parental attempts to change sexual orientation. In a related study, families that were highly religious were least likely to accept their LGBT children (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Religiously conservative families often have misinformation about sexual orientation and gender identity and need accurate information to help support their LGBT children in the context of their values and beliefs (for guidance see Ryan & Rees, 2012; Substance Abuse Mental Health & Services Administration, 2014). Moreover, parents and caregivers often conflate sexual orientation with gender expression. Discomfort with gender nonconformity may be at the root of much of parents' and caregivers' motivations for SOCE: in the current study, gender nonconforming youth were more likely to experience attempts to change their sexual orientation through conversion therapy with therapists and religious leaders. Further, our results show that immigrant parents are more likely to try to change their children's sexual orientation by sending them for clinical or religious intervention.

Related research has found that SOCE typically happens in the context of other family rejecting behaviors that contribute to health risks in young adulthood (Ryan et al., 2009). Parents, caregivers and others who provide support for LGBT children and adolescents need to understand that family rejection encompasses a wide range of behaviors, and education is critical for families, providers, and religious leaders on the relationship between family rejection and acceptance with health and wellbeing for LGBT young people (Ryan, 2009; Ryan & Chen-Hayes, 2013; Ryan et al., 2010; Substance Abuse and Mental Health Services Administration, 2015; Substance Abuse Mental Health & Services Administration, 2014).

Studies on responses of parents and caregivers with LGBT children indicate that parents' reactions are motivated by a number of concerns, which include helping their child "fit in" to their family and cultural world, responding to religious and cultural values, keeping their families together, and trying to protect their LGBT child from harm (Maslowe & Yarhouse, 2015; Ryan, 2009; Substance Abuse Mental Health & Services Administration, 2014). In other words, parents are typically motivated by doing what they think is best for their child. Nonetheless, our study did not directly examine the motives of the parents of study participants. However, these findings reinforce the critical need for culturally appropriate family education and guidance on sexual orientation and gender identity and expression, the harmful effects of family rejecting behaviors, including SOCE, and the need for supporting their LGBT children, even in the context of parental and familial discomfort and religious conflict.

There are several limitations of this study. First, study inclusion criteria called for current identification as LGBT; it is likely that this inclusion criterion excludes persons who are dissatisfied with their LGBT identity, or persons who had identified as LGBT during adolescence but not at the time

of the study. Thus we acknowledge that we did not include young people whose sexual orientation may be more fluid (e.g., sexual orientation in adolescence not consistent with sexual orientation in young adulthood). Second, although the study included a measure of family religiosity, there is no measure of specific religious affiliation, a factor that might be a further predictor of the role of parents in SOCE of their children. Third, the design is retrospective, and thus causal claims cannot be made. We cannot rule out the possibility that those who were most maladjusted as young adults retrospectively attribute parental behaviors during adolescence as attempts at changing their sexual orientation; we also cannot rule out the possibility that well-adjusted LGBT young adults may be less likely to recall experiences related SOCE. However, we note that the face validity of the specific measures is compelling: the alternatives are less plausible than the explanation that sexual orientation change attempts would likely undermine health and wellbeing.

Most attention to SOCE has focused on the ethics of professional practice and recent efforts to end such practice through legislation. This study highlights the crucial role parents play in SOCE—either directly themselves or through sending their children to therapists or religious leaders. Results point to the need for multicultural and faith-based family education resources and approaches to help parents and caregivers learn how to support their LGBT children in the context of their family, cultural, and religious values (see, for example, Kleiman & Ryan, 2013; Ryan, 2009; Ryan & Rees, 2012). In addition to supporting families and educating religious leaders and congregations, legislative and professional regulatory efforts to end SOCE therapies are important for raising awareness about and preventing a contraindicated practice that contributes to health risks, and for changing negative attitudes and bias regarding LGBT people.

Taken together, these findings provide a needed empirical framework for understanding the scope of SOCE in and outside of the home and the costs of sexual orientation change efforts directly from those individuals who are most affected—LGBT young people themselves. Historically, research and strategies to prevent SOCE have focused on mental health practitioners and much less on religious leaders, with limited awareness of the role of families in pressuring LGBT young people to change core identities. As indicated by this study, more attention is needed on family-based efforts to change a child's sexual orientation and gender expression. Because LGBT youth cannot escape family rejecting behaviors (see, for example, Ryan, 2009; Ryan & Rees, 2012), approaches to prevent and ameliorate efforts to change a child's sexual orientation and gender identity must include the broader social context that includes the home and social, cultural, and religious influences on families and caregivers to change or suppress a child's sexual orientation and gender expression.

