יום ראשון, 21 יוני 2020

לכב׳ הרב פרופ׳ דניאל שפרבר

הנדון: טיפולי המרה

בתחילת דברי ברצוני להבהיר כי הפניה לכבודו נעשית על דעתם של חברי ועדת אתיקה של איט״מ (האגודה הישראלית לטיפול מיני). אנו פונים אליך בעקבות כתבות שהופיעו לאחרונה בעיתוני המגזר הדתי המנסים ללמד זכות על טיפולים פסיכולוגיים שמיועדים לנערים ונערות המשתייכים למגזר הדתי, שמגלים בעצמם נטיות הומוסקסואליות. טיפולים אלה לדעת הכותבים מצילי חיים ועוזרים לצעירים שנמצאים במצב קשה עקב נטייתם המינית לצאת מחושך לאור.

אנו, מטפלים מיניים שעוסקים רבות בתחום, יודעים ממחקרים שההפך הוא הנכון. טיפולים שמנסים לגרום לצעירים להט״בים לשנות את נטייתם המינית גורמים לנזק נפשי בל יתואר, שמביא במקרים לא מעטים גם לאובדנות. טיפולי המרה נאסרו בארצות הברית ובאירופה בשל הסכנה הטמונה בהם וסיכון חיי מי שמתנסה בהם.

לאנשי טיפול הנשענים על מחקרים ברור שבחירה מגדרית איננה הפרעה, ובוודאי לא סטיה ולכן אין לטפל בה כדי לשנותה. אנו מודעים לכך שהדת איננה מקבלת את הנטייה המינית ההומוסקסואלית, ויחד עם זאת ישנם לא מעט דתיים הומוסקסואלים ולסביות שחיים חיים מאושרים, ובמידת הצורך נעזרים בטיפול פסיכולוגי שמסייע להם בהתמודדות עם סביבתם, אך הטיפול איננו סובב סביב סוגיות שינוי נטייתם המינית. למעשה, מחקרים מצביעים על כך שטיפולי ההמרה אינם יעילים בהחלפת הנטייה המינית.

כיום, אנו עדים לתופעה בה בעידוד רבנים ויועצים מהמגזר הדתי, הומוסקסואלים מונחים לחיות אורח חיים הטרוסקסואלי כשהתוצאה היא חיים כפולים: על פניו הם מנהלים לכאורה אורח חיים הטרו-נורמטיבי אך מאחורי הקלעים הם מספקים את צרכיהם המיניים עם בני זוג שמתאימים לנטייתם המגדרית. בפועל – האנשים הללו חיים בשקר כלפי בני/בנות הזוג שלהם וכלפי עצמם. כמטפלים מיניים, אנו מתריעים על הסכנה הכרוכה בטיפולי ההמרה.

נבקש לחדד – הכתבות המצדדות בטיפולים פסיכולוגים לשינוי הנטייה המינית אינם משתמשים עוד במושג ״טיפולי המרה״ בשל הביקורת הנוקבת נגדה, אך מדברים על טיפול פסיכולוגי לשינוי הנטייה המינית שזה הרי היינו הך.

מצורפים בזאת מאמרים שמחזקים את הטענה בדבר הסיכון הכרוך בטיפולים הנ״ל.

לאור הנאמר, אנו פונים לכבודו בשאלה האם לאור המידע, טיפולים אלו מותרים על פי ההלכה. אנו מודים לכבודו על העשייה הברוכה, ומודים לבתך שולמית על התיווך והנחישות לעזרה.

בברכה

ד״ר דן שרון, יו״ר ועדת אתיקה

בשם חברי ועדת אתיקה, איט״מ (האגודה הישראלית לטיפול מיני).

האם טיפולי המרה מותרים על פי ההלכה?

דניאל שפרבר

במענה לשאלתכם בעניין טיפול המרה (Conversion therapy) אקדים ואומר כי בתשובתי זו אין כל התייחסות, ובוודאי לא ערעור על כך שמעשה של משכב זכור, דהיינו יחסי מין אנאליים בין גברים, הוא איסור מן התורה שנכפלו בו הלאווים (ראו ויקרא י״ח כ״ב; שם כ׳ י״ג, וברמב״ם ספר המצוות לא תעשה ש״נ; רמב״ן על התורה לדברים כ״ג י״ח; ספר החינוך מצוה כ״ט וכו׳).

כמו כן יש להעיר כי ככל הנראה, לא כל בעלי הנטיות הללו שווים במידת משיכתם המינית הזו, המניעה אותם לקיום יחסי מין הומוסקסואלים, וכי ישנן דרגות שונות בכוח המשיכה הזאת. כלומר, לא כולם יוכלו לטעון כי הם ״אנוסים״, ואף שמבחינה הלכתית אין ״דין אנוס״ במשכב זכור, כי ״אין קישוי איבר שלא מדעת״ (עיינו יבמות נ״ג ע״ב; רמב״ם איסורי ביאה א׳ ט׳ ושם סנהדרין כ׳ ג׳). על כן, תשובתי זו מתייחסת אך ורק לשאלה: האם טיפולי המרה מותרים על פי ההלכה, או לא.

בחומרים שהובאו בפניי מאת ה-Independent Forensic Expert Group, קבוצה גדולה של מומחים לרפואה לענייני מיניות, נטען:

א. שטיפול זה, לפי עדויות מוסמכות כלל אינו אפקטיבי.

ב. הטיפול עלול לגרום לסבל רב, פיזי ופסיכולוגי, אפילו ארוך טווח עם תוצאות של נזק חמור.

ג. חלק משיטות ההמרה יש בהן משום עינוי (torture) ועל כן גופים בינלאומיים חשובים כללו את הטיפול הזה במסגרת המעשים האסורים משום עינוי. לכן טיפולי המרה נאסרו בכמה מדינות, כגון ארצות הברית, וארצות אירופה בשל הסכנה הטמונה בהם, שעשויה להגיע עד לכדי סכנת נפשות. והרי ידוע כי ישנו אחוז משמעותי של מטופלים שאיבדו עצמם לדעת בעקבות טיפול זה.

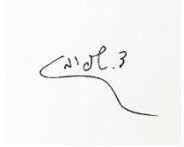
ואולם אלה הרבנים ואנשי הדת (ואף רופאים ופסיכיאטרים בכללם) הדוגלים בשימוש בשיטה זו, טענתם היא שהם עושים כן בכדי להציל את האדם מהעבירה, וכמובן חושבים הם כי ישנה תועלת במעשיהם. ואף אם יש בהנהגתם משום כפיה, הרי זו כפיה להרחיק את האדם מן העבירה.

ועל כן נשאלת השאלה, האם בכדי להרחיק את האדם מן החטא – חמור כפי שיהיה – מותר להשתמש בשיטה שישנו ספק ביעילותה וגורמת צער וסבל למטופל, ואפילו כשהדבר נעשה בהסכמתו. וגדולה מזו, האם הדרך הזו מותרת כאשר יש גם ספק בדיני נפשות.

