orientation or gender identity[11].

> "We started talking about my family history…The counsellor convinced me that because my mum left and my dad would spend more time with my two sisters…that I was looking for the attention my sisters had and that was the feelings for my gender identity, so they kept pushing that into my head."
>
> *Transgender woman, pansexual, 20s, SOCE & GICE*

In another case, a cisgender gay man was told that he must have repressed the memory of being abused by his father. Other techniques reported by several of the UK participants, loosely based on psychoanalytic principles, were forms of **psychodrama** in which participants were encouraged to act out traumatic events from their past in order to release repressed emotions.

> "They would then get the person to get a baseball bat and hit a box and get the anger that they repressed at the time out and then the idea was that same sex

[11] Causal theories reported to have been offered by conversion therapists are not based on robust empirical evidence.

> attraction would shift because of this anger that had been repressed and stored. That was the basic premise of a lot of their exercises."
>
> *Cisgender man, gay, 30s, SOCE*

Another technique reported (only by cisgender men in this sample) was **'healthy touch'** (also referred to as 'safe healing touch' or 'father-son style holding') in which men were encouraged to hug and touch one another. Although only loosely based on psychoanalytic ideas, the premise was that such touch supposedly fulfils unmet needs from childhood and helps men to bond in non-erotic ways. One man interviewed described an incident of sexual assault by a conversion therapist during 'father-son style holding'. Cisgender men were also encouraged to **engage in gender stereotypical activities** including participating in 'male-initiation rite of passage' adventure weekends.

Cognitive behavioural techniques

In line with a common belief among conversion therapists that same-sex sexual behaviour is a form of addiction, some of the efforts interviewees took part in were based on models of addiction recovery and involved **Alcoholics Anonymous style support or 'accountability' groups**. Interviewees were encouraged to **identify behavioural triggers** and given **guidance on setting boundaries** and how to avoid temptation. In some cases, this focused on particular techniques for **avoiding masturbation or viewing (gay) pornography.**

> "The guy that I'd work with would encourage me to resist watching pornography… it might be things like don't have a computer in your room, or noticing when you first feel tempted to go and look at porn and see what's going on, see if there's a trigger."
>
> *Cisgender man, heterosexual, 30s SOCE*

Such techniques were used in combination with **re-framing thoughts and feelings**, for example by encouraging individuals to view sexual attractions as something else (e.g. loneliness) or advising them to keep busy as a form of **distraction.** Interviewees were also encouraged to socialise with **heterosexual role models.**

Aversive techniques were not reported by interviewees. However, one transgender interviewee reported that a priest tried to instil fear by showing them a graphic video of gender reassignment surgery.

3.4 Settings and providers

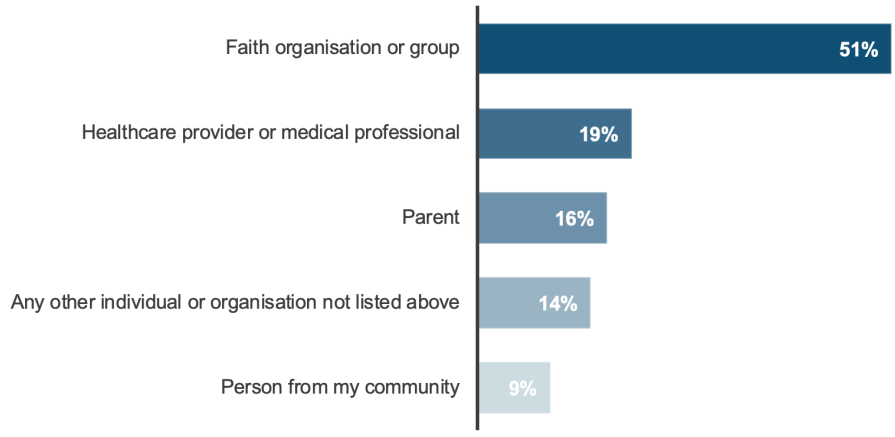
3.4.1 Findings from REA

Findings from several published surveys suggest that **conversion therapy tends to be delivered by religious providers** (e.g. Blosnich et al., 2020; Dehlin et al., 2015; Flentje, Heck & Cochran, 2013). One study that used random sampling found that over 80% of those who had experienced sexual orientation change efforts had experienced it from a religious provider (e.g. a priest, a pastor or a religious counsellor) compared to 31% who reported experiencing it from a health care provider (Blosnich et al., 2020). Studies also suggest that those who experience conversion therapy often do so with more than one provider (e.g. APA, 2009a; Dehlin et al., 2015). However,

these studies were based in the USA. As the settings and providers of conversion therapy may vary cross-culturally, this section draws primarily on UK evidence from the 2017 National LGBT Survey (GEO, 2018) and a UK survey of mental health professionals (Bartlett, Smith & King, 2009) to determine who is conducting conversion therapy.

The National LGBT Survey 2017 (GEO, 2018) found that of those respondents who had reported experiencing conversion therapy, faith organisations were by far the most likely group to have conducted this conversion therapy (51%), followed by healthcare professionals (19%) (see Figure 1).

Figure 1: Who conducted the so-called conversion therapy among those respondents who reported experiencing it in the National LGBT Survey 2017



Source: GEO (2018)[12]

Transgender respondents were slightly less likely to have undergone conversion therapy by faith organisations or groups (45%) than cisgender respondents (53%). Responses to the optional free-text question that discussed conversion therapy (n=230) often did so in the context of religion. Although the National LGBT Survey 2017 was the largest of its kind (n=107,850), it represented a self-selected sample and is not representative of all LGBT people in the UK. All respondents self-identified as LGBT and may be different from, or have different experiences to, people who do not wish to disclose their LGBT status or those who no longer identify as such. In addition, the survey did not ask how long ago the conversion therapy took place so may have captured historic forms of conversion therapy.

The fact that healthcare providers or medical professionals were the second most commonly reported providers of conversion therapy suggests **there are still some health care professionals delivering conversion therapy.** However, it is not clear how widespread this is. It is also possible that some health care professionals deliver conversion therapy while working or

[12] Note: Respondents could select multiple responses. %s shown are of the survey respondents who had received conversion therapy. A further 11% indicated that they 'preferred not to say' who conducted it.

volunteering for religious organisations rather than in healthcare settings[13]. A considerably higher proportion of transgender respondents said that it had been conducted by healthcare professionals (29%) than cisgender respondents (15%).

A UK-based survey of a random sample of members of UK psychotherapy and psychiatric organisations (n=1328) conducted in 2002 found that only a small minority (4%) of therapists reported that they would attempt to change a client's sexual orientation if a client asked for such therapy (Bartlett, Smith & King, 2009). A higher proportion (17%) reported having assisted at least one client to reduce or change homosexual feelings in the past, however this included historic cases. Strengths of this study include its random sample, together with a high response rate. However, it is possible that professionals who conduct conversion therapy might choose not to respond or may not be members of these bodies and thus these figures could be an underestimate. On the other hand, the survey was conducted in 2002 before these professional bodies had adopted a Memorandum of Understanding on conversion therapy and so may not represent the proportion of their members that would conduct conversion therapy in the UK today[14].

So, the evidence suggests that conversion therapy most commonly takes place in religious settings. There is also evidence that some healthcare professionals may be delivering conversion therapy, however it is not fully known how widespread this is, and there is ambiguity around the settings in which healthcare professionals deliver it. A further issue is that some of the findings are based on older evidence and therefore may not be reflective of current practice due to a recent Memorandum of Understanding that was put in place for healthcare professionals.

3.4.2 Findings from qualitative research

The findings from the REA were also reflected in the experiences captured in interviews with people who have undergone conversion therapy conducted for this report.

Individuals from their faith community

The majority of interviewees described experiences of individuals from their faith community attempting to change their sexual orientation or gender identity. Such attempts were commonly ad hoc and informal. What began as pastoral guidance would sometimes gradually and subtly progress to conversion attempts. The line between the two was often blurred.

The individual delivering the ‘conversion therapy’ was often **someone in a position of spiritual authority (e.g. a vicar, priest or youth pastor)** after the participant confided in them and sought guidance. These were often people from their local church community, although also individuals they met at religious conferences or festivals. Several interviewees were recommended conversion therapy by leaders at church youth groups or at university Christian Unions. These

[13] Although not meeting the inclusion criteria for the REA, respondents of the Ozanne Foundation’s UK-based 2018 Faith & Sexuality survey found that of those respondents with experience of sexual orientation change efforts, only a small minority had sought the advice of a health professional such as their GP (5%) or an NHS Psychotherapist (3%) compared to nearly half (47%) who had sought advice from a religious leader (Ozanne Foundation, 2019).

[14] The professional bodies surveyed have subsequently all issued position statements on conversion therapy as well as a joint Consensus Statement (2014) and are signatories of a Memorandum of Understanding (2017) in which they commit to ending conversion therapy within their professions.

authority figures sometimes broke confidentiality by sharing information about their sexual orientation or gender identity with others in their faith community and commonly signposted interviewees to religious individuals, groups or organisations for more formal attempts at change.

> "I got very involved in the youth group at that church, which I loved and I still have very positive feelings and memories of, but also that was where I had, I guess, some experience of what we're talking about today. It was when I was eighteen, I told a friend who was also in this youth group and then the second person I told was the youth pastor at the church…Then we just started speaking more and more often…we spoke about things to do with my parents, that classic relationship with parents, perhaps that's why."
>
> *Cisgender woman, lesbian, 20s, SOCE*

Faith organisation or group

Many of the interviewees had experienced more than one type of conversion therapy and the majority had undergone conversion therapy by a religious group or organisation. These organisations (including registered charities) commonly described themselves as **'pastoral support/counselling' organisations (or 'ministries')** for people with unwanted same-sex attractions or gender confusion. Some of these organisations have links with US-based conversion therapy groups[15].

These typically took the form of one-to-one and/or group pastoral support sessions that combined spiritual, psychoanalytic and cognitive behavioural techniques. Some of these organisations operated nationwide. In some cases, the people delivering the support were not trained in counselling or psychotherapy and described what they were delivering as 'talking ministry' or 'pastoral counselling' rather than 'therapy'. Others reported that the group they attended was run by a mixture of professionally trained and lay facilitators. In some cases, interviewees believed that trained mental health professionals worked or volunteered for the religious organisation, applying their professional skills and knowledge to conversion efforts.

> "Some of the guys would have been counsellors, some of them would have been therapists, accredited therapists and then they would often use quite a number of volunteers. So yeah, a real mixture of people."
>
> *Cisgender man, gay, 40s SOCE*

Some interviewees had themselves volunteered as peer facilitators and one had formerly held a leadership position within one of these organisations. Some attended **religious ('discipleship') courses** that aimed to improve participants' spiritual lives or sometimes were specifically focused on 'healthy relationships'. These were either short residential courses or delivered over a period of time within church groups. Although efforts to change sexual orientation or gender identity were not always the primary purpose of such courses, some had specific sessions relating to sexuality and relationships or had pre-prepared prayers and literature for those with same-sex attractions. Several interviewees reported experiencing exorcisms ('deliverance ministry') during these courses.

[15] Some of the groups referred to are members of the international coalition of ex-gay organisations called 'Positive Approaches to Healthy Sexuality' (formerly called 'Positive Alternatives to Homosexuality')

> "I did a course there for a year which was a discipleship course, and during that time a lot of stuff was involved in healing yourself, and your mental processes and so on. And as part of that I felt like I needed to heal being gay. That happened over a process of a year or so, and as part of that there was quite an extreme exorcism-like situation."
>
> *Cisgender man, gay, 30s, SOCE*

A number of the cisgender men reported attending weekend retreats or conferences by **inter-faith organisations that cater for men with unwanted same-sex attractions**. These were advertised as being for people of all faiths, and so religious doctrine or spiritual practices did not feature strongly within the techniques used by these organisations. Nevertheless, they were described as being run by 'men of faith'.

> "There was nothing faith-based, because it was all-faith and indeed none I suppose. It was aimed at people who had a strong faith, whatever that strong faith looked like. Because it was all encompassing there was nothing really that was relating to a faith, apart from I suppose a little like Alcoholics Anonymous."
>
> *Cisgender man, 'same-sex attracted', 40s, SOCE*

These events typically had links with US-based ex-gay organisations. Some of the weekend retreats were versions of US conversion therapy retreats. For instance, several men interviewed had attended weekend retreats in the UK delivered by a US-based ex-gay organisation. Several also reported travelling abroad to attend weekend retreats. Several interviewees reported having to sign non-disclosure agreements at the beginning of weekend retreats. Retreats involved lectures, psychodrama, 'healthy touch' and other group-based activities. Interviewees reported either finding out about these organisations online, were signposted to them by someone or learnt about them during some other form of conversion therapy. Several interviewees had attended various weekends run by more than one organisation.

Healthcare provider or medical professional

A number of interviewees reported experiencing conversion therapy delivered by private **psychotherapists and life coaches.** In most cases, these providers were described as being religious.