Notes

1. The sampling frame for the study included youth who identified as LGBT during adolescence. Of note, all transgender youth in this sample also identified as lesbian/gay, bisexual, homosexual, or queer.
2. Policy statements cautioning against SOCE have been issued across disciplines ranging from counseling (American Counseling Association, 2013) to medicine (Society for Adolescent Health and Medicine, 2013), nursing (International Society of Psychiatric-Mental Health Nurses, 2008), psychiatry (American Psychiatric Association, 2000; World Psychiatric Association, 2016), psychology (American Psychological Association, 2009), and social work (National Association of Social Workers, 2015).

Disclosure statement

No potential conflict of interest was reported by the authors.

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News » Local

Survivor: MIT grad student remembers "ex-gay" therapy

by Hannah Clay Wareham
Bay Windows
Thursday August 25, 2011

PRINT EMAIL

Samuel Brinton is not afraid to say he's gay.

That is, not anymore.

The 23-year-old Massachusetts Institute of Technology (MIT) graduate student is the son of two Southern Baptist ministers, and endured years of reparative therapy designed to "cure" him of his homosexuality while living in Kansas. Sam is used to telling his story?he speaks often about his experiences in the hopes that others who have endured similar struggles will find hope.

On the eve of the Exodus North Atlantic Regional Conference?an assembly of religious activists gathering to "heal the sexually broken," to be held at a small fundamentalist church in Auburn, New Hampshire from Sept. 16 to Sept. 18?Sam's story stands in contradiction to conservative Christian beliefs that it's possible to "pray away the gay."

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Sam was a pre-teen, living with his parents in a conservative religious mission in Florida, when a copy of Playboy magazine was somehow smuggled into the eager hands of the community's young boys. Overflowing with pride, Sam mistook his sexuality for sanctity and told his father that he was "so righteous, so holy," that he wasn't affected whatsoever by the pictures of scantily-clad women. He did, he admitted to his dad, sometimes feel that way about his best friend Dale.

"The next thing I knew," Sam says, "I woke up in the E.R."

12-year-old Sam had been "punched out cold" by his father, and would end up in the emergency room for similar reasons seven times in quick succession.

"He really thought if he scared me enough I would change," Sam remembers of his father.

At Sam's mother's suggestion, he found himself in therapy, happy to face Bibles on a coffee table rather than lying to hospital staff about his injuries.

During his first one-on-one appointment, the session leader?who Sam specifies was a "religious therapist" and not a doctor?told Sam, "I want you to know that you're gay, and

person in the world, that the government had killed all the other gay children, and that they'd kill him too if he acted gay. He carried this belief as truth until his second year of college.

Loneliness colored Sam's thirteen-year-old world. "I'm dying of AIDS, I'm completely alone, and the government is looking for me," Sam remembers feeling. The worst part? Sam's parents and therapist told him God had abandoned him and his chances at getting into heaven were shrinking every day. "The strongest thing my family has is its relationship to God, and now He hates me," Sam recalls.

For the next few months, the journal Sam kept?read by his therapist?fueled the sessions, which were escalating in intensity. What Sam calls "the first step" of his therapy involved attaching his hands to a table with leather straps, palms up. The therapist placed blocks of ice on each hand and showed Sam pictures of two men holding hands, so that the young boy began to associate touching men with the "burning cold."

"The second step" was similar, but the ice was replaced with copper heating coils that had been wrapped around his wrists and hands. The heat was turned on when pictures of two men holding hands were shown, but turned off when pictures of a heterosexual couple holding hands were shown. Following these sessions, Sam would shudder when hugged by his father, experiencing what he calls "heat flashbacks."

"The third step" accompanied Sam's first attempt at committing suicide (there have been five). He was strapped into a chair, and small needles were stuck into his fingertips. The needles were attached to electrodes, and Sam received shocks when shown pornographic images of two men engaging in sex acts.

"I'm ruined," Sam says today. "I cannot get rid of the shock" when he hugs a man, when he shakes a man's hand and feels attached to the electrodes once more. "I've gotten used to the pain."

During the months of therapy, Sam was kept in his bedroom "24/7." His parents told his younger sister that Sam had murdered someone, and they were hiding him from the police. Sam says he was "sequestered" to protect his parents' reputation at the mission.

As for the physical side of his therapy, Sam says of his parents, "they knew what was going on. They said they were going to do whatever it took to save my soul. They wanted me to go to heaven with them."

Sam attempted suicide again shortly thereafter. He said goodbye to his younger sister and climbed to the roof of the three-story commune his family lived in. Standing at the edge of the roof, Sam remembers telling himself, "If I don't change, they're going to kill me." Sam's mother?alerted by his sister?rushed to the roof to save her son, promising him, "I will love you again?if you just change."