ודומה כי התשובה לכך פשוטה למדי, כי כלל קבוע הוא ש״גרמא״ – קרי ״גרמי-בנזיקין״, אסור. כלומר, אסור לו לאדם לגרום נזק לחברו על ידי מעשה או דיבור, אם בממון – ואכן הטיפול עולה בממונו של המטופל – ואם בגופו ונפשו. לא זו בלבד אלא ששכנוע לעבור טיפול זה, הוא בבחינת גרמי בדיבור, ובייחוד כאשר מדובר במומחים (לדעתם), שהאיסור בו חמור מזה שבהדיוטות. וגדולה מזאת, כאמור, הנזק הוא נפשי ואפילו עד איבוד עצמי לדעת כתוצאה מטיפול שיש משום ספק ביעילותו. הרי לנו קו״ח בן קו״ח שהדבר אסור, גם אם הסכים המטופל, שהרי אין אדם בעלים על גופו, ואין לו רשות לחבל בעצמו, או לתת רשות לאחר לעשות כן.

אמנם מצינו מצבים שבהם ההלכה התירה לרופא לכוף את דעתו על החולה נגד רצונו. אלא שזה רק במקום שישנו ספק לחייו של החולה. וגם אז ההיתר הוא רק כשאין חשש לכך שעצם מה שמכריחים אותו לא יגרום לו לסכנה עוד יותר גדולה (ראו מגן אברהם יו״ד ס׳ שכ״ח ס״ק ו׳ ואגרות משה חיו״ד, ח״ד ס׳ כ״ד אות ו׳). אבל כאשר ישנו ספק בתועלת הטיפול וודאות בנזק שבו, ברור שהכפייה אסורה. יצוין שהשימוש כאן במונח חולה אינו אלא לצורך הדיון ההלכתי ואין בו בכדי הכרעה על מעמדם של בעלי הנטיות המיניות שאנו עוסקים בהן. בנוסף לכך, גם אלה שהתירו לכוף את האדם לקיום מצוות, לא סברו כן בנוגע להרחקת אדם מעבירה, דהיינו מניעת איסור לא תעשה (ראו רמב״ם, ספר המצוות שורש ד׳; אנציקלופדיה תלמודית כרך ל״ב ערך כפיה, סעיף ב׳, עמודות כ״ה-ל׳).

המורם מכל זה, שלפי דעתם של מומחים אף אם לא מוסכם הדבר על הכל, ביודענו שישנה גרימת סבל ואף סכנת נפשות, ובהסתפק אם ישנה באמת תועלת בטיפול ההמרה, נראה ברור בעיניי כי מבחינה הלכתית השימוש בדרך זו אסור בהחלט, גם אם זה רצונו של הפונה. יודגש שדברים אלה הם רק על דעתי האישית וראוי לצרף להם הסכמתם של רבנים נוספים.



דניאל שפרבר, ירושלים, התש״ף

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Review

Statement on conversion therapy☆

Independent Forensic Expert Group[1]

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ABSTRACT

Conversion therapy is a set of practices that aim to change or alter an individual's sexual orientation or gender identity. It is practiced in every region of the world by health professionals, religious practitioners, and community or family members often by or with the support of the state. Conversion therapy is performed despite evidence that it is ineffective and likely to cause individuals significant or severe physical and mental pain and suffering with long-term harmful effects. The purpose of this medico-legal statement is to provide legal experts, adjudicators, health care professionals, and policy makers, among others, with an understanding of: 1) the lack of medical and scientific validity of conversion therapy; 2) the likely physical and psychological consequences of undergoing conversion therapy; and 3) whether, based on these effects, conversion therapy constitutes cruel, inhuman, or degrading treatment or torture when individuals are subjected to it forcibly or without their consent. This medico-legal statement also addresses the responsibility of states in regulating the practice, the ethical implications of offering or performing it, and the role that health professionals and medical and mental health organisations should play with regards to it.

1. Introduction

Conversion therapy is a set of practices that aim to change or alter an individual's sexual orientation or gender identity. It is premised on a belief that an individual's sexual orientation or gender identity can be changed and that doing so is a desirable outcome for the individual, family, or community. Other terms used to describe this practice include sexual orientation change effort (SOCE), reparative therapy, reintegrative therapy, reorientation therapy, ex-gay therapy, and gay cure.

Conversion therapy is practiced in every region of the world. We have identified sources confirming or indicating that conversion therapy is performed in over 60 countries.[2]

In those countries where it is performed, a wide and variable range of practices are believed to create change in an individual's sexual orientation or gender identity. Some examples of these include: talk therapy or psychotherapy (e.g., exploring life events to identify the cause); group therapy; medication (including anti-psychotics, anti-depressants, anti-anxiety, and psychoactive drugs, and hormone injections); Eye Movement Desensitization and Reprocessing (where an individual focuses on a traumatic memory while simultaneously experiencing bilateral stimulation); electroshock or electroconvulsive therapy (ECT) (where electrodes are attached to the head and electric current is passed between them to induce seizure); aversive treatments (including electric shock to the hands and/or genitals or nausea-inducing medication administered with presentation of homoerotic stimuli); exorcism or ritual cleansing (e.g., beating the individual with a broomstick while reading holy verses or burning the individual's head, back, and palms); force-feeding or food deprivation; forced nudity; behavioural conditioning (e.g., being forced to dress or walk in a particular way); isolation (sometimes for long periods of time, which may include solitary confinement or being kept from interacting with the outside world); verbal abuse; humiliation; hypnosis; hospital confinement; beatings; and "corrective" rape.

Conversion therapy appears to be performed widely by health professionals, including medical doctors, psychiatrists, psychologists, sexologists, and therapists. It is also conducted by spiritual leaders,

☆ Please send correspondence to ifeg@irct.org. For full details about the Independent Forensic Expert Group, please visit https://irct.org/campaigns/istanbul-protocol.

[1] Djordje Alempijevic, Rusudan Beriashvili, Jonathan Beynon, Bettina Birmanns, Marie Brasholt, Juliet Cohen, Maximo Duque, Pierre Duterte, Adriaan van Es, Ravindra Fernando, Sebnem Korur Fincanci, Sana Hamzeh, Steen Holger Hansen, Lilla Hardi, Michele Heisler, Vincent Iacopino, Peter Mygind Leth, James Lin, Said Louahlia, Hege Luytkis, Jens Modvig, Maria-Dolores Morcillo Mendez, Alejandro Moreno, Valeria Moscoso, Resmiye Oral, Onder Ozkalipci, Jason Payne-James, Jose Quiroga, Hernan Reyes, Sidsel Rogde, Antti Sajantila, Matthis Schick, Agis Terzidis, Jorgen Lange Thomsen, Morris Tidball-Binz, Felicitas Treue, Peter Vanezis, Duarte Nuno Viera.

[2] IRCT research on conversion therapy available at https://irct.org/uploads/media/IRCT_research_on_conversion_therapy.pdf

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religious practitioners, traditional healers, and community or family members. Conversion therapy is undertaken both in contexts under state control, e.g., hospitals, schools, and juvenile detention facilities, as well as in private settings like homes, religious institutions, or youth camps and retreats. In some countries, conversion therapy is imposed by the order or instructions of public officials, judges, or the police.

The practice is undertaken with both adults and minors who may be lesbian, gay, bisexual, trans, or gender diverse. Parents are also known to send their children back to their country of origin to receive it. The practice supports the belief that non-heterosexual orientations are deviations from the norm, reflecting a disease, disorder, or sin. The practitioner conveys the message that heterosexuality is the normal and healthy sexual orientation and gender identity.