> "I then went to meet someone who was a Christian counsellor who specialised in people who had got sexual struggles…It could have been someone who was struggling with pornography, or it could have been someone who was struggling with infidelity outside their marriage. So, it was quite broad, but they were someone who was a Christian counsellor or therapist."
>
> *Cisgender man, 'same-sex attracted', 40s, SOCE*

One interviewee reported engaging in video calling consultations with a US-based clinical **psychologist** known for practising reparative therapy and another reported travelling to the US to have a consultation with a psychotherapist. In one case, an interviewee reported being offered conversion therapy by a counsellor, who happened to be Christian, while receiving counselling for depression.

Several transgender, non-binary and asexual interviewees described experiencing what they perceived to be a form of conversion therapy by **psychiatrists** during inpatient and outpatient care while receiving treatment for a mental health condition (e.g. schizophrenia). The treatment did not appear to be specifically designed to change their sexual orientation or gender identities but had a goal of getting them back to what the clinicians deemed to be 'a normal life', including aspects of their lives relating to their gender and sexuality.

> "The medical field, especially psychiatrists, wanted to believe it was a sign of mental illness. They figured, regardless of the fact that I was content with being asexual, that it was pathological, and that they could use that as a basis for my health…They took the fact my sexuality wasn't changing as an indicator that the medicine wasn't working, ignoring the fact the medicine was helping my other, actually distressing symptoms."
>
> *Non-binary person, asexual, 20s, SOCE*

Clinicians were described as encouraging and rewarding behaviours that conformed to their expectations around gender and sexuality (e.g. wearing clothing associated with their sex or expressing interest in a member of the opposite sex) and using medication to alter their lack of sexual interest[16]. Whether or not these experiences constitute 'conversion therapy' may depend on one's definition but they were perceived to be so by the interviewees.

Family members

Although parental efforts at sexual orientation or gender identity change are documented in the literature (e.g. Ryan et al., 2018), there was little reference to this by the UK interviewees in our sample. Three interviewees reported a **parent or grandparent requesting that a health professional or a religious leader help change them**. One of these also reported a parent putting pressure on them to have sex with people of the opposite sex.

> "She encouraged me into sexual relations with a man around my own age and told me it was 'normal' to not want to"
>
> *Cisgender woman, asexual, 20s, SOCE*

The findings from the qualitative research are consistent with findings from the existing literature and suggest that providers of conversion therapy include individuals within one's faith community, religious and inter-faith organisations, healthcare providers and family members.

[16] It should be noted that some severe mental health conditions may, in rare cases, present in a similar way to gender dysphoria (e.g. psychotic disorders can cause delusional beliefs about gender) or cause a lack of sexual interest. However, health professionals should not assume that an asexual or transgender identity is necessarily a symptom of a mental health condition even when they co-exist (Richards & Barker, 2013).

Who undergoes conversion therapy and why?

4. Who undergoes conversion therapy and why?

This chapter outlines the evidence regarding how prevalent conversion therapy is, which demographic groups within the LGBT population are more likely to be exposed to conversion therapy and the reasons people undergo it. Evidence from the REA will be examined to consider the prevalence of conversion therapy and which groups are most likely to be targeted. Evidence from the REA and the qualitative research conducted for this report will be used to identify factors that lead to people undergoing conversion therapy.

4.1 Overview

- No robust data exists on the number of LGBT people who have undergone conversion therapy and which sections of the population are most likely to undergo or be offered it in the UK.
- Available evidence suggests those with conservative religious beliefs are most likely to undergo conversion therapy.
- Studies with people who have undergone conversion therapy (mainly from the USA) are predominantly white Christian samples. However, the National LGBT Survey 2017 in the UK, found that respondents from ethnic minority groups and those of non-Christian faiths were more likely to report having undergone conversion therapy (although it was a non-representative sample).
- Evidence suggests that key motivations for seeking conversion therapy include:
    - A perceived conflict between one's religious values and one's sexual orientation or gender identity
    - A desire to be what is deemed to be 'normal' within their community
    - Feeling pressured to change by family members, people within their religious community or other pressures originating from their social environment.

4.2 How prevalent is conversion therapy?

4.2.1 Findings from REA

There is **little representative evidence regarding the prevalence of conversion therapies** due to the hidden nature of the population and a reliance on self-selected samples. This section draws on evidence from surveys of LGBT people in several countries including the UK.

In the 2017 UK National LGBT Survey (n=107,850), 2% of respondents reported having undergone conversion therapy and a further 5% reported having been offered it (1% were not sure) (GEO, 2018). Amongst cisgender respondents, there was not much variation in who had undergone or been offered conversion therapy by sexual orientation; bisexual respondents were the least likely to have undergone or been offered it (5%), and asexual respondents the most likely (10%)[17].

These findings can be compared to recently published results from surveys conducted elsewhere in the world. A Canadian survey (n= 8,388) of sexual minority men conducted in 2011-12 found 3.5% reported having ever been exposed to sexual orientation change efforts (Salway et al., 2020). Meanwhile, a survey of LGB people in China (n=15,611) found 6% reported conversion therapy being recommended or provided in a health setting (Suen & Chan, 2020). Both of these were also self-selected samples. Two US-based studies have reported the proportion of sexual minority men who had undergone sexual orientation change efforts in their studies as 15% (out of n=1,156) (Meanley et al., 2020) and 7% (out of n=1,518) (Blosnich et al., 2020); however, a strength of the latter study was that it used a probability-based sample (random digit dialling of US landline and mobile phone numbers) and its sample was more representative of the US population as a whole.

In the UK, the National LGBT Survey 2017 found that transgender respondents were more likely to have undergone or been offered conversion therapy (13%) than cisgender respondents (7%) (GEO 2018).[18] However, in addition to the survey not being a representative sample, the survey did not distinguish between transgender respondents who underwent conversion therapy to change their sexual orientation and those who underwent conversion therapy to change their gender identity. By comparison, a 2017 US Transgender Survey (n= 27,716) found 14% of transgender respondents had been exposed to gender identity change efforts (with 5% reporting exposure to such attempts between 2010 and 2015) (Turban et al., 2019)[19]. Although this was a large study, as with many other surveys, it was a self-selected sample.

It is important to bear in mind that the prevalence of conversion therapy may vary from country to country, however the evidence appears to suggest that a minority of LGBT people experience conversion therapy and that transgender people may be more likely to undergo or be offered it.

4.3 Which groups are most likely to undergo or be offered conversion therapy?

4.3.1 Findings from REA

There is little research that directly examines the demographics of those who undergo conversion therapy, so this section primarily draws on a systematic review that addressed demographics

[17] By comparison, a YouGov survey (n=5,375) commissioned in 2017 by Stonewall in the UK found 5% of LGBT respondents reported having been pressured to access services to question or change their sexual orientation (Bachmann & Gooch, 2018).

[18] The YouGov/Stonewall survey found 20% of transgender respondents reported having been pressured to access services to suppress their gender identity when accessing healthcare services (Bachmann & Gooch, 2018).

[19] This survey asked respondents “did any professional (such as a psychologist, counsellor, religious advisor) try to make you identify with your sex assigned at birth (in other words, try to stop you being transgender)?”.

(APA, 2009a) and data from the 2017 UK National LGBT Survey. A previous systematic review observed that the majority of participants in studies on sexual orientation change efforts have been white men and predominantly individuals from conservative Christian denominations (APA, 2009a), although there is some limited research with the Jewish community (Borowich, 2008). This pattern is also the case in subsequently published research. The 2017 UK National LGBT Survey (GEO, 2018) suggests those who undergo conversion therapy are more likely to be religious, ethnic minorities and male.

Religion

A previous systematic review of the evidence relating to sexual orientation change efforts concluded that they appear to be targeted primarily towards those who hold conservative religious beliefs (APA, 2009a). This may vary according to religious denomination, how questioning the individual is of their religion and the extent to which they internalise negative messages from their religion about their sexual orientation or gender identity (Tozer & Hayes, 2004). Studies have found that **religious fundamentalism or strong religious beliefs significantly predict participation in conversion therapy** (Maccio, 2010; Dehlin et al., 2015). However, most of the evidence comes from North America and there is a general lack of representation of people from non-Judeo-Christian religions.

The National LGBT Survey 2017 (GEO, 2018) found differences based on religion/belief with Muslim respondents most likely to have had or been offered conversion therapy (27%) followed by Jewish (16%), Hindu (16%) and Sikh (15%) respondents. Those without a religion/belief were the least likely (7%). These data should be treated with caution not only due to the self-selected sample but also because respondents' religious belief/identification may have altered as a result of negative experiences of religious-based conversion therapy (i.e. some respondents may have identified with a religion at the time they underwent conversion therapy but identified as having 'no religion' at the time of the survey). Meanwhile others may answer questions about religion on the basis of cultural heritage and identity rather than religious belief.

Ethnicity

Most studies of people who have undergone conversion therapy (mostly from North America) have contained predominantly white samples. However, in the UK, the National LGBT Survey 2017 found that Black (17%), Asian (16%) and 'other' ethnic groups (18%) were much more likely than White (7%) respondents to have undergone or been offered it. This pattern was similar across transgender and cisgender respondents (GEO, 2018). A Canadian survey of sexual minority men also found that ethnic minorities were more likely to report having undergone sexual orientation change efforts (Salway et al., 2020).

Gender

In the UK, the National LGBT Survey 2017 found that men more commonly reported having undergone or been offered conversion therapy (8%) than women (6%) (GEO, 2018). Although these differences are small, this pattern is consistent with studies on conversion therapy that have tended to receive predominantly male respondents (APA, 2009a).

Age

The National LGBT Survey 2017, in the UK found little variation in those who had undergone or been offered conversion therapy across age groups, suggesting that **this is not an issue that just affected older generations historically** (GEO, 2018).

4.4 Why do people end up undergoing conversion therapy?

4.4.1 Findings from REA

Much of the evidence about why people undergo conversion therapy comes from qualitative research, although information about motivations is also gathered in a small number of surveys (APA, 2009a; Flentje, Heck & Cochran, 2014; Karten & Wade, 2010; Maccio, 2010; Mikulak, 2020; Schroeder & Shidlo, 2002; Shidlo & Schroeder, 2002; Spitzer, 2003; Van Zyl, Nel & Govender, 2017, 2018; Weiss et al, 2010). **Evidence suggests that most conversion therapy is entered into voluntarily**, although it can be initiated by parents or family members, members of their community or in some cases by therapists. People may seek conversion therapy for a range of reasons. Motivations for undergoing conversion therapies reported within the literature include[20]:

- A belief that one's sexual orientation is incompatible with their religious faith
- Internalised stigma and shame associated with one's sexual orientation
- Fear and anxiety about the implications of being LGB
- Unsuccessful or negative same-sex sexual experiences
- Pressure or coercion from one's family, religious institution, psychotherapist or others in their social environment

Studies do not examine if there are differences in the motivations of men and women or between people of different ethnicities or religions. No evidence was identified that specifically examined the motivations of those who undergo gender identity change efforts. A systematic review by Wright, Candy and King (2018) on gender identity conversion efforts identified only four articles, three of which related to conversion therapy with transgender children upon their parents' request. The fourth article was a case study relating to a transgender adult who was seeking treatment for obsessive compulsive disorder in which the therapist claimed the treatment had shifted the client's gender identity[21]. In none of the cases described do the transgender clients appear to have sought out conversion therapy.

[20] Although it did not meet the inclusion criteria for the REA, a UK-based Faith and Sexuality 2018 survey by the Ozanne Foundation (2019) found that of those respondents who gave reasons for having undergone sexual orientation change efforts, the majority reported it was because they believed their same-sex attractions were sinful (72%), due to feelings of shame associated with their sexual orientation (63%) and because a religious leader disapproved of their sexual orientation (54%).

[21] At six year follow up, the client was found to be living as a transgender woman and awaiting gender confirmation surgery.

4.4.2 Findings from qualitative research

The available published evidence is largely from North America; however, similar themes were identified within the accounts of UK-based interviewees gathered for this report as described below.

Religious reasons

Religious reasons were most commonly cited among the interviewees who described **difficulty reconciling one's religious values with one's sexual orientation**. Many perceived their religious values to be incompatible with their sexual orientation and experienced an inability to integrate their religious identity with an LGB identity. This internal conflict was described as causing distress and led them to efforts to change their sexual orientation. Feelings of **religious guilt and shame** caused by a conflict between their faith and their sexual orientation was also common.

> "that's when the real conflict started to happen, and a challenge in terms of how I integrated my religious faith with being gay, and feeling the shame, a huge amount of shame in being gay within a very conservative environment."
>
> *Cisgender man, gay, 50s, SOCE*

Others sought sexual orientation change efforts out of **fear of eternal damnation**.

A desire to belong

Another important motivating factor reported by interviewees was a strong desire to belong within their families, religious communities, or friendship groups and a belief that being LGB was an inherent obstacle to belonging. Many of the UK-based interviewees had grown up belonging to a faith community, described their whole life as revolving around the church and their social circle primarily consisting of others within their faith community. They sometimes referred to their faith community as being separate from mainstream society and described them as existing in 'a bubble'.

