**To**: The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity

Office of the UN High Commissioner for Human Rights

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**Re: Conversion Therapy in the United States**

1. **What different practices fall under the scope of so-called “conversion therapy” and what is the common denominators that allow their grouping under this denomination?**

Conversion therapy includes any practice that claims or attempts to change a person’s sexual orientation, gender identity, or gender expression. Historically, medical and mental health professionals engaging in conversion therapy used medication (e.g., administering testosterone to gay men), so-called “chemical castration” (administering drugs that rendered men impotent), surgical castration, and aversive techniques such as electro-shock therapy, induced nausea and other behavior modifications—none of which worked, and all of which caused serious harm. Today, the most common form of conversion therapy is so-called “talk therapy,” based on a variety of false assumptions and theories about the supposed “causes” of LGBTQ identity. One of the most common—often known as “reparative” or “reintegrative” therapy—is the false belief that gay men are insufficiently masculine and that lesbians are insufficiently feminine. Another is the false assumption that all people who are LGBTQ have experienced sexual abuse or have other unresolved childhood traumas. While contemporary conversion therapy may appear less overtly abusive than older forms, it is equally ineffective and harmful.

These practices may be engaged in by licensed medical and mental health professionals, by unlicensed professionals such as life coaches, or by religious counselors or faith leaders.

In the United States, many LGBTQ youth are sent to residential “camps” or programs, often run by religious organizations, that subject them to intensive conversion therapy efforts.

1. **Are there definitions adopted and used by States on practices of so-called “conversion therapy”? If so, what are those definitions and what was the process through which they were created or adopted?**

As of December 2019, 18 states and the District of Columbia, as well as more than 60 localities, have enacted laws that prohibit licensed mental health professionals from subjecting minors to conversion therapy. All of these laws use a definition of conversion therapy that is closely modeled on that adopted by the State of California in 2012, when it enacted the first such law in the country. That definition was created through a lengthy and careful collaboration of legislators, advocates, and mental health professionals. The input of mental health professionals was particularly important to ensure that the definition is medically accurate and consistent with professional mental health standards.

In the United States, legislative and policy efforts to end conversion therapy are led by Born Perfect, a coalition of conversion therapy survivors and legal experts working together to end this harmful practice. Born Perfect is a project of the National Center for Lesbian Rights, one of the nation’s leading legal advocacy organizations for LGBTQ people. For more information, see [www.bornperfect.org](http://www.bornperfect.org).

1. **What are the current efforts by States to increase their knowledge of practices of so-called “conversion therapy”?  Are there efforts to produce information and data on these practices?**

In 2015, the Substance Abuse and Mental Health Services Administration of the federal Department of Health and Human Services convened a group of experts who conducted a comprehensive survey of existing scientific research and clinical experience regarding conversion therapy, with a particular focus on minors. The results were published in a report entitled: Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth, available at <https://store.samhsa.gov/system/files/sma15-4928.pdf>. The report concluded that conversion therapy puts minors at risk of serious harms and should never be conducted on minors under any circumstances.

1. **What kinds of information and data are collected by States to understand the nature and extent of so-called “conversion therapies” (e.g. through inspections, inquiries, surveys)?**

Unfortunately, there are no existing State mechanisms to collect information or data on the nature or extent of conversion therapies. In the United States, each State is primarily responsible for licensing and regulating licensed mental health professionals, which is enforced by governmental boards. In practice, however, these boards are largely reactive rather than proactive and generally only undertake investigations in response to complaints initiated by individual patients.

The Williams Institute, a research institution at the University of California at Los Angeles, has published a study estimating the number of people who have been subjected to conversion therapy in the United States: Conversion Therapy and LGBT Youth, available at <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Update-June-2019.pdf>.

1. **Has there been an identification of risks associated with practices of so-called “conversion therapy”?**

In 2009, the American Psychological Association surveyed then-existing scientific literature in a report entitled “Appropriate Therapeutic Responses to Sexual Orientation.” See Am. Psychological Ass’n, Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Aug. 5, 2009), available at https://perma.cc/KX75-3KW4(hereinafter, “APA Report”). The APA Report concluded that “sexual orientation change efforts” (SOCE) are ineffective and put patients—and especially minors—at risk of serious long-term harms. The APA’s conclusions included the following:

The APA Report recognized that “conversion therapy” is another commonly used term for SOCE: “[W]e use the term sexual orientation change efforts (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex[.]” APA Report at 2 n.\*\*; id. at 93-117 (citing numerous studies and references concerning “conversion therapy”).

The APA Report found that conversion therapy for minors is ineffective: “We found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation.” APA Report at 79.

The APA Report concluded that the available research demonstrated evidence of harm from conversion therapy: “[S]cientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its participants.” APA Report at 83.

The APA Report cited recent studies documenting harm from “non-aversive” techniques: With respect to recent studies, “the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction.” APA Report at 42.

The APA Report concluded that licensed mental health providers should not engage in sexual orientation change efforts with minors under any circumstances, regardless of whether techniques are aversive or non-aversive, and including for “children and adolescents who present a desire to change their sexual orientation”: “We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE. . . . These approaches would support children and youth in identity exploration and development without seeking predetermined outcomes.” APA Report at 79-80 (emphasis added).

The APA Report concluded that conversion therapy offers no unique benefits. “The positive experiences clients report in SOCE are not unique, and “the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation.” APA Report at 68; see also id. at 53 (same).