The purpose of this medico-legal statement is to provide legal experts, adjudicators, health care professionals, and policy makers, among others, with an understanding of: 1) the lack of medical and scientific validity of conversion therapy; 2) the likely physical and psychological consequences of undergoing conversion therapy; and 3) whether, based on these effects, conversion therapy constitutes cruel, inhuman, or degrading treatment or torture when individuals are subjected to it forcibly[3] or without their consent.

This medico-legal statement also addresses the responsibility of states in regulating this practice, the ethical implications of offering or performing it, and the role that health professionals and medical and mental health organisations should play with regards to this practice.

Definitions of conversion therapy vary. Some include any attempt to change, suppress, or divert an individual's sexual orientation, gender identity, or gender expression. This medico-legal statement only addresses those practices that practitioners believe can effect a genuine change in an individual's sexual orientation or gender identity. Acts of physical and psychological violence or discrimination that aim solely to inflict pain and suffering or punish individuals due to their sexual orientation or gender identity, are not addressed, but are wholly condemned.

This medico-legal statement follows along the lines of our previous publications on Anal Examinations in Cases of Alleged Homosexuality[1] and on Forced Virginity Testing.[2] In those statements, we opposed attempts to minimise the severity of physical and psychological pain and suffering caused by these examinations by qualifying them as medical in nature. There is no medical justification for inflicting on individuals torture or other cruel, inhuman, or degrading treatment or punishment. In addition, these statements reaffirmed that health professionals should take no role in attempting to control sexuality and knowingly or unknowingly supporting state-sponsored policing and punishing of individuals based on their sexual orientation or gender identity.

2. About the authors

The opinions expressed in this statement are based on international standards and the experiences of members of the Independent Forensic Expert Group (IFEG) in documenting the physical and psychological effects of torture and other cruel, inhuman, or degrading treatment or punishment (also ill-treatment). Consisting of 39 preeminent independent medico-legal specialists from 23 countries, the IFEG represents a vast collective experience in the evaluation and documentation of the physical and psychological evidence of torture and ill-treatment.

The IFEG provides technical advice and expertise in cases where allegations of torture or ill-treatment are made.[4] Its members are global experts on and authors of the Istanbul Protocol, the key international standard-setting instrument on the investigation and documentation of torture and ill-treatment.[3]

IFEG members also hold influential positions in and act as advisors to governments, international bodies, professional health associations, non-governmental organisations, and academic institutions worldwide on forensics in general and more specifically on the investigation and documentation of torture and ill-treatment.

3. Medical and scientific validity

There is no empirical evidence to support pathologising or medicalising variations in sexual orientation and gender identity. Studies have found that variation in sexual orientation is ubiquitous and that there is substantial variability in patterns of sexual and gender expression both between individuals and within individuals across time.[4] The World Medical Association (WMA) has strongly emphasised "*that homosexuality does not represent a disease, but a normal variation within the realm of human sexuality*."[5] For almost half a century, the Diagnostic and Statistical Manual of Mental Disorders (DMS-III, 1973) has stopped recognising homosexuality as a disorder. Similarly, for three decades, the World Health Organisation (WHO), which issues the International Statistical Classification of Diseases and Related Health Problems, has not defined homosexuality as a disorder (ICD-10, endorsed in 1990). Moreover, in 2018, the WHO declassified all remaining disorders correlated with same-sex attraction, such as ego-dystonic sexual orientation,[5] which had been (mis)used in the past to justify conversion therapy, thereby eliminating all medical bases correlated to sexual orientation that can be used to justify conversion therapy.

To our knowledge, there also are no credible scientific peer-reviewed studies that demonstrate that conversion therapy in any form is effective. On the contrary, in 2009, the American Psychological Association conducted a systematic review of peer-reviewed journal literature on conversion therapy and concluded that "*the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through [sexual orientation change efforts]*."[6] In 2016, the World Psychiatric Association issued a statement finding that "*[t]here is no sound scientific evidence that innate sexual orientation can be changed.*"[7]

Practices that purport to change an individual's sexual orientation or gender identity therefore lack any foundation in science or medicine and are unlikely to be effective. Instead, they are based on an antiquated misconception about the nature of sexual orientation and gender identity.

[3] This statement considers an examination to be "forcibly conducted" when it is "committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person incapable of giving genuine consent." International Criminal Court. Elements of Crimes. Art. 7(1) (g)-1. RC/11.2011:8.

[4] See, e.g., Independent Forensic Expert Group. Statement on Hooding. Torture. 2011; 21(3):186–189; Independent Forensic Expert Group. Statement on access to relevant medical and other health records and relevant legal records for forensic medical evaluations of alleged torture and other cruel, inhuman or degrading treatment or punishment. Torture. 2012; 22 (Supplementum 1):39–48. Independent Forensic Expert Group. Statement on Virginity Testing. Torture. 2015; 25(1):62–68; Independent Forensic Expert Group. Statement on Anal Examinations in Cases of Alleged Homosexuality. Torture. 2016; 26(2):85–91.

[5] "The gender identity or sexual preference is not in doubt but the individual wishes it were different because of associated psychological and behavioural disorders and may seek treatment to change it." World Health Organisation. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. 1992.

4. Physical and psychological effects

Conversion therapy represents a form of discrimination, stigmatisation, and social rejection. Many conversion therapy practices bear similarity to acts that are internationally acknowledged to constitute torture or other cruel, inhuman, or degrading treatment or punishment. Those include beatings, rape, forced nudity, force-feeding, isolation and confinement, deprivation of food, forced medication, verbal abuse, humiliation, and electrocution. These specific acts as well as the entire period during which the individual experiences them is recognised internationally to subject individuals to significant or severe physical and/or mental pain and suffering.

The fact that a treatment or practice has a valid medical use does not mean that it is not physically and psychologically harmful to individuals. In addition, a valid medical use for some conditions does not mean that the treatment is valid to treat other conditions under different circumstances. For instance, ECT or electroshock therapy applied with muscle relaxant and general anaesthesia is a recognised and valid form of treatment for psychiatric patients suffering from treatment-resistant, life-threatening depression. But in almost every instance, individuals will experience significant disorientation, cognitive deficits, and retrograde amnesia, which can be severely distressing. Concerningly, ECT is reportedly used for conversion therapy in some countries, although it is unproven and therefore medically invalid. In countries where ECT is still administered in its unmodified form (i.e., without anaesthetic and muscle relaxants), it not only causes significant psychological harm, but leads to violent convulsions commonly resulting in joint dislocations and bone fractures.

Medication is also used in conversion therapy and can cause significant physical and mental adverse effects. When such medication is medically inappropriate or used forcibly or without the individual's consent, it is likely to intensify the psychological terror or trauma related to the experience of conversion therapy and has been recognised as a method of torture or other cruel, inhuman, or degrading treatment.[8] Neuroleptics, anxiolytics, and anti-depressants (including thioridazine, citalopram, fluoxetine, and risperidone) have been used on individuals to diminish their sexual desire. In addition, they are often prescribed due to the false belief that psychosis or other mental disorder is the underlying cause of an individual's particular sexual orientation or gender expression. These anti-depressants, mostly from the selective serotonin reuptake inhibitor group, may cause sexual dysfunction, while anti-psychotic medications may cause movement disorders, mental slowing, tiredness, memory problems, numbness of the body, weight gain, and sexual dysfunction, among other effects, which serve only to compound an individual's distress and suffering.

All forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering.[9–12] All practices attempting conversion are inherently humiliating, demeaning, and discriminatory. The combined effects of feeling powerless and extreme humiliation generate profound feelings of shame, guilt, self-disgust, and worthlessness, which can result in a damaged self-concept and enduring personality changes. The injury caused by conversion therapy begins with the notion that an individual is sick, diseased, and abnormal due to their sexual orientation or gender identity and must therefore be treated. This starts a process of victimisation through conversion therapy. Individuals who have undergone the practice often experience a decrease in self-esteem, episodes of significant anxiety, depressive tendencies, depressive syndromes, social isolation, intimacy difficulties, self-hatred, sexual dysfunction, and suicidal thoughts. In many studies, the rates of suicidal ideation and suicide attempt are several times higher than in other lesbian, gay, bisexual, trans, and gender diverse populations who have not been exposed to conversion therapy.[13–15]

Conversion therapy can often lead to posttraumatic stress disorder.[11,16] Group therapy, camps and retreats may incorporate highly traumatic elements such as exposure to physical, verbal, and sexual abuse and humiliation. Talk or psychotherapy can also become a repeatedly traumatic event. Session after session, the individual is confronted with their own "deviancy," while repetition and duration increase its intensity and importance. We have seen that conversion therapies can lead to avoidance behaviours, hypervigilance (e.g., difficulty falling or staying asleep), intrusive flashbacks, traumatic nightmares, and other symptoms of posttraumatic stress disorder.

Children and minors are particularly vulnerable.[13,14,17] In children and minors exposed to conversion therapy, psychological symptoms are expressed in a significant loss of self-esteem and a sharp increase in suicidal or depressive tendencies. These can often lead to school dropout and the adoption of high-risk behaviours, self-destructive behaviours, and substance abuse. Conversion therapy causes a delay in sexual and personal development, which can lead to depression, increased feelings of guilt and stress, and can also bring about feelings of social rejection and social isolation. Minors are at especially high risk to develop serious psychological disorders afterwards, due to the loss of self-esteem, negative feelings toward oneself, self-loathing, feelings of debasement, and the forced rejection of one's own identity.

The long-term duration of many conversion therapies can be particularly harmful. Individuals often undergo therapy for several years to more than a decade.[9,17] The long-term duration creates chronic stress, which has been known to result in many negative health consequences, including stomach ulcers, gastrointestinal disorders, skin diseases, sexual and eating disorders, and migraines. Psychosomatic symptoms can be especially pronounced in children who are unable to express their difficulties and may manifest their distress through eczema breakouts, insomnia, sleep disorders, vomiting, asthma, and impaired growth or development. Psychological symptoms can become chronic. Despair, disillusion, and shame can last for many years. Even into adulthood, studies have found that exposure to conversion efforts results in adverse mental health outcomes, including severe psychological distress, lifetime suicidal thoughts, and lifetime suicide attempts.[13,14]

In both adults and minors, the failure of conversion therapy often exacerbates the individual's feelings of inadequacy, self-worthlessness, and shame.[9,12] Individuals often feel intense guilt of failure, reinforced by the idea that they are ill, unacceptable, incurable, and a burden to their families.

When health professionals are involved in the performance of this harmful act, in our experience, their involvement is likely to exacerbate the pain and suffering experienced by individuals given the betrayal it represents of the social norm of trusting health professionals. Betrayal of the fragile trust between patient and clinician can have severe consequences, leading to feelings of guilt, rejection, and humiliation. The individual can lose self-esteem and may exhibit anger or withdrawal, which will impair their future interpersonal and romantic relationships and professional life.

Where conversion therapy is ordered, conducted, or supported by public authorities, the experience of being betrayed by the law likely adds to the individual's mental pain and suffering. These amplify any shame and stigma they may already experience, including social rejection, victimisation and punishment by their family or religious community, and conflict with their faith.

5. Cruel, inhuman, and degrading treatment and torture

Torture and other forms of cruel, inhuman, or degrading treatment or punishment are unequivocally prohibited, without exception, by the UN Convention against Torture[18] as well as other international and regional human rights instruments. The UN Committee against Torture, the UN Special Rapporteur on Torture, the UN Subcommittee on Prevention of Torture, and the Office of the High Commissioner for Human Rights (OHCHR) have stated that conversion therapy contravenes the prohibition against torture and other cruel, inhuman, or degrading treatment or punishment. In its 2015 annual report, the OHCHR stressed that states "*have an obligation to protect all persons, including LGBT and intersex persons, from torture and other cruel, inhuman or degrading*

treatment or punishment" and found that conversion therapy breaches this duty.[19]

In May 2018, the UN Independent Expert on Sexual Orientation and Gender Identity observed that: "*The violence reported against persons on the basis of their actual or perceived sexual orientation or gender identity also includes … so-called 'conversion therapy'. Considering the pain and suffering caused and the implicit discriminatory purpose and intent of these acts, they may constitute torture or other cruel, inhuman or degrading treatment or punishment in situation where a State official is involved, at least by acquiescence.*"[20] Subsequently, the UN Special Rapporteur on Torture in July 2019 affirmed that: "*given that 'conversion therapy' can inflict severe pain or suffering, given also the absence both of a medical justification and of free and informed consent, and that it is rooted in discrimination based on sexual orientation or gender identity or expression, such practices can amount to torture or, in the absence of one or more of those constitutive elements, to other cruel, inhuman or degrading treatment or punishment.*"[21]

Based on these findings, the UN Committee against Torture, the UN Independent Expert on Sexual Orientation and Gender Identity, the UN Special Rapporteur on Torture, and the OHCHR have all called upon states to ban the practice. In 2016, the UN Committee against Torture recommended that a state take "*the necessary legislative, administrative and other measures to guarantee respect for the autonomy and physical and personal integrity of lesbian, gay, bisexual, transgender and intersex persons and prohibit the practice of so-called 'conversion therapy'.*"[22]

6. State involvement and responsibility

The UN Convention against Torture and other international and regional human rights instruments not only prohibit torture, but oblige states to prevent public authorities from "*directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in any acts of torture*" and other cruel, inhuman, or degrading treatment or punishment.[23] In several countries, we have found that public officials are directly involved in the provision of conversion therapy. In some cases, the therapy is offered and performed by medical personnel in state hospitals, public clinics, schools, and juvenile detention centres. Sometimes, the therapy is performed pursuant to an order by public officials, judges, or the police. All these acts would seem to contravene the international legal obligations of these states to prohibit and prevent torture and other cruel, inhuman, or degrading treatment or punishment.