These interviewees were commonly motivated to seek conversion therapy out of **a fear of being rejected by their community**. Being heterosexual was considered the norm within their communities and interviewees reported that they had been driven to conversion therapy by **a desperate desire to lead a 'normal' life**. Being LGB was not only seen as incompatible with their faith, but sometimes also with other aspects of their identity. For example, one black interviewee felt that his sexual orientation was not only incompatible with his faith but also with his ethnic identity.

> "When your church is your universe, you will do anything to stay in it because the consequence of being out of it is being basically abandoned…I think that's one of the reasons why I embraced conversion therapy because I wanted to be part of the church community…being black as well and from the Afro-Caribbean community, there wasn't any obvious queer role models I could look up to or if there were, they

> were often ridiculed by the wider black community. So, for me at a young age, I was taught wrongly that being queer and black was not compatible."
>
> *Cisgender man, bisexual, 30s SOCE*

A failure to connect and identify with other LGB people was also a motivating factor due to a difficulty integrating their perception of LGB people (often based on stereotypes) with the norms of groups to which they belong and their self-perception.

Negative sexual experiences

A number of men interviewed reported that **unfulfilling same-sex sexual experiences** had influenced their decision to undergo conversion therapy. Some reported that because they were keeping their sexual orientation a secret, they engaged in secretive, one-off sexual encounters with strangers that would leave them feeling dirty, guilty and emotionally unfulfilled. These men came to associate these experiences and emotions with being gay. Several interviewees also reported **a history of unwanted same-sex sexual experiences** which reinforced their negative associations with same-sex sexuality.

> "And then he stroked my leg, I felt really uncomfortable, but the thought that went through my head was 'he knows I'm gay', and I was like 'I don't want to be found out'…that pushed me further into denial of 'I am not going to be like him' because that's what gay men are like, they're predatory, I don't want to be like that."
>
> *Cisgender man, gay, 40s, SOCE*

Pressure or coercion from others

Another factor that several interviewees reported was feeling **pressured by members of their faith community** to attend a course or read ex-gay literature even after making clear that they did not wish to do so. Several participants also described experiencing **coercion from their parents**. For example, one young woman was locked in her bedroom for three days until she agreed to seek help to change her sexual orientation.

Although interviewees generally reported undergoing sexual orientation change efforts voluntarily, they also frequently reported being led into it under the guidance of people in a position of spiritual authority. Many felt that their 'choice' to undergo conversion therapy was driven by **powerful influences in their social environment** that limited their autonomy as explained in the quote below.

> "I don't think anybody chooses conversion therapy. I feel like they're forced to choose it because the influences that they have are telling them that they need to, so that's what happened with me. I felt like I was making a personal choice to go and do these things but when I look back on it I realise actually I was in a vulnerable position and didn't have much self-confidence to know what I wanted or what was good for me so I listened to those people in authority over me who convinced me that that was the choice I needed to make."
>
> *Cisgender woman, lesbian, 30s, SOCE*

Although the qualitative study contained only six transgender and non-binary participants, **none of the transgender interviewees reported seeking out or requesting conversion therapy**. Two reported psychiatrists treating their gender identities as if it were a symptom of their mental health condition (schizophrenia, PTSD) and four reported feeling pressured to engage in conversion efforts from family and/or religious leaders. In one case, a young transgender man reported feeling pressured by his grandparents to undergo conversion therapy with a priest. In the other three cases, after initially being welcomed into a church, leaders began to express disapproval of their gender identity, encouraged them to undergo pastoral counselling and eventually placed conditions on their participation in the church. One transgender interviewee was threatened with eviction from the house she was renting from her church if she did not change her gender expression.

> "It became clear that they [church leaders] didn't approve of it and I was frequently encouraged to go and listen to talks…They proceeded to arrange for some counselling sessions with one of their pastoral team…I was encouraged to part with all my female wardrobe…they said to me that if I wanted to carry on living there, I really had to stop all this silly stuff."
>
> *Transgender woman, heterosexual, 50s GICE*

Those who were dependent on family members, their faith community or lacked a wide social support network appeared to be particularly vulnerable to pressure and coercion.

What are the outcomes of conversion therapy?

5. What are the outcomes of conversion therapy?

This chapter outlines the evidence regarding the outcomes of conversion therapy in terms of whether it is effective at changing sexual orientation or gender identity, as well as whether it is associated with harms or benefits. Findings from the REA will primarily be used to answer these questions. Data from the qualitative research conducted for this report will be presented to illustrate how perceptions of effectiveness can change over time as well as to illustrate the perceived harms and benefits of conversion therapy by those who have undergone conversion therapy in the UK.

5.1 Overview

- The balance of evidence suggests that conversion therapy is unlikely to be effective and is associated with negative health outcomes.
- There is very little robust evidence to support claims that conversion therapy can be effective in achieving its aim of changing a person's sexual orientation or gender identity.
    - A number of studies have found very few people who undergo sexual orientation change efforts report any change. There are some studies that report higher levels of success; however, such studies have serious limitations or fatal flaws in study designs. Inconsistency in findings is likely due to a lack of scientific rigor.
    - Qualitative evidence has found that some individuals who have undergone conversion therapy report having been in denial about having changed. Some also report pretending to have changed in order to conform to others' expectations. Self-reports of success should be interpreted with this in mind.
    - No recent evidence regarding the effectiveness of conversion therapy for changing gender identity was identified.
- Some individuals report secondary benefits of conversion therapy (e.g. social support, a sense of belonging). However, it is likely that these benefits are not unique to conversion therapy and could be attained through alternative therapeutic approaches that do not attempt to change a person's sexual orientation or gender identity.
- There is a growing body of quantitative evidence that exposure to sexual orientation change efforts is statistically associated with multiple negative health outcomes (including suicidal thoughts and suicide attempts). This body of evidence is larger for sexual orientation change efforts; however, one recent study has also found that gender identity change efforts are associated with similar negative health outcomes. Although we need to interpret this data with care, such associations are consistent with verbal accounts of individuals who have undergone conversion therapy.

5.2 Are conversion therapies effective?

5.2.1 Findings from REA

Randomised controlled trials are the scientific gold standard for assessing the effectiveness of treatments. There are no randomised trials of conversion therapies. Evidence regarding whether modern forms of conversion therapies are effective at changing sexual orientation typically rely on surveys that retrospectively gather self-reported data regarding individuals' sexual orientation after the conversion therapy. Due to a lack of controlled prospective studies, a reliance on self-reporting, potential sampling biases, a lack of objective measures, a lack of follow-up data and the inclusion of various conversion therapy methods within studies (see Appendix 2), published research does not meet scientific 'gold standards' for making robust claims about effectiveness[22] [23]. Therefore, **there is no sound basis for claims that conversion therapy is effective at changing sexual orientation or gender identity**.

Several systematic reviews have concluded that there is no robust evidence that conversion therapy is effective (APA, 2009a; Serovich et al., 2008) [24]. **The balance of evidence suggests that efforts to change sexual orientation are unlikely to be effective**. A systematic review conducted by the American Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009a) concluded that efforts to change sexual orientation appear unlikely to be successful. They suggested that some individuals may modify how they label their sexuality or change their sexual behaviour, but these changes might only be temporary. They go on to state that some individuals do become skilled at ignoring same-sex attractions and go on to lead 'outwardly heterosexual lives', however this appears to be less common among those who were not to some degree attracted to members of the opposite sex (i.e. bisexual in orientation) prior to change efforts. No studies published since 2000 were identified that assessed the effectiveness of conversion therapies seeking to change a person's gender identity and any claims that it is possible to change a person's gender identity are unproven[25].

These conclusions are consistent with more recent evidence. A number of studies (including the largest) have found that, even among those most motivated to change, respondents rarely report

[22] There are a small number of more rigorous early studies that focus on the use of aversion therapy (e.g. electric shock and chemically induced nausea). These were generally found to be ineffective at modifying sexual orientation (APA, 2009a).

[23] One prospective study cited by some conversion therapy advocates (Jones & Yarhouse, 2007) was identified but did not meet our inclusion criteria as it was published in the grey literature. However, the study was considered in a systematic review (APA, 2009a) that concluded that the study's claims were unpersuasive due to methodological problems including the absence of a control or comparison group, and deficiencies in the choice of measures and statistical analysis. The authors of the study themselves also acknowledge that their method "fails to meet a number of ideal standards" (p. 408) for studies of this type.

[24] A review by the US Substance Misuse and Mental Health Services Administration (2015) also concluded that the existing research does not support the premise that psychological interventions can alter sexual orientation or gender identity.

[25] By the mid-1970s there was early clinical evidence that attempts to modify gender identity by psychological means (e.g. psychotherapy or aversion therapy) typically failed and that gender reassignment surgery combined with affirmative psychological support more consistently resulted in positive outcomes (Yardley, 1976). There is also more recent evidence that transgender affirmative healthcare is associated with positive outcomes for transgender people (APA, 2009b).

any modification of sexual orientation (e.g. Bradshaw et al., 2015; Dehlin et al., 2015; Maccio, 2011). For example, in the largest survey of its kind Dehlin et al (2015) found that only one respondent out of 1,019 (0.1%) who had undergone sexual orientation change efforts subsequently identified as 'heterosexual'. No respondent reported the complete elimination of same-sex attraction and only 3% reported any change in their sexuality. Of those who did report some change, this was not always a change in sexual attraction but included modification of sexual behaviour (e.g. not acting on same-sex attractions) or a change in how they thought about their sexual orientation (e.g. that it did not define who they were). This study was based on self-report data and shares many weaknesses of other studies. For instance, we do not know whether the small minority who reported modification of their sexual behaviour maintained this over time.

There are inconsistent findings with some studies reporting higher levels of self-reported sexual orientation change (e.g. Nicolosi, Byrd, & Potts, 2000b; Spitzer, 2003). However, even within these studies self-reported change appears to be incremental and reports of a complete change from exclusively same-sex oriented to exclusively heterosexual are rare. A lack of scientific rigor may explain inconsistent findings.

Previous systematic reviews suggest that studies reporting to find significant sexual orientation change are seriously methodologically flawed (APA, 2009a; Serovich, 2008). In addition to general methodological limitations that preclude any robust claims of effectiveness, one systematic review (APA, 2009a) found some studies were fatally flawed due to using unreliable measures and inappropriate statistical tests (e.g. Jones & Yarhouse, 2007; Nicolosi, Byrd, & Potts, 2000b). Another study published in 2018, that reported significant shifts in sexual orientation, was subsequently retracted by the journal it was published in due to concerns over the statistical analyses (RETRACTED: Santero, Whitehead & Ballesteros, 2018)[26]. Another study reporting significant change (Spitzer, 2003) has subsequently been repudiated by its own author. Spitzer (2012) has publicly accepted that criticisms of his study were largely correct, that it was impossible to answer questions of effectiveness with the study design used and that there was no way of determining if participants' accounts of change were valid[27]. Due to such methodological problems, findings of change are unpersuasive.

Few participants in published qualitative studies describe conversion therapy as successful (Fjelstrom, 2013; Johnston, & Jenkins, 2006; Shidlo & Schroeder, 2002; Van Zyl, Nel & Govender, 2017). Qualitative evidence cannot robustly answer the question of effectiveness; however, it can help us to interpret quantitative evidence. Qualitative studies have found some individuals describe perceived effectiveness of conversion therapy changing over time from an initial 'honeymoon period' through to 'disillusionment' (Fjelstrom, 2013; Shidlo & Schroeder, 2002; Van Zyl, Nel & Govender, 2017; Weiss et al., 2010). As such, asking conversion therapy clients about effectiveness at one point in time is likely to be unreliable.

[26] This article was retracted since the start of the current review. It is included here as it is often cited by conversion therapy advocates.

[27] See Drescher and Zucker (2006) for a thorough critique of Spitzer's (2003) study. Other studies cited by conversion therapy advocates (e.g. Nicolosi, Byrd, & Potts, 2000b; RETRACTED: Santero, Whitehead & Ballesteros, 2018) share many of the same flaws as Spitzer's study including biased samples that recruit participants via conversion therapists.

5.2.2 Findings from the qualitative research

This was also the case in the present study with UK interviewees. **Most interviewees experienced no change in their sexual orientation or gender identity,** perceived conversion efforts to have been a failure and subsequently went on to accept their same-sex sexual orientation or gender identity. Only two interviewees (one man and one woman) reported now identifying as heterosexual and were currently married to people of the opposite sex. While the man who identified as heterosexual at the time of interview believed himself to have been changed, the woman who identified as heterosexual was not confident the apparent change was a result of the conversion therapy. She believed it could have been due to natural sexual fluidity and reported some previous sexual attractions to men when she identified as lesbian[28]. Another man interviewed did not identify as gay but continued to experience same-sex attraction[29]. Several others reported some minor changes such as in their sexual behaviour or described their sex lives as less 'compulsive' but continued to experience same-sex attraction. Some of these interviewees considered conversion therapy to have been (at least partially) 'successful' on the basis of secondary therapeutic benefits (see Section 5.3). This included two interviewees who were periodically undergoing forms of conversion therapy at the time of interview[30]. Among the majority of interviewees who believed conversion therapy to have been a failure at the time of interview, many reported previously experiencing temporary perceptions of change due to expectation of change and being in denial.

