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Victor Madrigal-Borloz

Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity

Office of the UN High Commissioner for Human Rights

via email <ie-sogi@ohchr.org>

Dear Mr. Madrigal-Borloz,

Thank you for the opportunity to provide input relative to your report on “conversion therapy” internationally.

Family Watch International is a nonprofit international educational organization in consultative status with the Economic and Social Council of the United Nations. With members and supporters in 170 countries representing various cultures, faiths, and socioeconomic backgrounds, we believe we can provide some context that could be helpful to you in your report.

We would like to briefly address the question related to how “conversion therapy” should be defined and the related question of risks associated with therapy (questions 2, 5 and 6b in the “Call for input”).

As you noted in the call for inputs, phrases such as “conversion therapy” and many others encompass a range of practices ranging from physical interventions to therapeutic discussions directed by a client related to how that individual can integrate the experience of same-sex attraction or gender dysphoria with other commitments, values and relationships at the core of their lived experience. The failure to carefully differentiate these radically diverse practices in discussions (and, in some cases, in legislation) about this issue has created undue confusion and severely hampered the ability of states to prevent abuses while allowing appropriate self-determination by persons who seek assistance.

The most important contribution your report could make would be to demonstrate a careful distinction between coercive practices that should be condemned and eradicated and exercises in self-determination that deserve deference. This would advance your mandate to protect against violence and discrimination while “respecting religious value systems” (Human Rights Council resolution 32/2).

This distinction is already inherent in relevant UN documents. For instance, the Committee Against Torture, explained: “The Committee is concerned at allegations of *involuntary placement* and *ill treatment* of lesbian, gay, bisexual and transgender persons in private centres in which sexual reorientation or dehomosexualization therapies are practised” (CAT/C/ECU/CO/7, par. 49, emphasis added). In another report, the Committee referred to “so-called ‘normalization therapies’, in pursuit of which members of sexual minorities are said to have been *involuntarily confined* to medical institutions and allegedly *subjected to forced treatment*, including *electric shock therapy* and other ‘*aversion therapy*’, reportedly causing psychological and physical harm” (CAT/C/57/4, par. 69, emphasis added). Another Committee report expressed concern “about reports that private and publicly run clinics offer the so-called ‘gay conversion therapy’ to change the sexual orientation of lesbian and gay persons, and that such practices include the *administration of electroshocks* and, sometimes, *involuntary confinement* in psychiatric and other facilities, which could result in physical and psychological harm” (CAT/C/CHN/CO/5, par.55, emphasis added). Importantly, that report recommended that the relevant state party take “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’, and *other forced, involuntary or otherwise coercive or abusive treatments* against them” (CAT/C/CHN/CO/5, par. 56). Here, the distinction is clear that coercive practices can be distinguished between practices that “guarantee respect for the autonomy and physical and personal integrity.” In this document, the “conversion therapy” with which the Committee is concerned is one of (as evidenced by the use of the word “other”) a number of practices characterized by force, involuntariness, coercion and abuse.

Similarly, the Committee on the Rights of the Child expressed concern about reports of “*coercive* treatment of transsexual and homosexual persons, in particular children” (CRC/C/RUS/CO/4-5, par. 55, emphasis added). In another setting, it affirmed the “rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy” and condemned “the *imposition* of so-called ‘treatments’ to try to change sexual orientation” (CRC General Comment No. 20, emphasis added). The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment decried reports of “persons being *denied medical treatment*, *subjected to verbal abuse* and *public humiliation*, *psychiatric evaluation*, a *variety of forced procedures* such as sterilization, State-sponsored forcible anal examinations for the prosecution of suspected homosexual activities, and invasive virginity examinations conducted by health-care providers, hormone therapy and genital normalizing surgeries under the guise of so called ‘reparative therapies’” (A/HRC/22/53, par.76. emphasis added). The concern here is clearly with “forced” procedures to which individuals are “subjected.” This sense is strengthened later when the Special Rapporteur encouraged states to repeal laws that allow “intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical display, ‘reparative therapies’ or ‘conversion therapies’, *when enforced or administered without the free and informed consent of the person concerned*” (par. 88, emphasis added; see also A/HRC/31/57, pars. 48, 72(i)). The Human Rights Committee encouraged one state to “redouble its efforts to eliminate fully the practice of *placing such persons in institutions* for treatment to ‘cure their sexual orientation or gender identity’” (CCPR/C/ECU/CO/6, par. 12, emphasis added).