Furthermore, states have a responsibility to "*prohibit, prevent and redress torture and ill-treatment in all contexts of custody and control*," not just those operated by public entities.[23] We have found in almost 30 countries that conversion therapy is being committed, instigated or supported by private institutions and private individuals acting in an official capacity and executing a state function. This includes health professionals in private clinics performing conversion therapies or private schools providing it. The UN Convention against Torture and other human rights instruments require that states oversee the provision of services that are in the public interest, such as health and education. As stated by the UN Committee against Torture, states have the special duty to protect the life and personal integrity of persons by regulating and supervising these services, regardless of whether the entity providing them is public or private.[23] Accordingly, personnel in private hospitals and clinics as well as teachers are considered to act in an official capacity on behalf of the state, as they are executing a state function[23] and should similarly be prevented from directly committing, instigating, inciting, encouraging, acquiescing in, or otherwise participating or being complicit in any acts of torture and ill-treatment, including conversion therapy.

In over a dozen countries, we found that conversion therapy practices, e.g., beatings, isolation, exorcisms, and "corrective" rape, appear to take place primarily in the private sphere by religious practitioners, traditional healers, or sometimes by community and family members. These acts which are not originally directly attributable to the state (i.e., acts committed by private individuals) can nevertheless lead to state responsibility, due to the lack of due diligence to eliminate, prevent, investigate, and punish acts of torture and other cruel, inhuman, or degrading treatment or punishment. The failure of the state to act in due diligence leads to a form of encouragement or *de facto* permission of those harmful practices.[23]

The UN Committee against Torture has applied this principle to states that have failed to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking.[23] A parallel can thus be drawn to the obligation to ban the practice of female genital mutilation which also takes place in a context of profound discrimination. As stated by the UN Special Rapporteur on Torture: "*Domestic laws permitting the practice contravene States' obligation to prohibit and prevent torture and ill-treatment, as does States' failure to take measures to prevent and prosecute instances of female genital mutilation by private persons.*"[23]

Children enjoy special protection. An alarming number of minors are subjected to conversion therapy; indeed, minors may account for the majority of all cases.[24] The UN Convention on the Rights of the Child requires the best interests of the child to be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies.[25] The Convention on the Rights of the Child requires states to take all measures to "*protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*"[25] Conversion therapy, which is rooted in profound discrimination, lacks scientific and medical validity, is ineffective, and is likely to cause the minor significant or severe pain and suffering, clearly violates these standards. When a minor is subjected to conversion therapy, in addition to amounting to torture or other cruel, inhuman, or degrading treatment, it may constitute a form of child abuse and neglect.

7. Professional and ethical standards

Conversion therapy is inconsistent with the fundamental ethical principles and professional duties of health professionals for the following reasons:

1) It is clear that conversion therapy is a form of cruel, inhuman, or degrading treatment when it is conducted forcibly on individuals or without their consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted. International standards of professional ethics unequivocally prohibit health professionals from participating in or condoning any treatment or procedure that may constitute cruel, inhuman, or degrading treatment or torture.[26,27]
2) Variation in sexual orientation and gender identity is not a disease or disorder. Health professionals, therefore, have no role in diagnosing it or treating it. The provision of any intervention purporting to treat something that is not a disease or disorder is wholly unethical.[28] If adults voluntarily seek out assistance in hope of changing their sexual orientation, ethical professionals are advised to explain why they don't attempt this type of practice and not to refer clients to someone who does.[29]
3) Conversion therapy is ineffective and harmful. Health professionals must abide by their core ethical principles to act in the best interests of patients (beneficence) and to "do no harm" (non-maleficence).[30] The likely harm of conversion therapy cannot be outweighed by any clinical benefits, as there are none. Moreover, health professionals are prohibited from offering treatments that are recognised as ineffective or purport to achieve unattainable results. Offering conversion therapy thereby constitutes a form of deception, false advertising, and fraud.[31]

4) Ensuring informed consent may be impossible in most circumstances. As noted in previous statements, examinations based on profound discrimination may create situations where a person is incapable of giving genuine consent.[1] This is likely the case when conversion therapy is being conducted based on the order of a public authority, when the individual's liberty is restricted, or when the individual is a minor coerced by family members or others in a position of authority or trust.

   In the case of conversion therapy, informed consent would require that an individual is informed about the practices that will be applied, as well as their ineffectiveness, the likely physical and psychological harm that will result, and the inability to achieve the desired result. The individual's consent must be considered invalid if acquired without this knowledge or as a result of false information; and it should be considered suspect, particularly in the case of minors.

5) Conversion therapy creates an inherently discriminatory environment. Even when an individual wants the therapy, the individual may be motivated by self-hatred or a conflict between their actual sexual orientation or gender identity and the self-image that they feel it is safe or acceptable to present to themselves and others. It would be counter therapeutic for the practitioner to add to those internalised feelings. Their efforts would be ineffective in reducing the individual's desires even if the individual's behaviour changes, leaving the client with unexpressed feelings that have the potential to be very damaging.[32] Instead, any psychiatric or psychotherapeutic approaches to treatment must not focus on the individual's sexual orientation or gender identity, but on the conflicts that may arise between their orientation, identity, and religious, social, or internalised norms and prejudices.[33]

8. Role of health professionals in policing and punishing sexual orientation and gender identity

The practice of conversion therapy runs contrary to respect for the dignity, humanity, and rights of individuals, including to privacy, self-determination, non-discrimination, and to be free from torture and ill-treatment.

Most major medical and mental health organisations have repudiated the practice of conversion therapy. It continues, however, to be widespread and practiced by health professionals and others due to pervasive discrimination and societal bias against lesbian, gay, bisexual, trans, and gender diverse individuals. This represents a challenge to individual health professionals and medical and mental health professional organisations.

Health professionals who are conducting conversion therapies are contributing to a social, cultural, or state-sponsored system of profound repression and stigmatisation against their patients, targeted on the basis of their sexual orientation and gender identity. Health professionals should understand that by providing these treatments, they are serving to perpetuate social customs and norms that are in conflict with their ethical obligations and respect for the rights and dignity of individuals, and that, ultimately, they may be facilitating or participating in cruel, inhuman, or degrading treatment or torture.

The WMA has condemned conversion therapy as a violation of human rights and has called for its practitioners to be denounced and subject to sanctions and penalties.[33] It has also called on national medical associations to "*promote ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly corrected, and the physicians guilty of ethical violations must be disciplined and rehabilitated.*"[34]

As more awareness is raised about the issue of conversion therapy both globally and nationally, national medical and mental health associations should create accessible mechanisms for the public to register complaints against health professionals who offer conversion therapy or who have harmed them by performing this practice. Health professionals who conduct conversion therapies violate the basic standards and ethics of our profession and should be reported by their colleagues to the appropriate authorities.[35] National medical and mental health associations should encourage and support health professionals in denouncing this practice and reporting colleagues who practice it.

Recently, there has been a growing trend to call for a ban on conversion therapy in many parts of the world, although few countries have done so yet.[36] National medical and mental health associations should support these legislative initiatives and the development of programmes to support individuals who have been harmed by the practice.[37]

9. Conclusion

Conversion therapy has no medical or scientific validity. The practice is ineffective, inherently repressive, and is likely to cause individuals significant or severe physical and mental pain and suffering with long-term harmful effects. It is our opinion that conversion therapy constitutes cruel, inhuman, or degrading treatment when it is conducted forcibly or without an individual's consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted.