Temporary perceptions of change

A number of interviewees reported periods of time while undergoing conversion therapy when they thought change had occurred but in hindsight attributed this to a short term 'placebo effect' due to their expectation of change. Many of those who experienced conversion therapy in a religious context reported being told that they must have 'faith' for it to work so **tried to persuade themselves that they had been 'healed'**.

> "I think there is a placebo effect in it. They are so convinced it's going to work, so for a very limited period of time, maybe days or weeks, not even a month you would have that feeling of maybe it did work."
>
> *Cisgender woman, lesbian, 30s, SOCE*

Some interviewees described becoming skilled at distracting themselves (e.g. through keeping busy) and had temporarily believed change had occurred but **now believe that they were previously in denial.**

> "I buried it really, pushed it down and carried on, got very busy, but it was still in the background…I think at the time I went 'oh that's it dealt with', and so then I just

[28] Natural fluctuations in sexuality may occur but this is not evidence in itself that that sexual orientation can be deliberately modified by conversion therapies. Furthermore, it is unclear to what extent self-reported sexual fluidity represents changes in sexual orientation or simply changes in how people label their sexual orientation over time.

[29] This interviewee described his sexual orientation as 'same-sex attracted'.

[30] These two interviewees continued to periodically attend conversion therapy weekend retreats both in the UK and in other countries. One identified his sexual orientation as 'gay' and the other as 'same-sex attracted' despite having engaged with conversion therapy for a number of years.

> ignored it and I very much was in denial for a long, long time because again I busied myself with church...I look back and think yeah actually you were really in denial."
>
> *Cisgender man, gay, 40s, SOCE*

For some this process of denial took the form of **outwardly acting as if change had occurred** and declaring to others that it had. Others explained that they pretended that change had occurred to be accepted within their community or to please others. One gay man who had become co-leader of a conversion therapy course explained that the longer he deceived himself and others, the more difficult it became to openly admit that no change had occurred.

Such qualitative findings have implications for the interpretation of effectiveness studies. Self-reported success needs to be considered in light of developmental shifts in perceived effectiveness (Shidlo & Schroeder, 2002). In particular, studies that ask participants about the outcomes of conversion therapy at a single time point, particularly during or shortly after therapy, may not provide a reliable reflection of perceptions of effectiveness over the longer term.

5.3 Are there any benefits of conversion therapy?

5.3.1 Findings from REA

Evidence regarding secondary benefits (i.e. benefits other than changing or minimising feelings or behaviour relating to sexual orientation or gender identity) comes in the form of retrospective self-report surveys and qualitative studies with people who have undergone conversion therapy (APA, 2009a; Beckstead, 2002; Nicolosi, Byrd & Potts, 2000b; Shidlo & Schroeder, 2002; Throckmorton & Welton, 2005). Conversion therapy advocates often claim that in addition to changing a person's sexual orientation or gender identity, such 'therapy' can result in improvements in mental health. A systematic review concluded that **there is no sound basis for claims that mental health or quality of life improve as a consequence of conversion therapy** (APA, 2009a).

Nevertheless, benefits have been reported by some individuals within surveys and qualitative studies (e.g. Beckstead, 2002; Nicolosi, Byrd & Potts, 2000b; Mikulak, 2020; Shidlo & Schroeder, 2002; Throckmorton & Welton, 2005). Those studies conducted by conversion therapy advocates and that recruit via conversion therapy networks (e.g. Nicolosi, Byrd & Potts, 2000b) appear to report more benefits than those that use other recruitment methods (e.g. Bradshaw et al., 2015). The benefits reported include:

- Having a place to discuss conflicts and emotional distress
- Receiving empathy from others who understand the conflict they are experiencing
- Experiencing understanding and recognition of the importance of religious values
- Finding social support and interacting with others in similar circumstances
- Increased sense of belonging

It can be noted that many of these **perceived benefits are not unique to conversion therapy but are common across most types of therapy and support groups** (APA, 2009a). These

benefits could potentially be gained through alternative therapeutic approaches that do not seek to change a person's sexual orientation or gender identity (APA, 2009a; Wolkomir, 2001). A systematic review concluded that it is unlikely that sexual orientation change efforts provide any unique benefits other than those documented for social support groups generally (APA, 2009a). In several qualitative studies participants reported initially finding conversion therapy to be beneficial (e.g. an increased sense of hope), followed by negative effects later (Beckstead and Morrow, 2004; Mikulak, 2020; Shidlo and Schroeder, 2002) (see Section 5.4).

5.3.2 Findings from the qualitative research

Although not a representative sample, the majority of the UK-based interviewees reported no benefits of engaging in conversion therapy, but a third reported experiencing some secondary benefits. These were reported mainly by cisgender men who had taken part in conversion therapy in a group setting with other men with unwanted same-sex attraction. The most common benefit reported was experiencing a sense of belonging and connection with other men in the same situation. In several cases, the group element provided an opportunity to meet other men like themselves which reduced their feeling of being different. For some it was the first time they had met other people with a same-sex sexual orientation. In some cases, lasting friendships were formed with those they met at conversion therapy weekend retreats and a sense of community was formed outside of the conversion therapy context.

> "I had always felt that I was a weird human being, that there was something wrong with me, and then suddenly I see all these great men, it was a feeling of being part of something."
>
> *Cisgender man, gay, 50s, SOCE*

Some felt that the conversion therapy provided an opportunity for them to talk about other issues in their lives in much the same way one might benefit from speaking to any therapist or counsellor.

> "When you say how has the ministry helped, I think it's in ways like that which are probably quite sensible, common sense sort of ways of dealing with things that anybody, any therapist would probably help you with, but that's what I mean, and this isn't a professional ministry if you like, but it's still helped me even today with things that aren't to do with sexuality."
>
> *Cisgender man, heterosexual, 30s SOCE*

These findings fit evidence from the REA and suggest that many of the perceived benefits some people gain from conversion therapy could be gained by other means such as participating in support groups for LGBT people of faith or speaking to a professional therapist who follows best practice guidelines.

5.4 Is conversion therapy harmful?

5.4.1 Findings from REA

A growing number of studies are finding that **exposure to conversion therapies is associated with multiple indicators of poor health** (Blosnich et al., 2020; Dehlin et al., 2015; Meanley et al., 2020; Ryan et al., 2018; Salway et al., 2020; Turban, et al., 2020) for both sexual orientation and gender identity change efforts. A wide range of harms have also been reported within surveys and in qualitative research with those who have undergone sexual orientation change efforts (APA, 2009a; Beckstead, 2002; Beckstead & Morrow, 2004; Bradshaw et al., 2015; Fjelstrom, 2013; Flentje, Heck & Cochran, 2014; Mikulak, 2020; Shidlo & Schroeder, 2002; Van Zyl, Nel & Govender, 2017; Weiss et al., 2010). A previous systematic review concluded that there was evidence (largely in the form of qualitative studies) that some individuals perceive they have been harmed by conversion therapy but that methodological limitations precluded definitive conclusions (APA, 2009a)[31].

There is stronger evidence from subsequently published studies that have comparison groups of LGBT people who have not undergone conversion therapy and demonstrate statistical differences in mental health outcomes. Within these studies, **exposure to sexual orientation change efforts is consistently associated with higher likelihood of suicidal thoughts and suicide attempts** compared to LGB people who have not undergone conversion therapy (Blosnich et al., 2020; Dehlin et al., 2015; Ryan et al., 2018; Salway et al., 2020). One recent study has found that compared to sexual minority adults with no experience of sexual orientation change efforts, those who had undergone conversion therapy were twice as likely to have had suicidal thoughts, had 75% increased odds of planning to attempt suicide, 88% increased odds of attempting suicide resulting in minor injury and 67% increased odds of attempting suicide resulting in moderate or severe injury (Blosnich et al., 2020). Particular strengths of this study include its random (probability-based) sample.

There is also recent evidence that gender identity change efforts are associated with similar negative health outcomes. A large US-based study (n=27,715) found that respondents' **exposure to gender identity conversion efforts (by secular professionals or religious advisors) is significantly associated with increased odds of reporting severe psychological distress and suicide attempts** compared with transgender adults who had discussed gender identity with a professional but who were not exposed to conversion therapy (Turban et al., 2020). No significant differences were found when comparing transgender respondents' exposure to gender identity change efforts delivered by secular professionals versus religious advisors. Strengths of this study include its large sample size and the high degree of survey completion. However, the study lacks data regarding the degree to which conversion therapy occurred (e.g. duration, frequency, forcefulness) or what techniques were used and was a self-selecting sample.

There is also a need to be careful when making *causal* interpretations from such studies. For instance, an alternative explanation could be that LGBT people with mental health problems are more likely to seek out conversion therapy. However, one study controlled for adverse childhood experiences (e.g. physical or sexual abuse) that are also associated with suicidal thoughts (Blosnich et al., 2020). Meanwhile, another study found that associations with negative health outcomes were markedly stronger for those who had experienced both parental attempts to change their sexual orientation and conversion therapy from a therapist or religious counsellor

[31] Early studies that focus on the use of aversive treatments (e.g. electric shock and chemically induced nausea) found some participants suffered harmful side effects including depression, suicidality and anxiety (APA, 2009a). However, these findings cannot necessarily be generalised to modern forms of conversion therapies.

compared to those who had experienced just one of these (Ryan et al., 2018). On the basis of this evidence, alternative explanations for this finding are less plausible than the conclusion that conversion therapy has a negative impact on mental health.

The authors of these studies have tended to explain the associations between conversion therapy and negative health outcomes using the Minority Stress Model (Meyer, 1995, 2003). There is a growing body of evidence that stigma associated with minority sexual orientations and gender identities (manifested as prejudice and discrimination) is a major source of chronic stress that can have a variety of negative mental health consequences for LGBT people (including suicidal thoughts) (Baams, Grossman & Russell, 2015; McNeil, Ellis & Eccles, 2017; Meyer, Frost, Nezhad, 2015). Conversion therapy by its nature and purpose promote the rejection of minority sexual orientations and gender identities and therefore may reinforce and contribute to self-rejection, internalised stigma and their associated negative health outcomes (APA, 2009a; Blosnich et al., 2020).

This interpretation of the evidence also fits with reports of perceived harm within qualitative studies with people who have undergone conversion therapy (APA, 2009a; Beckstead, 2002; Beckstead & Morrow, 2004; Bradshaw et al., 2015; Fjelstrom, 2013; Flentje, Heck & Cochran, 2014; Shidlo & Schroeder, 2002; Van Zyl, Nel & Govender, 2017; Weiss et al., 2010). Reported harms include:

- depression and suicidality
- decreased self-esteem and increased self-hatred
- self-blame for treatment failure
- feelings of guilt and shame
- social isolation and loss of social support
- deteriorated family relationships
- a loss of faith
- wasted time and resources

Furthermore, **in qualitative studies participants clearly attribute these harmful outcomes to the conversion therapy**. Although qualitative research cannot robustly answer the question of whether conversion therapy is harmful, it can provide some *indication* of why it might be experienced as such. Those who perceived conversion efforts to have been a failure, while believing that change was possible, reported blaming themselves, experiencing poor self-image and emotional distress (APA, 2009a).

5.4.2 Findings from the qualitative research

As most of the evidence above is from North American studies, the qualitative data gathered as part of this report extends these findings to a UK sample. **The majority of interviewees reported perceiving conversion therapy to have been harmful.** Many believed that conversion therapy reinforced feelings of stigma and shame which undermined their mental health. They commonly

reported conversion therapy had negatively affected their self-esteem and that messages conveyed during conversion therapy had left many feeling there was 'something wrong' with them.

Most spoke in general terms about how the conversion therapy made them feel rather than attributing harm to specific techniques, although several interviewees referred to exorcisms as being 'traumatic' experiences and spoke of how the inaccurate and negative representations of LGBT people by conversion therapists had reinforced stereotypes and negative associations with their sexual orientation or gender identity.

Depression, suicidal thoughts and self-harm

Many interviewees described experiencing depression, suicidal thoughts and in some cases had attempted suicide. Interviewees commonly attributed this to conversion therapy exacerbating the internal conflict between their faith and their sexual orientation or gender identity and prolonging their lack of self-acceptance.

> "I was suicidal and self-harming at one point and then I made the conscious decision to not have anything more to do with conversion therapy, because all I was seeing was suicide, self-harm and depression in the people around me, and not seeing anyone change."
>
> *Cisgender man, gay, 30s, SOCE*

> "I would hurt myself, I would self-harm."
>
> *Transgender woman, pansexual, 20s, SOCE and GICE*

In addition, some interviewees referred to self-harming and restricting eating behaviour which they clearly attributed to the stress caused by the conversion therapy and in several cases stated that they had never experienced this either before or after the conversion therapy. One cisgender man reported engaging in substance abuse and risky sexual behaviour that ultimately led to him contracting HIV. He attributed his risky behaviour to feelings of worthlessness caused by conversion therapy. Although it is not possible to determine to what extent such harm is a result of not accepting one's sexual orientation versus the conversion therapy itself, these two were perceived to be interlinked because conversion therapy actively encouraged them to not accept their sexual orientation.