Even where the proscribed practices are not explicitly addressed in terms of coercion, the context of grouping the therapy with other coercive practices makes clear that the use of force is the salient feature. Thus, a United Nations joint statement described “harmful so-called ‘therapies’ to change sexual orientation, *forced* or coercive sterilization, *forced* genital and anal examinations, and unnecessary surgery and treatment on intersex children *without their consent*” (United Nations Joint Statement, *United Nations entities call on States to act urgently to end violence and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI) adults, adolescents and children*, 2015, emphasis added). The Committee Against Torture described practices of denying medical treatment, “verbal abuse and public humiliation, psychiatric evaluations, sterilization, and hormone therapy and genital-normalizing surgeries under the guise of so-called ‘reparative therapies’” (CAT/C/57/4, par.67).

While some documents are not careful about distinguishing between coercive and non-coercive practices (see CCPR/C/KOR/CO/4, par. 15; A/HRC/14/20, par. 23; CAT/C/57/4, par.81), the majority are, suggesting the importance of the distinction.

Other bodies have recognized the distinction. The Committee on Economic, Social and Cultural Rights decried “regulations *requiring* that LGBTI persons be treated as mental or psychiatric patients, or requiring that they be ‘cured’ by so-called ‘treatment’” (CESCR General Comment No. 22). The Pan American Health Organization noted “a growing number of reports about degrading treatments, and physical and sexual harassment under the guise of such ‘therapies,’ which are often provided illicitly. In some cases, adolescents have been subjected to such interventions involuntarily and even deprived of their liberty, sometimes kept in isolation for several months” (*“Cures” for an illness that does not exist*, 2012).

Many of the national laws noted in the Call for Inputs follow a similar approach. Ecuador’s criminal law prohibits the infliction of serious physical or psychological harm or dehumanizing treatment and heightens the penalty when these crimes are committed in order to modify gender identity or sexual orientation (Ecuador Codigo Organico Integral Penal, art. 151). Brazil’s law combines prohibitions on coercion with non-coercive practices (CFP Res 01/1999). Others merely note that the mere experience of same-sex attraction or gender dysphoria do not constitute mental illness (Fiji Mental Health Act 2010; Uruguay Law 19529).

In contrast to the distinctions between coercive practices and patient self-determination reflected in many of these international laws and documents, the policy positions of professional groups typically do not clarify what practices they are referring to when they discuss “conversion therapy” or similar concepts. For instance, the position statements of the World Medical Association and the World Psychiatric Association cited in the Call for Inputs. Of course, these are not empirical studies but statements of policy. The World Medical Association statement does not reference any studies in making its assertion. The World Psychiatric Association statement does include references, but these do not illuminate the potential risks of various approaches to therapy or indeed what kinds of practices are commonly utilized as treatments. In fact, the study it references in support of the assertion that “so‐called treatments of homosexuality can create a setting in which prejudice and discrimination flourish, and they can be potentially harmful” is not an empirical study but just another editorial statement.

As a result of the already-noted failure to distinguish between coercive and client-determined treatment, it is not clear whether the asserted harms proposed in the policy statements would apply only where a “treatment” involves force and coercion (which we can intuitively conclude would result in harm), or whether they would apply even when a counselor merely talks with a client about how they might reconcile their sexual feelings or practices with other commitments, values, and relationships at the client’s request (which we would assume would not cause harm). This failure to make a distinction between types of practices grouped together under the term “conversion therapy” undercuts the value of nearly all literature on the practice of such therapy or the risks associated with it. As a task force of the American Psychological Association noted, “what constitutes [sexual orientation change efforts] in empirical research is quite varied” and the research “cannot provide clarity regarding which specific efforts are associated with which specific outcomes” (Report on the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p.31).