As a form of cruel, inhuman, or degrading treatment or torture, states have an obligation to ensure that both public and private actors are not directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in conversion therapy. States also have a responsibility to regulate all health and education services, which may be promoting this harmful practice.

Health professionals that offer conversion therapy are violating the basic standards and ethics of our profession. Health professionals should understand that by offering these treatments, they are serving to perpetuate social customs and norms that are in conflict with respect for the rights and dignity of individuals; they are engaging in false advertising or fraud; and they may be facilitating and participating in cruel, inhuman, or degrading treatment or torture. Where minors are concerned, in addition to torture and other cruel, inhuman, or degrading treatment, they may be facilitating or perpetrating child abuse and neglect.

Health professionals should refuse to conduct conversion therapy and report their colleagues who advertise, offer, or perform them to the appropriate authorities. National medical and mental health associations should take steps to hold practitioners accountable and work with civil society and government officials to pass laws that ban conversion therapy.

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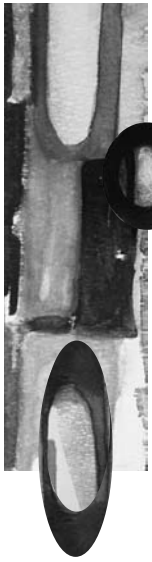

Chapter 28

Sexual Orientation Conversion Therapy: Fact, Fiction, and Fraud

Douglas C. Haldeman

The practice of attempting to change the unwanted same-sex attractions of homosexual and bisexual individuals predates any other form of treatment for lesbian, gay, bisexual, and transgender (LGBT) clients. Clinical assumptions about the pathology of same-sex attraction were derived largely from prevailing cultural norms (Haldeman, 1994). However, the "mental illness" model of homosexuality was discarded by the major mental health organizations in the 1970s, and same-sex attractions are now considered a normative variant of the human experience (American Psychological Association [APA], 2009).

Not all segments of contemporary American culture have fallen in line with the social scientists, however. The overwhelming motivation of those seeking to change their sexual orientation through therapy or other means derives from incompatibility with religious beliefs (APA, 2009; Tozer & Hayes, 2004). It has been estimated that up to one quarter of the American public believes in traditional conservative Christian concepts such as an active interfering deity, an afterlife featuring a day of judgment, and "the rapture" (Herman, 1997). Therefore, conversion therapies, or sexual orientation change efforts (SOCE) as these practices are now called (owing to the fact that most of such efforts surely do not qualify as therapy), still have a considerable following.

Because of the fact that such interventions are unsuccessful (APA, 2009), clinicians who work with LGBT clients can expect to see, at least on occasion, individuals who have undergone such efforts and failed. The residual effects of such "treatment" failures vary from person to person. For some, the interventions themselves simply serve to underscore the constant and unchangeable nature of sexual orientation. The failure to change comes as something of a relief. The individual who has prayed, resisted, and done

any other number of "antigay" activities prescribed by the ex-gays is finally able to let go of what is often experienced as an impossible quest.

For others, however, the interventions result in posttraumatic effects, and for some it is the treatment failure itself that is at issue. The discomfort with being gay, compounded with the shame of having been unable to change it, is difficult enough. When these factors are paired with rejection by family and the community of faith, the results can be devastating. In this chapter, a sampling of case material, contextualized by cultural factors, is used to reflect some of the complicated reactions of those conflicted individuals who have sought unsuccessfully to change their sexual orientation.

First, however, we must acknowledge that SOCE are firmly rooted in a sociocultural context that pathologizes same-sex attraction and homosexual/bisexual orientation. There can be no discussion of SOCE without mentioning the fact that the notion that sexual orientation can be changed is the cornerstone of arguments presented by religious conservatives in the service of abrogating civil rights for LGBT individuals. According to them, everything that protects vulnerable LGBT individuals—from hate crimes legislation to antidiscrimination laws to same-sex marriage—is unnecessary because sexual orientation can be changed. This renders LGBT people a "pseudominority" irrespective of the fact that civil rights are granted to all manner of individuals whose lives are based on variables of choice (e.g., freedom of religious expression). If indeed sexual orientation is in fact a normal variant of the human experience (APA, 2009), all of the arguments against LGBT rights fall like a house of cards.

At the same time, it is essential to note that the identification with and expression of any kind of religious practice or dogma is a personal right and beyond the scope of any criticism or disrespect from mental health organizations (APA, 2008). As social scientists, we acknowledge the importance of religious affiliation for many people and do not attempt to evaluate or interfere with the construction of religious tenets. They lie outside the scope of science. Conversely, we do not view religious dogma as an appropriate basis for social policy or mental health interventions. Furthermore, our respect for religious tradition does not prevent us from evaluating the psychological effects of religious identification when it conflicts with an individual's experience of sexual orientation—in fact, it calls us to do so. For the individual embedded in certain conservative religious traditions, the notion of living as a gay person is unthinkable because of the ostracism that would result from family and community as well as the confusion that is associated with integrating into the gay community. Heterosexual marriage or celibacy thus becomes a personal imperative.

This is not to imply that all communities of faith, or even all conservative communities of faith, include heterosexual identity as a requirement for membership. However, it is clear that nearly all individuals who have undergone SOCE in some form have done so in the service of their religious beliefs (APA, 2009; Tozer & Hayes, 2004) and their understanding that heterosexual identity is a requirement for good standing in their families and communities of faith. Therefore, the clinician working with this population must be sensitive to the role and import of religion in the

client's life while attempting to orient the client to the reality of the self and to assist him or her in navigating the LGBT community as a means of recreating an experience of family and community.

This makes it necessary to tread in a delicate way with some clients whose coming out process has resulted in significant losses of family and social network with no replacement immediately available owing to an unfamiliarity with the LGBT community. The literature has documented clinical interventions for those who have been harmed in SOCE (Haldeman, 2002).

Following are two cases that demonstrate the complexities of working with SOCE survivors. It should be noted from the outset that both cases are of gay males. The SOCE literature, such as it is, has focused nearly all of its efforts on men. It has been speculated that this is because conservative religious groups, and U.S. culture in general, are more tolerant of women's same-sex attraction.

A Case of Familial Religious Extremism

Justin was raised in a conservative Christian family. His parents belonged to a nondenominational Bible church in which behaviors such as "talking in tongues" and a concept of hellfire and damnation were assumed truths. He expected, correctly as it turned out, that if he were to come out as gay his family would reject him. Nevertheless, Justin's self-awareness as gay was so strong that he knew no amount of praying or therapy would change it. He came out to his family at age 23, after a long period of soul searching, and brought to session an e-mail he had subsequently received from his mother. It should be noted that Justin had engaged in ineffective religious-based SOCE for several years prior to his coming out.

In the message, Justin's mother told him that she knew Satan had inhabited his soul and that she would pray for him. She requested that he not contact any family members until he had disavowed his "evil lifestyle" and accepted Jesus as his personal savior. Justin is diagnosed with an acute adjustment disorder with depressed mood as well as self-defeating and masochistic personality features.