Many interviewees reported experiencing improvements in their mental health upon ending the conversion therapy. Many went on to find supportive others and learned to accept their sexual orientation or gender identity, for example through finding more LGBT affirmative religious groups.

Self-blame

When efforts to change sexual orientation were unsuccessful, interviewees reported feeling a sense of failure and would initially blame themselves rather than the conversion therapy.

> "The more it didn't work the more I started to feel like, well there must be something wrong with me because they are so convinced it's working, and they're so convinced

> it has happened for other people. Well why isn't it for me? I must be so bad and so sinful that I'm beyond God's redemption."
>
> *Cisgender woman, lesbian, 30s, SOCE*

Interviewees reported that those who led the conversion efforts would suggest that success was dependent on their level of religious faith or commitment which in a number of cases led the interviewees to blame themselves rather than question the validity of the conversion therapy.

Feelings of anger and resentment

Interviewees also reported that conversion therapy had negatively affected their lives by delaying their social, emotional and sexual development. Some interviewees felt anger and a sense of loss for the years they could otherwise have spent in healthy, happy same-sex relationships if only people in authority had reacted more affirmatively.

> "There is a lot of anger to do with the fact I feel that the best years of my life were stolen or given to a belief which meant that I was single and celibate, and you can never have those years back."
>
> *Cisgender woman, lesbian, 50s, SOCE*

Social Isolation

Another common harmful effect of conversion therapy reported by interviewees was the social isolation that occurred both during and after conversion therapy. Several interviewees received advice to distance themselves from LGBT or 'liberal' friends as a way of avoiding 'corrupting' influences. Some were also advised not to disclose their sexual orientation to others. Such advice led them to become socially isolated and prevented them from accessing social support from alternative sources such as peers. In a number of cases, interviewees who decided to stop their efforts to change and accept their sexual orientation or gender identity found themselves excluded by their faith community and lost their whole social support network.

> "I was effectively ex-communicated, because it wasn't working…I'd had a whole community that I'd grown up with, there were people that I trusted, there were people that I saw as role models, and they all were taken away in one go."
>
> *Cisgender man, gay, 40s, SOCE*

Others took the initiative to leave their faith community to escape the pressure they were under to change. However, this loss of community was still experienced as painful and socially isolating.

Damaged family relationships

Several interviewees expressed that conversion therapy affected their relationships with their parents, particularly due to suggestions that their sexual orientation or gender identity was caused by poor parenting, childhood trauma or abuse. For example, in one case the interviewee's pastor suggested that he may have repressed memories of being abused by his father which put a strain on their relationship.

> "For a good few years afterwards I almost doubted my memory, so it did pull me further away from my parents…I had this memory almost implanted in me...It did put a rift between my dad and I for a while, I don't think he'd realised why, but I emotionally detached myself from him for quite a while because constantly every time I saw him, I thought about it."
>
> *Cisgender man, gay, 20s, SOCE*

The harms reported within our qualitative interviews reflect those identified from the REA and illustrate that harmful outcomes are directly attributed to conversion efforts by those who undergo them.

What measures have been taken to end conversion therapy around the world?

6. What measures have been taken to end conversion therapy around the world?

This chapter provides an overview of the different types of legislative measures taken around the world to end conversion therapy, what legal challenges they have faced and what effect they have had. This section is based on desk research from a search of the grey literature[32].

6.1 Overview

- The number of legal jurisdictions that are passing legislation to restrict or end conversion therapy is growing rapidly. Measures taken include:
    - Legal bans or restrictions:
        - A growing number of countries have nationwide laws (Brazil, Ecuador, Germany and Malta) or sub-national laws (Canada, Spain, USA) that ban or restrict the practice of conversion therapy. These vary in scope from those that apply only to conversion therapy conducted by health professionals with minors to others that are more comprehensive in nature.
    - Regulation of health professionals:
        - A number of jurisdictions regulate health professions in ways to prevent the provision of conversion therapy by health professionals (Albania, Argentina, Uruguay, Fiji, Nauru, Samoa and Switzerland). This can function as an indirect ban on healthcare professionals delivering conversion therapy.
    - Child protection legislation:
        - Several jurisdictions have proposed that parental forms of conversion therapy may, in certain circumstances, be considered a form of parental abuse and could fall within child protection law. Some bans have also specifically focused on conversion therapy conducted with minors to protect children.
    - Equality/Anti-discrimination legislation:
        - Several jurisdictions have included provisions regarding conversion therapy in equality laws that prohibit discrimination on the basis of sexual orientation and gender identity.
    - Consumer protection legislation:

[32] The information provided is as of June 2020. While every effort has been made to ensure this information is accurate and confirmed by primary sources (i.e. the laws themselves), in some cases we have needed to rely on secondary sources which may not always be accurate.

        - Court cases have been successfully brought against conversion therapy providers under existing consumer protection law (e.g. New Jersey, USA).
        - Some legal restrictions on conversion therapy prevent services charging for 'fraudulent' conversion therapy (Vancouver, Canada).
    - Advertising regulation:
        - Some legal restrictions include the prohibition of advertising conversion therapy (e.g. Brazil, Malta).
    - Health insurance legislation:
        - Several jurisdictions have prohibited health insurers from providing coverage for conversion therapies (e.g. Ontario, Nova Scotia and Edward Island – Canada)

- There is little evidence on the impact of these measures or how well they are enforced. However, in one jurisdiction with a comprehensive ban (Madrid) a life coach offering conversion therapy has been fined. It is unlikely that action would have been successful under jurisdictions with bans more limited in scope.

6.2 What kind of measures have been undertaken?

Around the globe a rapidly growing number of countries and legal jurisdictions are passing legislation to restrict or end conversion therapy (Drescher et al., 2016; ILGA, 2020). A number of legislative approaches have been taken around the world including **legal bans on conversion therapy and the use of existing legislation to bring legal proceedings against conversion therapy providers.** Some legislative approaches also seek to restrict conversion therapies through regulatory measures such as regulating health professionals, advertising or health insurance. Table 4 provides a typology of legislative approaches taken (see Appendix 3 for a more detailed summary of legislative measures by jurisdiction and a list of sources)[33].

Table 4: Legal measures to end conversion therapy

Type of measure	Description	Example jurisdictions
Legal bans or restrictions	Legislation to restrict or end conversion therapy. The breadth and scope of such legislation varies as does the penalties imposed. Some apply only to health professionals (Germany, Ontario, Nova Scotia, Prince Edward, Murcia), specific professionals (e.g. psychologists) (Brazil) or particular healthcare	• Brazil • Ecuador • Malta • Germany • Canada (3 provinces)

[33] This list may not be exhaustive and reflects the time at which this research was undertaken.

	settings (e.g. addiction rehabilitation centres) (Ecuador). Some apply only to conversion therapy practiced with minors (e.g. Germany, Malta and laws in most Canadian provinces and US states). Some are more comprehensive and apply to any form of conversion therapy without qualifying providers or recipients (the Spanish regions of Andalusia, Aragon, Madrid and Valencia and the Canadian city of Edmonton).	• Spain (5 regions) • USA (20 states)
Regulation of health care professions (de facto bans)	Laws that regulate health care professions in ways that prohibit registered professionals from providing conversion therapy. These function as indirect bans. Professionals who violate such regulations face disciplinary procedures and may have their license or registration revoked. In some countries psychotherapists and life coaches are not regulated health professions and so do not fall within the scope of such regulation.	• Argentina • Uruguay • Samoa • Fiji • Nauru • Switzerland
Child protection legislation	Child protection laws to establish that attempts by parents or legal guardians to change a child's sexual orientation or gender identity constitute a safeguarding concern.	• Chile (proposed bill) • Taiwan
Equality/Anti-discrimination legislation	The application of equality legislation or the amending of anti-discrimination law to explicitly define conversion therapy as an act of discrimination against LGBT people.	• Chile (proposed bill) • Spain (5 regions)
Consumer protection legislation	The application of consumer rights legislation to paid-for conversion therapy. Conversion therapies may be deemed fraudulent practices due to being based in pseudo-science or for deceptive or inaccurate claims in its advertising. Consumer rights provisions may also be included within new laws designed to restrict conversion therapy.	• Vancouver (Canada) • Illinois (USA) • Connecticut (USA) • New Jersey (USA)
Advertisement legislation	Legislation that bans, restricts or regulates the advertisement or promotion of conversion therapy. A number of bans include provisions that specifically prohibit advertising.	• Brazil • Malta
Health insurance legislation	Restricting conversion therapy by prohibiting health insurers from providing coverage for such treatments, for example on the basis that homosexuality is not a diagnosable mental health condition, that conversion therapies are not effective treatments or that healthcare professional bodies do not endorse them.	• the Netherlands • Ontario (Canada) • Nova Scotia (Canada) • Prince Edward Island (Canada)

		• New York City (USA)

Legal bans or restrictions

Legislative measures to restrict conversion therapy vary in their scope and legal character in relation to whether they are limited to specific types of providers or recipients. Many laws are fairly limited in scope applying only to conversion therapy by specific providers or when delivered with particular groups of recipients.

Many laws are limited to conversion therapy provided by licensed health professionals (Germany, Ontario, Nova Scotia, Prince Edward, Murcia). Legislation in Brazil is even further limited in scope, applying only to licensed psychologists. The law in Ecuador applies only to conversion practices within addiction rehabilitation centres (other than extreme forms that would constitute 'torture' in Ecuadorian law). Nova Scotia (Canada) applies primarily to health professionals but also includes non-professionals 'in positions of trust or authority' which could include religious leaders.

Most measures enacted also only apply to conversion therapy carried out with minors (e.g. Germany and most Canadian provinces and US states that have laws). Malta's law is slightly broader applying to conversion therapy with any 'vulnerable person' (including anyone under 16 years of age, people with mental health conditions or anyone deemed so by a court taking into account their personal circumstances).

The bans in force in Madrid, Andalusia, Aragon and Valencia (Spain) as well as one in the Canadian city of Edmonton (Canada) are the most all-encompassing bans so far, applying to any intervention that aims to change a person's sexual orientation or gender identity (including religious counselling) without qualifying providers or recipients (ILGA, 2020).

Legislation that specifically ban or restrict conversion therapy do not always appear as specific laws on conversion therapy but may take the form of provisions within or amendments of existing legislation (e.g. the Isle of Man are in the process of amending a Sexual Offences and Obscene Publications Bill to include a clause that would ban conversion therapy).

Child protection legislation

Child protection laws have been used to restrict conversion therapy. For instance, in 2018 the Taiwanese Ministry of Health and Welfare issued a letter to local health authorities stating that any individual performing conversion therapy on children may be liable for prosecution under the Protection of Children and Youths Welfare and Rights Act. A bill proposed in Chile in 2019 would also define parental attempts at conversion therapy as a safeguarding issue by characterising them as acts of domestic violence.

Equality/Anti-discrimination legislation

The application of anti-discrimination law to conversion therapy has been proposed. For instance, in 2019 a proposed bill brought forward in Chile characterised parental attempts at conversion therapy as an 'act of arbitrary discrimination'. The bans on conversion therapy in five Spanish

regions also appear as provisions within omnibus social equality laws for protecting LGBT people from discrimination.

Consumer rights legislation

There have been a number of lawsuits brought against conversion therapy providers using consumer protection law (e.g. Ferguson et al. v. JONAH et al; Dubrowski, 2015). There are also sub-national bans that prohibit the charging of a fee for services that seek to change a person's sexual orientation or gender identity on the basis that they constitute fraudulent practices (e.g. Vancouver).

Regulation of healthcare professions

Several jurisdictions have introduced laws that regulate health care professions in ways that prohibit professionals from diagnosing someone with a mental illness based exclusively on their sexual orientation or gender identity (Argentina, Fiji, Nauru, Uruguay and Samoa). Although these laws do not explicitly ban conversion therapy, they can function as indirect bans that effectively prevent conversion therapy being delivered by mental health professionals within healthcare settings. Those who violate these regulations may face disciplinary measures and risk having their licenses or registration to practice revoked. These indirect bans only apply to regulated professions. In some countries (such as the UK) psychotherapists and life coaches are not regulated professions and so would not fall within the scope of regulation.

Advertisement legislation

Several legal bans on conversion therapy around the world include the prohibition of advertising or the promotion of conversion therapy (e.g. Brazil, Malta, Madrid, Murcia, Andalusia, Aragon).

Health insurance legislation

Several jurisdictions have also opted to restrict conversion therapy by prohibiting health insurers from providing coverage for such treatments. For instance, in 2012 the Dutch Health Minister announced that healthcare insurance coverage did not need to cover conversion therapies as homosexuality was not a psychiatric diagnosis. A number of subnational bans also prohibit conversion therapies from being considered 'insured services' (e.g. Ontario, Nova Scotia, Prince Edward Island, New York City). A bill currently being considered at a federal level in the USA would also ban the use of Medicaid funding to cover conversion therapy.

6.3 What legal challenges have these measures faced?

To date, **no final judicial decision has overturned a ban on conversion therapy**. There have been several (ultimately) unsuccessful attempts to overturn US state laws. Arguments used by those opposed to legislative restrictions have been based around the right to self-expression, parental rights and religious rights. Although these are indicative of the type of arguments that any ban on conversion therapy might encounter, it is important to note that these challenges were brought under a different legal system and were subject to different legal tests than would be the

case in the UK. In particular, the jurisdictions were not signatories to the European Convention on Human Rights, which may impose a higher level of scrutiny. Although preliminary injunctions were initially successful, both cases were unsuccessful at a court of appeal (see Table 5).