The APA Report concluded that conversion therapy could not be justified by invoking client autonomy or self-determination. “We believe that simply providing SOCE to clients who request it does not necessarily increase self-determination but rather abdicates the responsibility of LMHP [licensed mental health professionals] to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm.” APA Report at 70.

In 2015, the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services conducted an updated survey of existing research on conversion therapy and published a report and recommendations based on “consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance.” Substance Abuse and Mental Health Serv. Admin., U.S. Dep’t of Health and Human Serv., Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth (Oct. 2015), at 1, available at https://perma.cc/KAC4-BHXD (hereinafter, “SAMHSA Report”). The report found “none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.” *Id*. It concluded: “Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment.” *Id*.

Other medical and mental health organizations that have reached similar conclusions include: the American Medical Association, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Physicians, National Association of Social Workers, American Psychoanalytic Association, American Counseling Association, American School Counselor Association, and Pan American Health Organization. JA 57-60.

Subsequent research has strengthened these conclusions. A recent peer-reviewed study found that lesbian, gay, and bisexual adolescents subjected to conversion therapy were nearly three times more likely to attempt suicide and experience serious depression than other LGBT youth. In fact, more than 60 percent of young adults who had been subjected to conversion therapy as minors reported attempting suicide. See Caitlin Ryan et al., Parent-Initiated Sexual Orientation Change Efforts with LGB Adolescents: Implications for Young Adult Mental Health and Adjustment, 67 J. Homosexuality 159 (2020), available at https://doi.org/10.1080/00918369.2018.1538407.

With respect to transgender youth, a recent cross-sectional study of 27,715 transgender adults found that “recalled exposure to gender identity conversion efforts was significantly associated with increased odds of severe psychological distress during the previous month and lifetime suicide attempts compared with transgender adults who had discussed gender identity with a professional but who were not exposed to conversion efforts.” Jack L. Turban et al., Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults, JAMA Psychiatry (Sept. 11, 2019), available at https://doi.org/10.1001/jamapsychiatry.2019.2285. This risk was even greater for transgender adults reporting identity conversion efforts before the age of 10, who were four times more likely to experience suicide attempts than other transgender individuals. *See id*.

1. **Is there a State position on what safeguards are needed, and what safeguards are in place to protect the human rights of individuals in relation to practices of so-called “conversion therapy”?  This question includes the following:**
   * 1. **Safeguards to protect individuals from being subjected to “conversion therapies”.**

In the United States, the only legal safeguards to protect individuals from being subjected to conversion therapy are state and local laws that prohibit licensed mental health professionals from subjecting minors to conversion therapy.

In addition to those statutory protections, every leading medical and mental health professional has issued formal policy statements warning both practitioners and patients that conversion therapy is unethical, ineffective, and harmful. It is important to note, however, that these organizations have no authority to sanction mental health professionals who violate these standards; the only entities with the authority to do so are state licensing and regulatory boards.

* + 1. **Broader statutory rules or administrative policies to ensure accountability of health care and other providers.**

In addition to laws and professional standards that expressly prohibit conversion therapy, state licensing and regulatory boards have the authority to sanction any licensed mental health professional who engages in conversion therapy under general ethical and practice guidelines. Similarly, even in states that do no have laws that expressly prohibit conversion therapy, any patient who has been subjected to conversion therapy could bring a malpractice case against the provider.

Some individuals have also successfully sued therapists or unlicensed professionals who engage in conversion therapy under consumer fraud laws.

1. **Are there any State institutions, organizations or entities involved in the execution of practices of so-called conversion therapy? If so, what criteria have been followed to consider these as a form of valid State action?**

Historically, many states forcibly institutionalized LGBTQ people and subjected them to involuntary “treatment” designed to change their sexual orientation, gender identity, or gender expression. Even today, many LGBTQ youth in state care are subjected to both formal and informal conversion therapy, ranging from informal efforts by staff in group homes or juvenile justice facilities (such as punishing youth for being LGBTQ) to formal conversion therapy counseling. These governmental practices are widespread, despite being abusive and unlawful.

1. **Have any State institutions taken a position in relation to practices of so-called “conversion therapy”, in particular:**
   1. **Entities or State branches in charge of public policy;**

The Substance Abuse and Mental Health Services Administration of the federal Department of Health and Human Services (see question 3 above).

* 1. **Parliamentary bodies;**

18 state legislatures and more than 60 local governments have enacted laws prohibiting licensed mental health professionals from subjecting minors to conversion therapy, based on the medical consensus that conversion therapy is ineffective and harmful.

* 1. **The Judiciary**;

Several state courts have issued rulings in favor of individuals bringing consumer fraud claims against therapists and unlicensed religious counselors. These rulings are based on a recognition that taking money in exchange for services that claim to change sexual orientation or gender identity is fraudulent.

* 1. **National Human Rights Institutions or other State institutions**;

There are few governmentally-sponsored federal human rights institutions in the United States. To our knowledge, none has addressed this issue.

* 1. **Any other entities or organizations.**

Every leading medical and mental health professional organization in the United States has issued policy statements condemning conversion therapy as unethical, ineffective, and harmful. See See Nat’l Ctr. For Lesbian Rights, Born Perfect: Toolkits, Resources & Statements, available at http://www.nclrights.org/bornperfect-toolkit-resources-statement/ (collecting statements) (last accessed Dec. 19, 2019).