In fact, the APA task force concluded: “Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE” (APA Task Force, 2009, p. 42).

The conflation of coercive practices and client self-determination has been a feature of legislation in legislation in the United States. There, the minority of states have adopted laws that would prevent children and youth from seeking therapeutic help of any kind unless that help is premised on the idea that an LGBT identity and behavior must be embraced, regardless of the therapeutic goals of the child and her or his parents or guardians. More recently, states have begun to consider legislation that reflects the coercion/self-determination distinction. For instance, in 2019, one state considered a bill that would probity coercive practices but allow parents and children to explore counseling that would help the child reconcile sexual feelings with deeply held beliefs (2019 Utah House Bill 399). News reports suggest other U.S. states will consider similar legislation in 2020.

One significant risk of conflating coercive practices with client self-determination is that the resulting legislation and regulations threaten important human rights of adults and children. The International Covenant on Economic, Social and Cultural Rights recognizes the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and the Universal Declaration of Human Rights, states that “everyone has the right to … medical care and necessary social services” (UHDR, art. 25:1). This right would clearly be infringed if the law bans an individual’s choice of non-coercive and non-abusive treatment. Banning therapy would also interfere with the right to self-determination or liberty (UHDR, art. 3) and “the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media” (UHDR, art. 19).

In the United States, constitutional concerns with dictating the type of topics counselors and therapists could discuss with clients were initially dismissed by lower courts in the belief that state and local governments could exercise unfettered control over the speech of processionals. The U.S. Supreme Court, however, dismissed this idea in another context, specifically disavowing the reasoning used to uphold therapy bans, and abrogating the decisions (Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2371–72 (2018)). A more recent lower court decision concerned a local municipal law that did “not differentiate between coercive or aversive therapy, and simple ‘talk therapy’” and found the city lacked authority to regulate a practice governed by state law. The court noted the law inserted the government “into the middle of this sensitive, intense and private moment” between a youth and mental health therapist, likely invaded privacy rights, and interfered with parental rights (Vazzo v. Tampa, U.S. District Court, Middle District of Florida, October 4, 2019, pp. 19-21).

State parties could, and should, prohibit coercive practices like those noted in the UN literature—electroshock therapy, involuntary confinement, abuse, etc.—without limiting circumscribing human rights like free expression, self-determination and parental authority. The same cannot be said of prohibitions on “talk therapy” directed by a client to explore ways to reconcile sexual orientation and gender identity with other core traits and commitments of that client.

For a more extended discussion, see “[How Laws Banning Non-Coercive Therapy are Harmful and Violate Fundamental Human Rights](https://familywatch.org/wp-content/uploads/sites/5/2019/12/How_Laws_Banning_Sexual_Reorientation_Therapy_are_Harmful_and_Violate_Human_Rights_website_12-17-19.pdf).”[[1]](#footnote-1)

In summary, your report would make an important contribution to protecting freedom and equality “in dignity and rights” (UDHR, art. 1) by carefully differentiating between coercive and abusive practices and those that respect client self-determination and encouraging states to adopt laws that reflect that distinction.

Sincerely,

Family Watch International

1. Available at [https://familywatch.org/wp-content/uploads/sites/5/2019/12/How\_Laws\_Banning\_Sexual\_‌Reorientation\_Therapy\_are\_Harmful\_and\_Violate\_Human\_Rights\_website\_12-17-19.pdf](https://familywatch.org/wp-content/uploads/sites/5/2019/12/How_Laws_Banning_Sexual_Reorientation_Therapy_are_Harmful_and_Violate_Human_Rights_website_12-17-19.pdf) [↑](#footnote-ref-1)