Table 5: Legal challenges and arguments

Legal Challenge	Jurisdiction and year	Plaintiff arguments	Court reasoning
Pickup et al. v. Brown et al. and Welch et al. v. Brown et al.	California, 2013	**Freedom of speech:** Plaintiffs argues that the law infringed conversion therapists' right to free speech. **Parental rights:** Plaintiffs claimed that the law violated parents' right to direct the upbringing of their children.	**Freedom of speech**: The court judged that the law regulates conduct not speech and that while communication that occurs during therapy was entitled to protection under the US constitution, it was "not immune from regulation". Further, they note that the law was adopted "for the important purpose of protecting public health, safety and welfare". **Parental rights**: The court judged that while it did not dispute the fundamental right of parents to raise their children as they see fit, that the Plaintiffs "cannot compel the State to permit licensed mental health [professionals] to engage in unsafe practices, and cannot dictate the prevailing standard of care".
King et al. v. Christie et al.	New Jersey 2014	**Freedom of speech:** Plaintiffs claimed that the law violated freedom of speech because conversion therapy is administered through verbal communication. **Freedom of religion:** Plaintiffs claimed that the law violated their free exercise of religion because it covertly targets their religion by prohibiting counselling that is generally religious in nature.	**Freedom of speech:** The court reasoned that the law regulates conduct not speech and that there was nothing to prevent professionals voicing their opinions in public or private, provided they did not practice conversion therapy. Furthermore, they stated that therapy was not immune from regulation on the basis of it being delivered by the spoken word. **Freedom of religion:** The court reasoned that the "right to freely exercise one's religion...does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability". They reasoned that the law was based on the legislature's neutral concern that conversion therapy is harmful and was of general applicability because it applied regardless of whether the provider or the recipient was motivated by religion.

A number of further challenges are still in progress in the United States (ILGA, 2020). As many of the legislative measures around the world have been recently introduced it is possible that further challenges may occur in years to come.

6.4 What effect have these measures had?

No published studies were identified that specifically examined the effect of these measures and it is unclear to what extent laws to restrict conversion therapy are enforced. Due to the recent nature of many of the legal measures, little is known about what impact they have had on conversion therapy practices. The law in Madrid (one of the most all-encompassing laws) has been successfully enforced resulting in a conversion therapist being fined (see Box 1).

Box 1: Case Study - Madrid

In 2019, the Community of Madrid fined a life coach €20,001 for offering conversion therapy via their website. The strap line for the website was "Yes, you can regain your heterosexuality" and the individual described herself as a 'coach' specialising in working with people with same-sex attraction and people addicted to pornography. In 2016 a complaint was filed by the LGBT rights group Arcópoli in which they presented the contents of the life coach's website to the authorities. An investigation was launched during which further complaints were made by two individuals claiming the coach had offered to cure them of their same-sex attractions. After a three-year process, in 2019 the coach was found to have violated Madrid's Comprehensive Protection Law against LGBTIphobia and Discrimination (2016) and was fined the minimum sanction for a 'very serious' infraction of the law. The sanction was hailed by LGBT rights groups as a "historic and pioneering sanction".

The successful action in this case was possible due to Madrid's comprehensive approach which applies to any intervention that aims to change a person's sexual orientation or gender identity without qualifying providers or recipients and also prohibits the promotion of conversion therapies. It is possible that this case would not have been successful under jurisdictions that apply only to registered health professionals as life coaching is often not a regulated health profession.

Source: El Pais (2019)

Several successful lawsuits have also been brought against conversion therapy providers in the USA and China using existing legislation such as consumer protection law. For example, in 2015 JONAH (Jews Offering New Alternatives to Homosexuality) was found to have violated the New Jersey Consumer Fraud Act by fraudulently claiming to provide "services that could reduce or eliminate same-sex attraction". The organisation was ordered to cease operating and to dissolve

(Dubrowski, 2015). In 2018, the defendants were found to be in breach of the order by operating under a new name (Jewish Institute for Global Awareness) and were ordered to pay damages[34].

An international report by ILGA (2020) has documented how other conversion therapy providers are rebranding and adapting their public-facing messages in light of ever-growing legislative measures to restrict their practices (see also Outright Action International, 2019). In addition to those documented elsewhere, the international coalition group for ex-gay organisations recently changed its name from 'Positive Alternatives to Homosexuality' (PATH) to 'Positive Approaches To Healthy Sexuality'[35].

ILGA (2020) note that many providers now deny they deliver 'conversion therapy', even accepting that conversion therapy is harmful, but continue to operate in the same way. Some organisations state that changing a person's sexual orientation or gender identity is not their primary aim but maintain that change is possible and may occur alongside treatment. For example, the Reintegrative Therapy Association, led by the son of reparative therapist Joseph Nicolosi, claims on its website that 'reintegrative therapy' is "entirely separate from conversion therapy" and that it aims to treat trauma and addiction rather than sexual orientation. However, it then goes on to state that "as these dynamics are resolved, the client's sexuality can sometimes change on its own"[36].

Some groups also avoid referring to homosexuality and gender incongruence as 'disorders' on their websites, instead using terms such as 'healthy sexuality', 'sexual brokenness' and 'gender confusion'. ILGA (2020) has also noted that some forms of conversion therapy brand themselves in ways that imply they cause no harm. For example, one approach (that is advocated by a Christian ex-gay organisation in the UK[37]) is called 'Sexual Attraction Fluidity Exploration in Therapy' and is abbreviated to 'SAFE-T'. When introducing measures to restrict conversion therapies, legislators should therefore consider ways in which organisations may rebrand and alter their public-facing messages.

[34] New Jersey Superior Court, Ferguson et al. v. JONAH et al. (Memorandum of decision), 19 June 2019, 1, 2
[35] PATH has at least four UK-based member organisations listed on their website. The life coach fined in Madrid promoted herself as "a Certified Coach in sexual orientation by PATH".
[36] https://www.reintegrativetherapy.com/reintegrative-therapy
[37] https://www.core-issues.org/change-oriented-therapy

Conclusions

7. Conclusions

This section concludes by drawing out some of the policy implications of the findings as well as considering gaps in the evidence identified by the REA (see Table 6 for a summary of findings by research question and type of conversion therapy).

Table 6: Summary by research question and type of conversion therapy

Research Question	Sexual Orientation Change Efforts (SOCE)	Gender Identity Change Efforts (GICE)
RQ1: What forms does conversion therapy take?	SOCE tended to be delivered by faith groups, mental health professionals or family members. It often takes the form of talking therapies or spiritual guidance and intervention.	Limited evidence available but some conversion therapists appear to consider all LGBT people to have a form of gender disorder. Some evidence that conversion therapy for transgender people tends to be delivered in a similar way to SOCE (i.e. talking therapies or religious interventions).
RQ2: Who experiences conversion therapy and why?	No representative prevalence data exists specifically for SOCE. The best available data from the UK suggests approximately 2% of cisgender LGB respondents had undergone conversion therapy and a further 5% had been offered it However, it is not possible to confirm whether the change efforts experienced by these cisgender LGBT respondents were specifically directed at changing sexual orientation (or their gender identity). Those exposed to SOCE tend to have a strong religious faith. Motivations for seeking conversion therapy tend to be associated with conflict about sexual orientation.	No representative prevalence data exists but some evidence (from both the UK and the US) appears to suggest that transgender respondents may be more likely to be offered or receive conversion therapy than cisgender sexual minorities. The best available data from the UK suggests that 4% of transgender respondents had undergone conversion therapy and a further 8% had been offered it. As with the SOCE, it is not possible to tell whether change efforts were directed at changing transgender respondents' gender identity or their sexual orientation.
RQ3: What are the outcomes of conversion therapy?	No robust evidence that conversion therapy can change sexual orientation. Consistent evidence of self-reported harms associated with conversion therapy.	No evidence that conversion therapy can change gender identity. Limited but reasonably strong evidence that self-reported harms associated with conversion therapy.
RQ4: What measures have	An increasing number of legal jurisdictions have enacted measures to restrict or ban	Many legal measures used to restrict conversion therapy appear to apply to

been taken to end conversion therapy around the world?	SOCE which vary in scope. Some bans have also included a prohibition of advertising conversion therapy. Limited evidence on effectiveness of measures. Successful legal action challenging conversion therapy relate to SOCE.	both SOCE and GICE. Some jurisdictions initially brought in measures that applied only to SOCE and later extended them to include GICE.

7.1 Policy implications

Given that conversion therapy is commonly based on inaccurate information about sexual orientation and gender identity, there is scope for awareness raising activities among healthcare professionals and faith groups. Evidence that some mental health professionals may mistake minority sexual orientations and gender identities as symptoms of existing mental health conditions may also suggest that health professionals may benefit from further training on issues of gender and sexual diversity (BPS, 2019).

Conversion therapy can take many different forms, take place in a range of settings and may not openly present itself as ‘conversion therapy’. Policy around conversion therapy should consider the range of ways that conversion therapy can manifest itself to comprehensively tackle the issue.

Although the majority of people who undergo conversion therapy appear to do so voluntarily, they also describe being led into conversion therapy by those in a position of authority either within religious institutions or within their families. In addition, a number of unethical practices by people in positions of authority were documented by UK interviewees, including the provision of inaccurate information (affecting the individual’s ability to give full and valid consent), individuals being coerced to undergo conversion therapy, being asked to sign non-disclosure agreements and, in one case, sexual assault by a conversion therapist. Several interviewees characterised what they had experienced as forms of ‘spiritual abuse’. This suggests that a particular focus of policy could be around working with organisations to prevent the abuse of positions of trust and authority.

There is a growing body of evidence that conversion therapy may be harmful. Evidential reasoning would also suggest by its nature and purpose conversion therapy is likely to reinforce and contribute to self-rejection and internalised stigma that is associated with minority stress and negative health outcomes (APA, 2009a).

An American Psychological Association Task Force (2009a) suggest aspects of conversion therapies that should be avoided include overly directive treatment that insists on changing a person’s sexual orientation, the communication of inaccurate, stereotypic or unscientific information, the use of unsound and unproven interventions and misinformation on treatment outcomes. Policy could seek to target these most problematic aspects of conversion therapy.

There is little evidence on what works to end conversion therapy in terms of legislative measures. However, given that much conversion therapy appears to take place in religious settings, legislation that applies only to health professionals is likely to have only a limited impact on ending conversion therapy. Policy makers should bear in mind the way in which conversion therapy providers may rebrand and change their public-facing message in response to criticism and legal restrictions. In addition to legislative measures to ban or restrict conversion therapy, policies could

focus on developing constructive dialogue with religious groups. Such dialogue could be used to educate them about the harms of conversion therapy and encourage alternative approaches to pastoral guidance with LGBT people of faith that avoid the aspects most likely to cause harm.

7.2 Evidence gaps

This Rapid Evidence Assessment has identified a number of gaps in the evidence base relating to conversion therapy (see Table 7).

Table 7: Key evidence gaps

Gap	Description
Prevalence of conversion therapy.	There is a lack of representative data due to self-selected samples and lack of representative data of the LGBT population in the UK.
Experiences of sexual and gender minorities beyond those who identify as LGBT.	Further research is needed to examine the conversion therapy experiences of asexual, non-binary and intersex persons as well as health professionals' attitudes towards and knowledge of people who identify as such. Further research is also needed into the conversion therapy experiences of those with same-sex attractions who do not identify as LGB.
Conversion therapy experiences of ethnic minority groups and those from non-Christian faiths.	More information is needed to understand the forms that conversion therapy takes among these groups.
Evidence relating to gender identity change efforts.	There is currently relatively little evidence regarding gender identity change efforts. Further research could specifically examine transgender people's experience of conversion therapies and the forms it takes. Additional research on the harms associated with gender identity change efforts would also be useful.
Lack of 'gold standard' evidence on effectiveness.	No randomised control trials of conversion therapy exist. However, such designs are practically and ethically difficult to conduct in relation to conversion therapy and it is unlikely that any will be conducted in future. Lower quality evidence and evidential reasoning may need to be relied upon when making policy decisions.
Impact of legislative and non-legislative measures.	Comparison data before and after legislative measures would help determine their effectiveness in ending conversion therapy. Research on the effectiveness of non-legislative measures such as awareness raising, education and training programmes would also help inform policy making.

In addition to the evidence presented in this report, future research addressing the evidence gaps identified above could usefully inform future policy making in relation to conversion therapy.

Appendices

8. Appendices

Appendix 1 - Glossary

Please note that we are aware that the terminology used in relation to the recognition of people's sexual orientation or gender identity may depend on the context of its use. Some people may define some terms differently than we have done. We have tried to use terminology that is generally accepted. No offence or omission is intended. Please find below the definitions we have used.