Justin's attempt to adopt a rational perspective about his family's cruel behavior is quickly eroded because on a profound, almost cellular, level he is devastated. He has been brought up to believe in a harsh, judgmental deity and everlasting punishment for those who do not follow the rules. It would be impossible to overstate the role of mindfulness-based ACT work to help Justin accept his grief and anger about having been so badly treated by his family. The clinician working with people such as Justin needs to be patient as the warehouse of negative affect is unpacked. In Justin's case, anger over being betrayed by those who claimed to have loved him alternates with grief associated with abandonment. This arouses no small amount of countertransferential desire to comfort and soothe him; therefore, frequent reminders that he has done nothing wrong serve to help him neutralize his shame about being gay. For the first few months in treatment Justin is in an acute phase of grief and needs support and reassurance.

At the same time, it is reasonable to reinforce Justin's sense that his sexual orientation is not amenable to change; this he understands after years spent trying to "pray away the gay." Just as the ACT work aids in the acceptance of emotional experience, it is also useful in the integration of same-sex attraction into the identity. SOCE, after all, are ineffective in large measure because they demand a disintegration of the self and a compartmentalization of sexual desire. This is as unhealthy as it is unrealistic.

As the mourning period of losing his family gives way to a more pragmatic perspective (that sounds something like "So now what do I do?"), it is appropriate to orient Justin to the reality before him. This involves the strategy of constructing the replacement family. The families of LGBT individuals often include people who are not legally or biologically related. As Justin's grief over the loss of his family of origin gives way to loneliness, it becomes appropriate to raise this issue with him.

"Have you thought about who your friends will be?" the therapist asks.

"No. I mean, yes, I miss my family and my old friends but I know I can't be around them anymore."

"Who would you like to be around?"

"People who accept me for who I am."

Most models of sexual orientation identity development include some aspect of relationship with other LGB people, as well as some concept of how to live in the gay community (Fassinger & Arseneau, 2006). There are several reasons for this: it solidifies the individual's identity and also provides the very necessary human comforts of companionship and social interaction.

It is useful for the therapist to have some idea about local LGBT resources. All major cities and most urban areas have an array of LGBT social and interest groups; these are easily accessed through online searches. In Justin's case, however, connecting with the gay social world would prove challenging. He finds the social environment of gay bars to be foreign and intimidating; in addition, he is not a drinker. Joining social interest groups within the gay community likewise proves difficult for Justin. Unlike some who are in recovery from SOCE, he is not interested in an alternative gay-positive religious group. Justin seems intent on deleting all references to religion from his consciousness. In addition, he is not keen on any particular sort of athletic, political, or cultural activities for which there are gay groups. He feels uncomfortable around groups of his "own kind," so to speak, and experiences a particular aversion to men he perceives as "effeminate."

Justin's entry into the world of romantic relationships with other men is further complicated by the fact that although his same-sex fantasy life is well developed, he has never actually had sex with another man. Justin's sexual fantasies have a sadomasochistic orientation. Whether his fantasies about being punished in sexual situations are the result of his internalized shame about being gay is speculative. What is apparent, however, is that as his sexual behavior developed, it appeared likely to lead him into potentially dangerous situations.

"Well, I finally had sex!" Justin reports brightly at the opening of one session.

"Oh? Do you want to tell me about it?"

"Well, I found an S&M club where you can join and get into 'scenes' with different kinds of people. I found a guy who wanted me to be his servant, and we had a great time."

The therapist proceeds very carefully, not wanting to be perceived as passing a negative judgment but also wanting Justin to be thoughtful about his sexual adventures. This is compounded by the countertransferential difficulty the therapist is developing with Justin's sexual exploration, fearing that Justin is missing a more "conventional" step in the evolution of his psychosexual expression.

At one point, Justin finds a "master" online who is said to be well known for his management of sexual domination scenarios. Justin engages in a scene in which he is physically bound to the point of severe discomfort. Despite the master's request that Justin inform him when the line between pleasure and serious pain has been crossed, Justin tolerates the procedure. At the end, he has suffered temporary but serious neurological consequences resulting in the partial loss of the use of his right arm and hand. Fortunately Justin recovers full function, but the recovery takes weeks.

This episode is a wake-up call for the therapist. "Justin, I am very sorry to hear about what happened to you; it must be so painful. I also think we should talk, when you are ready, about the sexual choices you are making."

"I know," he replies, very downcast. Justin is understandably frightened by this experience; it also activates his "shame core" associated with being gay. When he starts regaining his full motor function, he and the therapist revisit the issue.

"What do you think about the future of your sexual life, now that you are recovering from your injury?" asks the therapist. Justin commits to revising his internal "sexual script" and states his intention to focus on developing a circle of friends, exploring the possibility of finding a boyfriend, and being more careful in his sexual behavior. Revising a long-rehearsed internal sexual script is not easy. In this case, the therapist works with Justin to make mental "bridges," using visualization and masturbatory reconditioning, between his erotic fantasies of punishment and humiliation and potentially less dangerous erotic behaviors. Justin moves toward revising his choice of partners from those that reside purely in the domain of sadomasochistic fantasy to those whose characteristics (dominant, strong, assertive) retain some element of his historical fantasy repertoire but are ultimately better suited for life with a real partner.

Justin makes admirable progress toward these goals. The experience of allowing himself to be a participant in a homopositive society starts to erode his internalized shame and negativity. Justin is also able to start confronting his intimacy avoidance and begins to date. He meets a man who is 15 years older than himself, whom Justin describes as "smart, kind, and protective." The couple has been together for 2 years and are doing very well.

In retrospect, it is easy to attribute Justin's internalized (and actual physical) torture to a homophobic cultural upbringing and a vicious rejection by his family of origin. Although this is likely, we cannot say it with certainty. We can, however, say that the sociocultural influences to which Justin was subjected in early life and the subsequent family rejection had

a negative effect on his mental well-being. The assessment and treatment of trauma, therefore, become important elements of treatment with men who have been involved in SOCE.

This case evoked a spectrum of countertransferential feelings on the part of the therapist, many of which necessarily were screened out or minimized given Justin's fragility. At first, Justin's recounting of harsh treatment by his family aroused feelings of protectiveness in the therapist. Here it was important for the therapist to remain empathic without veering into being overly soothing; in being empathic, the therapist guides the client to soothe himself or herself with mindfulness and self-statements. As Justin became sexually active, the therapist's feelings of comfort gave way to ones of alarm and concern that his client was out of control. Yet the therapist needed to be measured in response to this as well. Tempting though it may have been to ask, "What were you thinking?" upon Justin's disclosure that he had become injured in a sadomasochistic sex scene gone wrong, it was more productive to address his behavior from a value-neutral, problem-solving perspective. This way, the therapist would enable Justin to come to his own conclusions about how to integrate his sexual interests into his life and feel positive about sex—as opposed to risking exacerbating his client's already significant feelings of shame with a judgment-laden response.

A Case of Post-"Ex-Gay" Social Isolation

Mark, 32, comes to treatment with concerns about intimacy in adult interpersonal relationships. He states that he is a successful businessman in the area of real estate development and that he is very conscientious about his work. As a result, he is financially well off and his opinion is sought after among his peers. Nevertheless, he is socially reclusive, spending most weekends by himself, seeking sex online. He rarely hooks up. When he does, it is with others who are sexually submissive, endorsing their devotion to him as the primary component of their erotic stimulation.