Asexual	Someone who does not experience sexual attraction.
Bisexual	Attraction towards more than one gender or sex. Distinct from pansexual, which includes attraction towards people regardless of gender or sex.
Cisgender	Used in this report to refer to people whose gender identity matches their sex assigned at birth, i.e. who are not transgender.
Conversion therapy	Interventions aimed at changing someone's sexual orientation or gender identity (typically from minority sexual orientations or gender identities to heterosexual and cisgender). Also referred to as reparative therapy, Sexual Orientation Change Efforts (SOCE) or Gender Identity Change Efforts (GICE).
Ex-gay	A person who has undergone 'conversion therapy' and has ceased to identify as lesbian, gay or bisexual but may still experience same-sex attraction and engage in same-sex behaviour.
Ex-gay ministry	A term used for conversion therapy that takes place in religious settings or by religious organisations.
Ex-gay movement	A movement of religiously based self-help groups for distressed individuals with unwanted same-sex attraction who often refer to themselves as ex-gay.
Gay	A term used to describe someone who has an emotional, romantic or sexual orientation towards someone of the same sex or gender.
Gender dysphoria	A medical diagnosis that someone is experiencing discomfort or distress because there is a mismatch between their sex and their gender identity.

Gender expression	A person's outward expression of their gender. This may differ from their gender identity or it may reflect it.
Gender identity	A person's internal sense of their own gender. This does not have to be man or woman. It could be, for example, non-binary.
Gender Identity Change Efforts (GICE)	Interventions aimed at changing someone's gender identity from transgender to cisgender.
Gender incongruence	A mismatch between an individual's sex and their gender identity. This may or may not be accompanied by discomfort or distress. This is identified as a sexual health issue by the World Health Organisation and not a mental or behavioural disorder.
Gender reassignment	A protected characteristic under the Equality Act 2010. A person "has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex". Subject to certain exceptions, the Equality Act 2010 prohibits discrimination because of gender reassignment, for example in employment or in the provision of services. This includes treating employees or service users less favourably because of a mistaken belief that the person is proposing to undergo, is undergoing, or has undergone the process of reassigning their gender. Exceptions can only be justified if they are a proportionate means of achieving a legitimate aim.
Heterosexual	A term used to describe someone who has an emotional, romantic or sexual attraction towards someone of the opposite sex or gender. Also referred to as straight.
Homosexual	A term used to describe someone who has an emotional, romantic or sexual attraction towards someone of the same sex or gender. Also referred to as gay.
Intersex	An umbrella term for people with sex characteristics (hormones, chromosomes and external/internal reproductive organs) that differ to those typically expected of a male or female. Intersex people may identify as male, female, non-binary or intersex.
Lesbian	A term used to describe a woman who has an emotional, romantic or sexual orientation towards someone of the same sex or gender. Some women who fit this definition may prefer to identify as gay.

LGBT	An abbreviation used to refer to lesbian, gay, bisexual and transgender people. In this report it is used as an umbrella term for any minority sexual orientation or gender identities (including asexual, non-binary).
Minority gender Identity	Used in this report to refer to anyone not identifying exclusively as a man or woman (e.g. non-binary) or identifying as transgender or anyone with a transgender history.
Minority sexual orientation	Used in this report to refer to anyone not identifying as heterosexual. This includes individuals identifying as gay, lesbian, bisexual, pansexual, asexual, same-sex attracted etc.
Non-binary	An umbrella term used to describe gender identities where the individual does not identify exclusively as a man or a woman. They may regard themselves as neither exclusively a man nor a woman, or as both, or take another approach to gender entirely. There are many included within this, such as agender, genderqueer and gender fluid.
Pansexual	Attraction towards people regardless of gender or sex.
Queer	A term used mainly by people who identify with a minority sexual orientation or gender identity. In the past, it was used as a derogatory term for LGBT individuals.
Reparative therapy	A specific form of conversion therapy associated with British theologian Elizabeth Moberly and American psychologist Joseph Nicolosi. The term is often used interchangeably with conversion therapy.
Sex	Registered by medical practitioners at birth based on physical characteristics. Sex can be either male or female. Assignment is based on hormones, chromosomes and genitalia.
Sexual fluidity	A term for natural changes in sexual attractions or identity. Sexual orientation is stable and unchanging for most people, but some people may experience change. This is distinct from deliberate attempts to change a person's sexual orientation.
Sexual identity	A term used to refer to the label people use to describe their sexual orientation. This may or may not be a true reflection of their actual sexual attractions. Common sexual identities include straight, lesbian, gay, bisexual, pansexual and asexual.
Sexual orientation	Describes who a person is emotionally, romantically or sexually attracted to.
Sexual Orientation Change Efforts (SOCE)	Interventions aimed at changing someone's sexual orientation from a minority sexual orientation to heterosexual.

Straight	Someone who is attracted to members of the opposite sex. Also referred to as heterosexual.
Transgender/Trans	An umbrella term used to describe individuals who have a gender identity that is different to the sex recorded at birth. This might lead to gender dysphoria or incongruence. Non-binary people may or may not consider themselves to be transgender.
Transsexualism	A term historically used as a medical diagnosis for transgender people. This was later replaced with the diagnosis of gender identity disorder and most recently with the diagnosis of gender dysphoria or gender incongruence.
Unwanted same-sex attraction	A term used by those seeking to change their sexual orientation who do not wish to identify as lesbian, gay or bisexual.
Variations in sex characteristics	An umbrella term used to describe physical sex development which differs from what is generally expected of ‘males’ or ‘females’. These variations are congenital and may be chromosomal, gonadal, anatomical or hormonal. This is more commonly known as intersex.

Appendix 2 - Research method

A. Rapid Evidence Assessment

The rapid review was conducted to review evidence published from January 2000 to June 2020. It was based on rapid evidence assessment (REA) methods, and the REA guidance produced by the EPPI-Centre for Civil Service on Rapid Evidence Assessment (Civil Service, 2014) was used as a framework for the review.

Inclusion criteria for review
In order to complete the REA within the time available only empirically based evidence identified within the available time was included to address the first three research questions (RQ1, RQ2, RQ3)

The following inclusion criteria were used for academic literature:

- Empirical studies (quantitative or qualitative), case studies, and systematic reviews of literature relating to conversion therapy that address one or more of the research questions
- Studies published in English since 1 January 2000 that were obtainable within the time available
- Studies published in academic journals or on the websites of professional organisations
- Studies from any country
- Studies on any form of conversion therapy

The following exclusion criteria were applied:

- Narrative/unsystematic literature reviews
- Books/extracts from books
- Book reviews
- Editorials/commentaries
- Studies not published in English
- Studies published prior to 2000
- Studies that did not provide data that would help answer the research questions

An additional search of the grey literature was included to address the final research question (RQ4) on international practice. For RQ4 the inclusion criteria were that the evidence related to legislative measures to end conversion therapy. The mere expression of opposition to the practice of conversion therapy (e.g. Government ministers announcing their opposition; psychological professional bodies expressing opposition) were excluded.

Search strategy, screening and data extraction

Three approaches were taken for identifying evidence: academic database searches, a call for evidence and a grey literature search.

A systematic search was conducted of the following academic databases: PsychARTICLES, PsychINFO, MEDLINE, CINAHL Complete, Academic Search Complete, Proquest Central and Scopus. Search terms were selected based on those used in previous reviews of conversion therapy in consultation with an psychology subject librarian and agreed in conjunction with GEO. Search terms used included 'conversion therapy' and its synonyms ('reparative therapy', 'ex-gay', 'reorientation therapy', 'change efforts', 'cure therapy', 'change therapy', 'reintegrative therapy', 'corrective rape') in combination with 'sexual orientation' or 'gender identity' and synonyms ('sexual minority', 'lgbt', 'lgb', 'gay', 'lesbian', 'bisexual', 'transex*', 'transgender*', 'homosex*'). All articles which included the search terms in the title, abstract or keywords were retrieved. A full reference list search was not conducted due to the time limitations for completion of the REA.

A call for evidence was sent via two email lists for psychologists specialising in sexual orientation, gender identity or LGBT issues (one UK based and one international), an email list for UK LGBT health researchers and to representatives of the MoU on conversion therapy working group.

Once the academic literature search was complete the retrieved items were screened. First, the titles and abstracts were reviewed against the inclusion and exclusion criteria. Full texts of articles were then obtained. The full texts were read and compared against the inclusion and exclusion criteria. If papers were judged not to meet the inclusion criteria they were excluded. The original search was run at the beginning of the project in January 2019 for the period 1 January 2000 to 31 December 2018. The search was then re-run for the period 1 January 2019 – 30 June 2020 to capture any studies published in the intervening period so the REA was as up-to-date as possible. This resulted in 46 articles being identified in total.

The strengths and weaknesses of each study were critically appraised in relation to methodological issues. The Mixed Methods Appraisal Tool (MMAT) was used to critically appraise the articles (Pluye et al., 2011). The MMAT can be used to appraise most types of methodology and design. Due to the lack of evidence for answering some research questions, no studies were excluded on the basis of methodological weaknesses. Instead, methodological weaknesses within the literature are addressed in the reporting of findings. All articles were reviewed by one reviewer and a sample of 10% were independently assessed by a second reviewer to ensure consistency.

Data was extracted according to the author and year, study design, number of participants and findings relevant to each research question. In order to produce the final report, the data collected for each of the research questions were synthesised. The data were explored for patterns and the findings of studies were interpreted in light of the findings of other studies.

Quality of Studies

The quality of studies was generally found to be **average** using the MMAT tool with the quality of studies assessing effectiveness being lower due to design limitations (see Table 8 for common methodological limitations).

Table 8: Key methodological limitations of published studies

Limitations	Description
A lack of prospective, controlled studies	There is a lack of randomised controlled trials that involve random allocation of participants to treatment groups and a control condition or studies that take measurements pre and post treatment. As such it is not possible to make robust claims of effectiveness or make robust causal inferences.
Studies rely on retrospective self-reports	Any 'pre-test' measures are usually based on remembering how they felt prior to the therapy. This makes the findings vulnerable to biases deriving from the individual justifying to themselves the time, effort and money they've invested in the therapy, and the individual perceiving change because they have been led to expect change. Studies typically don't use objective measures. Findings from qualitative studies may not be accurate due to the unreliability of recall.
A lack of studies that follow individuals over time	Most studies take measures at a single time point either during or post intervention. It is therefore not possible to assess the long-term effects of conversion therapies or whether any reported changes are sustained in the long term.
Studies use different measures of 'success'	Measures used typically relate to sexual attraction, sexual behaviour or sexual identity. However, changes in sexual behaviour or identification are not a valid indicator that a change in sexual orientation has occurred. Many studies address one or several of these outcomes.
Studies include a wide variety of conversion therapy methods	Studies adopt broad definitions of conversion therapy with varied approaches and techniques included within a single study. As such, it is difficult to attribute any efficacy, benefit or harm to particular intervention approaches, components or providers.
Studies rely on self-selecting samples	Studies generally do not use recruitment strategies designed to obtain representative samples. Studies often rely on self-selected sampling and recruit either via conversion therapy networks and/or LGBT networks. Such sampling strategies may introduce sampling biases that make it difficult to generalise the findings to the wider population.

To answer RQ4 which relates to measures taken around the world a search of the grey literature was required as none of the studies from the academic literature could adequately answer this question or provide up-to-date information. This involved searching the websites of organisations including the International Lesbian, Gay, Bisexual, Transgender and Intersex Association (ILGA), entries for conversion therapy in Wikipedia and Equaldex (a wiki-style collaborative LGBT rights

knowledge base) and media sources via Openly (a global digital platform by Thompson Reuters for LGBT+ news). Efforts were made to verify information on these websites via accessing original sources, triangulation (e.g. comparing information from one source with information from another source) and through contact with international experts compiling similar information. As RQ4 relates to the legal status of conversion therapy in different countries, many original sources were not in English. Where possible sources were translated to verify information from the original source. Every effort has been made to ensure the accuracy of information presented however in some cases we had to rely on secondary sources that may not always be accurate.

B. Qualitative interviews

For the qualitative study, semi-structured interviews were carried out with 30 individuals with experience of efforts to change sexual orientation or gender identity. Prior to data collection ethical approval was granted through Coventry University's institutional ethics procedures. Interviewees were provided with an information sheet and consent form that explained the purpose of the study, what would be involved and how their data would be handled. Most interviews were conducted either face-to-face, via video calling or by phone. Interviews were conducted between April and July 2019. The average length of interviews was 62 minutes (range 30 - 102 minutes). Interviews were audio recorded with the interviewees' consent and fully transcribed. Two participants with autism chose to provide written responses to the questions instead of a verbal interview. Interviewees were asked about their personal background, the circumstances leading up to their experiences of conversion therapy, what it involved and what the outcome was. Following the interview, interviewees were given a £10 shopping voucher to thank them for their time and were provided with information signposting them to sources of support. Interview data were anonymised to protect their identities.

Sampling and sample characteristics

A wide range of recruitment strategies were used:

- A call for participants was distributed through social media and via professional email lists for psychologists and those working in the area of LGBT health.
- A variety of stakeholder organisations and individuals were contacted about the study including LGBT organisations, religious organisations, networks for LGBT+ people of various religious faiths as well as mental health professional bodies.
- The Ozanne Foundation[38] contacted respondents of their *Faith and Sexuality survey* who had reported experiencing conversion therapy and had consented to be contacted regarding future research.
- Fliers about the research were distributed at two Pride festivals (Birmingham and Coventry) that coincided with the data collection period. As the word 'therapy' may not accurately reflect the nature of all conversion efforts, we specifically invited anyone who had experienced 'efforts to change their sexual orientation and gender identity'.

[38] The Ozanne Foundation works with religious organisations to eliminate discrimination based on sexuality or gender. In 2018 the Foundation conducted a UK-based Faith and Sexuality survey to examine the role of religious belief on people's understanding and acceptance of their sexuality.

Potential participants were directed to a screening survey to register their interest in taking part in the project where they were provided with full information about the research. If they were willing to take part after reading the information they were asked to provide some information about themselves (e.g. age, gender, sexual orientation, gender identity, ethnicity, religion), some basic information about the conversion therapy (e.g. how long ago they experienced conversion therapy) and their contact details.

Screening was conducted to screen for eligibility and to help recruit a sample of participants with a diverse range of experiences. Participants who indicated that they had experienced conversion therapy within the last twenty years were contacted to invite them to take part in an interview. The criteria for taking part was that the participant must have had first-hand experience of efforts to change from a minority sexual orientation or gender identity to heterosexual or cisgender. For the purposes of this research, efforts to change sexual orientation via gender reassignment was not included (see Ashley, 2019 for a discussion of gender affirmative care in relation to conversion therapy).

The final sample consisted of 30 interviewees, of which twenty-eight lived in England, one in Scotland and one in Northern Ireland. The majority of interviewees (87%) lived in urban areas. The sample was predominantly white (28) and Christian (22) despite attempts to reach out to black and ethnic minority and non-Christian faith groups. A summary of sample characteristics is provided in Table 1 (see Section 2.2). To be eligible all indicated that they had experienced conversion therapy in the last 20 years and two-thirds (20) of the sample had experienced conversion therapy within the last 10 years[39]. Some interviewees' experience of conversion therapy extended over a prolonged period of time, in some cases over a number of years.

Data analysis

The data was analysed using framework analysis (Ritchie & Spencer, 1994), an approach specifically developed for applied policy research which has also been widely used in healthcare, public policy and psychological research. It is a matrix-based method involving the construction of a framework into which data can be coded. Data were analysed using a five-step approach as shown in Table 9.

Table 9: Stages of analysis

Stage	Description
1. Familiarisation	Immersion in the raw data
2. Identifying a framework	Identifying the key issues by which the data can be indexed
3. Indexing	Systematically applying the framework to each interview transcript

[39] No major differences were noted in the experiences of those who had experienced conversion therapy in the last 10 years compared to those who had experienced it within the last 20 years.

4. Charting	Summarising data according to category and participant within a table
5. Interpretation	Finding patterns and making sense of the data, in relation to the research questions

Appendix 3 - Measures taken by country

Table 10: Measures taken internationally (by country)[40]

Country	Detail	Source
Albania	De facto ban since May 2020. Albania's national psychological association banned its members from practising conversion therapy. As membership is required to practice in the country, this effectively bans conversion therapists among psychologists,	"Albania psychologists barred from conducting gay 'conversion therapy'". *Reuters*, 18 May 2020
Argentina	De facto ban since 2010. Mental health professionals have been regulated to prevent diagnoses exclusively on the basis of sexual orientation or gender identity	Right to the Protection of Mental Health Law 26,657, Article 3-C.
Australia	In 2016 in the state of Victoria, the Health Complaints Bill 2016 created a Health Complaints Commissioner with powers to take action against unethical medical treatment including some forms of conversion therapy. The law took effect in 2017. In 2019 the Victoria Premier announced that the state would ban conversion therapy.	Health Complaints Bill 2016.
Brazil	In 1999 Brazil was the first country to introduce a nationwide legal restriction of conversion therapy. The Federal Council of Psychology ordered that "psychologists will not collaborate with events and services that propose treatment and cure for homosexuality" or publicly "reinforce existing social prejudices towards homosexuals as having any psychic disorder"	Federal Council of Psychology, Resolution No. 1/99 (1999), article 3; Federal Council of Psychology, Resolution No. 1/18 (2018).
Canada	Three Canadian provinces (Ontario, Nova Scotia and Prince Edward Island) have banned conversion therapy. The cities of Vancouver, Edmonton and Calgary have also passed bylaws. A federal bill and a bill in British Columbia are currently being considered.	Affirming Sexual Orientation and Gender Identity Act (2015), Section 1. Sexual Orientation and Gender Identity Protection Act (2018). Sexual Orientation and Gender Identity Protection in Health Care Act (2019). Motion on Conversion Therapy (2018). The City of Edmonton Bylaw 19061: Prohibited Businesses Bylaw (2019).

[40] As of June 2020.

		Allen, M. “City of Calgary votes to ban conversion therapy**”**, *The Globe and Mail*, 25 May 2020.
Chile	Amendment of existing legislation. In May 2019, a bill was introduced to amend the law on domestic violence (Law No. 20,066) and anti-discrimination law (Law 20,069). Amendments to the former would establish that any acts by legal guardians aimed at changing a child’s sexual orientation or gender identity would constitute domestic violence against a child and the latter amendment would list such acts by as “acts of arbitrary discrimination” and would allow any person to file a complaint in favour of the child.	Bulletin N ° 12660-18, Draft Law: Modifies Law N ° 20.066, and Law N ° 20.609,
China	Successful litigation. In 2014 a Beijing court ruled in favour of a gay man in a case against a clinic that practiced hypnosis and electric shock conversion therapy. In 2016 a man from Henan Province sued a hospital for forcing him to undergo conversion therapy and was awarded an apology and compensation.	"Victory for plaintiff in gay conversion case", *China Daily*, 19 December 2014. Phillips T, "Gay man sues Chinese psychiatric hospital over 'sexuality correction'", *The Guardian*, 14 June 2016.
Ecuador	Nationwide legal restrictions. In 2012 a Ministerial Agreement prohibited conversion therapy in certain institutions. In 2014 an amendment to the Ecuadorian Penal Code outlined aggravating circumstances for the crime of torture when it is perpetrated in order to change a person’s sexual orientation or gender identity. This was as a result of heinous acts of mistreatment coming to light in Ecuador.	Ministerio de Salud Pública (Ecuador), Acuerdo Ministerial No. 767 (2012); Comprehensive Organic Penal Code, Article 151(3).
France	The Law Commission of the French National Assembly has set up a fact-finding mission with a view to introducing a bill to create a specific offense within the criminal code aimed at punishing “conversion therapy”	“Flash fact-finding mission of the commission on laws on practices purporting to change the sexual orientation or identity of a person” Asemblé Nationale, December 2019.
Fiji	De facto ban. In 2010 the Mental Health Decree 2010 prohibited conversion therapy in the field of mental health. This only applies to health professionals.	Mental Health Decree 2010 (Decree No. 54 of 2010), Section 3(1)(d).
Germany	Nationwide ban. In 2020, Germany passed a bill that banned nationwide conversion therapy for minors and forbids advertising of conversion therapy. It also forbids conversion therapy for	Federal government bill: Bill on protection against conversion treatment (2019).

	adults, if they undergo it by force, fraud or pressure.	
Ireland	Nationwide ban being considered. In 2018 the Prohibition of Conversion Therapies Bill 2018 passed second reading in Seanad Éireann (the upper house) and currently awaits a third reading and passage in the Dáil Éireann (the lower house).	Prohibition of Conversion Therapy Bill (2018).
Malta	Nationwide ban. In 2016 the Parliament of Malta approved the Affirmation of Sexual Orientation, Gender Identity and Gender Expression which banned conversion therapy. It was the first European country to ban conversion therapy and the most comprehensive when introduced.	The Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act. Act No. LV (2016).
Mexico	Mexico is currently considering a bill that would outlaw conversion therapy at a federal level. There are also sub-national bills under consideration in Mexico City and the State of Jalisco	Parliamentary Gazette No. 27 (Tome II), 8 August 2018, page 514
Nauru	De facto ban. In 2016 the Mentally Disordered Persons Act was amended to prevent mental health professionals from diagnosing people as mentally disordered exclusively on the basis of sexual orientation.	Mentally Disordered Persons Act (as amended in 2016), Section 4A(1)(d).
Netherlands	In 2012 the Dutch Health Minister announced that healthcare insurance coverage did not need to cover conversion therapies as homosexuality was not a psychiatric diagnosis.	"End of reimbursement for conversion therapy seems to be in sight" *COC Netherland*, 3 May 2012.
New Zealand	In 2018 the New Zealand Justice Minister announced a ban on conversion therapy would be considered as part of a review of the Human Rights Act 1993. A bill to prohibit conversion therapy was then introduced to Parliament in October 2018.	Prohibition of Conversion Therapy Bill (2018).
Poland	The Nowoczesna party and Campaign Against Homophobia have drafted a bill that would ban conversion therapy if passed.	“Poland with the new act banning the use of conversion pseudotherapies on the LGBT people”, *Kampania Przeciw Homofobii*. 22 February 2019
Samoa	De facto ban. In 2007 the Mental Health Act 2007 prohibited conversion therapy in the field of mental health. This ban only applies to registered health professionals.	Mental Health Act (2007), Section 2.

Spain	Sub-national bans. Five regions of Spain have banned conversion therapy including Madrid, Murcia, Andalucía, Aragón and Valencia. With the exception of Murcia, all bans appear broad in scope. The bans in force in Madrid, Andalucía, Aragón and Valencia (together with the one in the Canadian city of Edmonton) are the most comprehensive bans introduced thus far applying to any conversion therapy intervention (including religious counselling) without qualifying providers or recipients. Spain is now looking to introduce a national bill that would outlaw conversion therapy at the national level.	Law No. 3/2016 Comprehensive Protection against LGTBIphobia and Discrimination for Reason of Orientation and Sexual Identity in the community of Madrid, article 3 (o). Law No. 8/2017 To guarantee the rights, equal treatment and non-discrimination of LGTBI people and their relatives in Andalusia, article 3 (o). Law No. 23/2018 Equality of LGBTI people. Law No. 18/2018, Equality and comprehensive protection against discrimination on sexual orientation, expression and gender identity in the Autonomous Community of Aragon article 4(4). Law No 8/2016, Lesbian, gay, bisexual, transgender, and intersex social equality, and policy equality actions against discrimination on sexual orientation and gender identity in the Autonomous Community of Murcia.
Switzerland	De Facto ban. In 2016 the Swiss Federal Council issued a statement that in their view the monitoring of psychotherapy was the responsibility of the supervisory body under the existing Psychology Professions Act, that conversion therapies constitute a violation of professional duties and that the supervisory authority may impose disciplinary measures up to and including the prohibition to practice. They further stated that the courts should decide on a case-by-case basis whether performing such therapy is a crime.	Interpellation: Prohibition and Punishability of Therapies to "Treat" Homosexuality in Minors (2016).
Taiwan	De facto ban. In 2018 the Ministry of Health and Welfare issued a letter to all local health authorities stating that sexual orientation conversion therapies are not regarded as legitimate healthcare and that performing such therapies were an infringement of human rights liable to prosecution under the Criminal Code or the Protection of Children and Youths Welfare and Rights Act depending on the circumstances. Prior to this the Taiwanese Government were considering codifying a ban under the Physicians Act and Psychologists Act	Ministry of Health and Welfare (Department of Medical Affairs), “Responses to the complaint submitted by civil organizations concerning “conversion therapy”, Yi-Zih No. 1071660970, 22 February 2018

	which would have introduced severe fines and short-term license suspensions.	
UK	In the Isle of Man (a self-governing British crown dependency) a new provision has been added to the Sexual Offences and Obscene Publications Bill (2019), which has now completed the clauses stage. Clause 88 would make it an offence for a person to practice, or to offer to practice conversion therapy. Conversion therapy is defined as being "any form of therapy which demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other and which attempts to change a person's sexual orientation or gender identity or suppress a person's expression of sexual orientation or gender identity" The UK Government has committed to exploring legislative and non-legislative options for ending so called 'conversion therapy' and are currently examining the best ways to end the practice.	Sexual Offences and Obscene Publications Bill 2019 The Government Equalities Office LGBT Action Plan 2018
USA	Sub-national bans. As of June 2020, 20 states and two districts (District of Columbia and Puerto Rico) have bans against conversion therapy. Most have a relatively limited scope, applying only to licensed professionals (as providers) and minors (as recipients). Two bills are being considered at a federal level. One would make advertising conversion therapy a deceptive practice under the Federal Trade Commission Act. The other would ban the use of Medicaid funding to cover conversion therapy.	"Virginia becomes 20th state to ban conversion therapy for minors", NBC News, 3 March 2020. HB 386 Conversion therapy; prohibited by certain health care providers. See ILGA (2020) for list of laws in the other 19 states and 2 districts
Uruguay	In 2017 the Mental Health Law states that no mental health diagnosis can be made on the exclusive basis of sexual orientation and gender identity.	Mental Health Law (2017), Article 4.

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