Mark wants to develop a healthy primary relationship but has no idea how to go about it. He reports that as a youngster he was an only child raised by a single mother who left him with his grandparents for long periods of time. Mark states that he missed her greatly and attributed her absences to his misbehavior. When she would return, he states that he would do anything to please her.

At 18 Mark came out to his mother as gay. She was horrified and immediately demanded that he enroll in an "ex-gay" program, a request with which he complied. He reports having tried unsuccessfully for nearly 10 years to redirect his primary erotic attraction to men. When Mark finally announced to his family that he had given up trying to change his sexual orientation, his mother grudgingly accepted that he would be gay.

Despite his professional success, Mark is lonely and feels that his sociosexual life is dysfunctional. He desires companionship in the form of a primary relationship with another man. He is diagnosed with dysthymic disorder and social anxiety.

The primary themes of post-SOCE trauma typically include those felt and enacted elements (depression, guilt, suicidality, demasculinization, intimacy avoidance; Haldeman, 2002) that are evident in Mark's attitudes and behavior. The negative sequelae of failed attempts at SOCE most typically manifest in terms of interpersonal problems. The original community has been relinquished when, finally, the individual recognizes that his same-sex attractions cannot be subverted through engaging in traditional masculine activities, cannot be deleted by developing a "healthy" relationship with a father figure, and will not be eradicated through prayer. When the individual hits the "SOCE bottom," to use a recovery term, he must grieve the loss of the connection and privilege associated with his historical origins and face the challenges of navigating a new social world. This often creates anxiety as well as profound loss. Furthermore, because the individual has been trained to associate male identity and gender role expectations with heterosexuality, he often feels a sense of demasculinization upon coming out.

Mark's story illustrates a secondary theme of life after SOCE: the experience of the self as a failure. This sense may be generalized throughout the person's life, or, as in Mark's case, it may be limited to social and romantic interactions. Mark's work life, for example, is a model of accomplishment: professional advancement, prestige and power, as well as monetary reward. Mark takes his work seriously and handles his responsibilities in ways that exceed expectations. His productivity appears to be exceptional. However, his internal experience of it is meaningless. Mark describes his work as a role that he understands and fulfills to the best of his ability. It provides a structure in which he functions like a machine.

With sense of identity confused with the inappropriate application of traditional gender norms, Mark invests all of his sense of personal efficacy in work. His sexual encounters are episodic and always with strangers whom he has met online, for one time only. These erotoromantic events become episodic, quick ventures into a fantasy world in which he is sexually worshiped and adored in an effort to compensate for an arid lack of emotional connection with other men. "I only feel something when someone is kneeling at my feet," he explains, "and even then, it doesn't last."

Mark's experience of his professional self is undermined by the profound sense of despair associated with his personal life. He knows many people and has a variety of superficial relationships but does not experience close friendship, let alone romance. Mark is lonely and has never overcome the shame associated with failing his many attempts at changing his sexual orientation. He grudgingly accepts his same-sex attractions and is unable to sustain an intimate connection.

Mark's case offers a complex interplay between his history and his present life. It challenges him to resolve long-unfulfilled attachment fantasies but also to cope with a present-day life that is absent any real emotional intimacy. His association with male identity and the expression thereof in an intimate relationship is deeply connected with his unsuccessful attempt to change his sexual orientation. His erotoromantic life remains firmly

embedded in a landscape of sexual mastery and servitude in which a submissive partner adores him. In reality, his life is devoid of any intimate relationships. Mark's "shame core" is an obstacle but also a sense of being less than a real man, or demasculinized, because of the toxic effects of the conversion therapy and ex-gay programs he attended, which reinforced the notion that "real" men can't be gay.

To be sure, Mark's interpersonal dysfunction cannot be wholly attributed to the negative effects of SOCE; the social context promoting SOCE shares some of the blame as well. At this juncture, it is reasonable to consider approaches to healing the wounds caused by SOCE. These involve a reclaiming of the masculine self in a (gay) context that is appropriate for the client. Learning that real men can indeed be gay is a primary task for Mark. Comprehending the relevant dimensions of gender identity (Englar-Carlson & Stevens, 2006) and reinforcing this in the therapeutic relationship is of primary importance.

Behavioral plans between sessions are critical. It is essential that Mark develop a support network before attempting to engage in a romantic relationship. And how does one develop that support network? One day, Mark offers his therapist a hint in response to an important question.

"Mark, tell me about one thing that you think real men do," the therapist says.

"They play sports."

"And you don't?" asks the therapist.

"No."

"You don't like them?"

"No, it's not that," Mark explains. "I'm actually a big sports guy. I just don't want to play on a team like it was high school and go through all that again." Here Mark explains that "all that" referred to the humiliation he suffered because of the teasing and bullying of the other boys.

"Maybe it's possible for you to rethink not only what it means to be a gay man but what it means to be an athlete. You say you don't think you can be both. But it sounds as though you are both," observes the therapist.

The therapist then explains that there are a number of gay sports leagues and teams in the area and asks Mark to investigate something athletic he thinks he might like. Mark seeks out a local gay runners group. He is then able to engage in an activity he has always enjoyed and associated with his sense of being male and transform it into a gay social context. After making friends within the group, he begins to explore other gay sports groups (skiing, baseball) and takes his enthusiasm to the Gay Games, where he competes in several track and field events. He comes back with a new sense of pride, a reclaimed identity as a gay man, and continues to integrate his gay sexual orientation into the sense of identity from which it was truncated by SOCE long ago.

As explained with Justin's case, countertransference can be a complex factor in working with survivors of SOCE. Given some of the egregious harms endured by clients at the hands of inept reparative therapists, it is easy for the therapist to fall into an alliance with the client and join in the outrage or whatever emotion is aroused. This should be avoided in favor

of an empathic but more neutral stance. It is always easier for the client to heal without the emotional interference of the therapist's personal reactions. This is particularly true of survivors of SOCE, however, because these clients have sought to change their sexual orientation in an attempt to please others. This tendency can easily be replicated in a therapeutic effort to undo the damage of SOCE.

Conclusion

These cases illustrate some of the harmful effects of SOCE as well as provide suggestions for how they may be therapeutically addressed. Why is there no policy opposing SOCE altogether? There are two reasons. First, those on both sides of the argument have only anecdotal claims of harm. Proscribing any form of "treatment," even one as poorly based and described as SOCE, is an unusual step and would require sufficient scientific evidence. Second, it is clear that not all who undergo some form of SOCE experience sustained or even short-term harm. As long as there are cultural and religious groups who harbor sexual prejudice and raise their children in such an atmosphere, there will be a market for SOCE. Time, however, is against them. If trends in public opinion continue, the interest in SOCE will eventually die out along with the homophobia that promotes them.

In the meantime, it is in the interest of clients who have attempted some form of SOCE for clinicians to be aware of their numerous potential negative effects on some people. It is also important for clinicians to be aware of appropriate practice guidelines for work with LGBT clients (APA, 2011; Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling, 2009). After all, SOCE are not ineffective because it is not possible to instruct some bisexually oriented people in the ways of heteroeroticism. SOCE are ineffective because they demand a fragmentation of the spirit and a suppression of desire—neither of which is sustainable or in the best interest of the client.

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