Sam decided then that it would be more painful to jump and not die than to live with a secret, and turned to his mother, faking it as hard as he could. "I think it's done," he remembers saying, and adds as an aside: "And then I began my acting career." Instantly it was as though the months of painful therapy had never happened. The household returned to normalcy, and Sam continued to pray every day for God to make him straight.

"I was still convinced I was alone, gay, and dying of AIDS," he says.

Upon moving to Kansas, Sam threw himself into extra-curricular activities at his public high school, continuing to keep his secret. It wasn't until his second year at Kansas State University?where he had a dual major of nuclear engineering and opera?that Sam met another gay person. His lesbian friend was discussing her partner, and before Sam knew it, he was crying and yelling to their friends that she didn't mean it, she didn't know what she was saying?convinced that their friends would report them to the government and his worst childhood fears would be realized.

Despite numerous instances of discrimination and prejudice on the KS campus, Sam began to come out of the closet. Openly gay, he ran for student body president, telling himself, "I deserve this place here too." News of his bid for president?amplified when he won the primary?drew statewide attention. Conservative Christian activist Fred Phelps and his followers picketed the campus, carrying signs that read, "GOD HATES SAM," splashed with Sam's photo.

Following an anonymous mass email slandering his campaign and personal life, Sam didn't win the general election, but that doesn't bother him. "I had made my point," he shrugs, allowing that his thick skin helped save him from biased criticism. "You cannot really hurt me," he says. "I know what true pain is."

Sam went on to pass a city ordinance protecting LGBT people from discrimination in his college town of Manhattan, Kansas. He was named the Top LGBT Activist in the country last year by the Campus Pride organization. He serves as national secretary for a progressive fraternity for GBT men, and is studying nuclear engineering on an MIT fellowship. "My life is heaven," he says, smiling. "My life is perfect."

Sam has found that the very best part of his life, however, is helping others who are struggling with their sexuality or with reparative therapy. "My core goal is to make them know they are not alone," he says. "You are okay just the way you are."

Despite his positive, optimistic outlook, fears peek over the horizon. "We have a presidential candidate whose husband practices reparative therapy," Sam says of Republican Michele Bachmann. "Not only would our country be led by someone who believes in this, but it would be politically supported."

Sam says he's living proof that reparative therapy is "killing people." A support group to which he belongs began with ten members; eight have since taken their own lives. Sam is ever on the lookout for opportunities to help others in the same situation, with the message that not only does it get better?it can be made better.

"I know who I am," Sam says now. "I know I can't change it. I'm strong in my faith, and I'm strong in my sexuality." And Sam is sure he's still going to heaven.

Join the Impact - MA, of which Sam is a member, will be protesting the September Exodus conference in New Hampshire. For more information, please visit www.jointheimpactma.org.

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Liaison Committee on Medical Education—student representative

The Liaison Committee on Medical Education (LCME) is the joint Committee of the AMA and the Association of American Medical Colleges that serves as the nationally recognized accrediting agency for U.S. allopathic medical schools.

Responsibilities

Student members of the LCME participate fully in LCME activities, including serving on one survey team during the year, and have full voting privileges. The selected students begin their official year of service on July 1, but also will be expected to attend the June LCME meeting as an orientation.

Requirements

- The applicant must be a 4th-year medical student during the 2020-2021 academic year. If an MD/PhD student, he or she must have completed the clerkship year.
- The applicant should be in good academic standing and be able to commit sufficient time to LCME duties, including attending three LCME meetings during the year, participating in one survey visit, and serving as a reviewer of reports from survey teams and schools.
- The student should show evidence of interest in medical education, such as curriculum committee membership and/or participation in accreditation or other quality assurance activities at the school.
- A letter of support from the dean or dean's-designate is required.

Terms of Service: One year, commencing July 2020

CACREP Guiding Statement

Guiding Statement on 2016 CACREP Standard 1.O

Standard I.O states the following:

Counselor education programs have and follow a policy for student retention, remediation, and dismissal from the program consistent with institutional due process policies and with the counseling profession's ethical codes and standards of practice.

Standard I.O applies to students enrolled in the counseling program(s). The intent of Standard I.O is that programs adopt and adhere to the current American Counseling Association's (ACA) and/or its divisions' codes of ethics. The counseling program(s) must provide the knowledge and skills that enable students to fully comply with the ACA Code of Ethics.

If a student engages in behavior(s) that violate these ethical codes while in the program, programs are expected to follow their due process policies in determining the basis for remediation and/or dismissal from the program.

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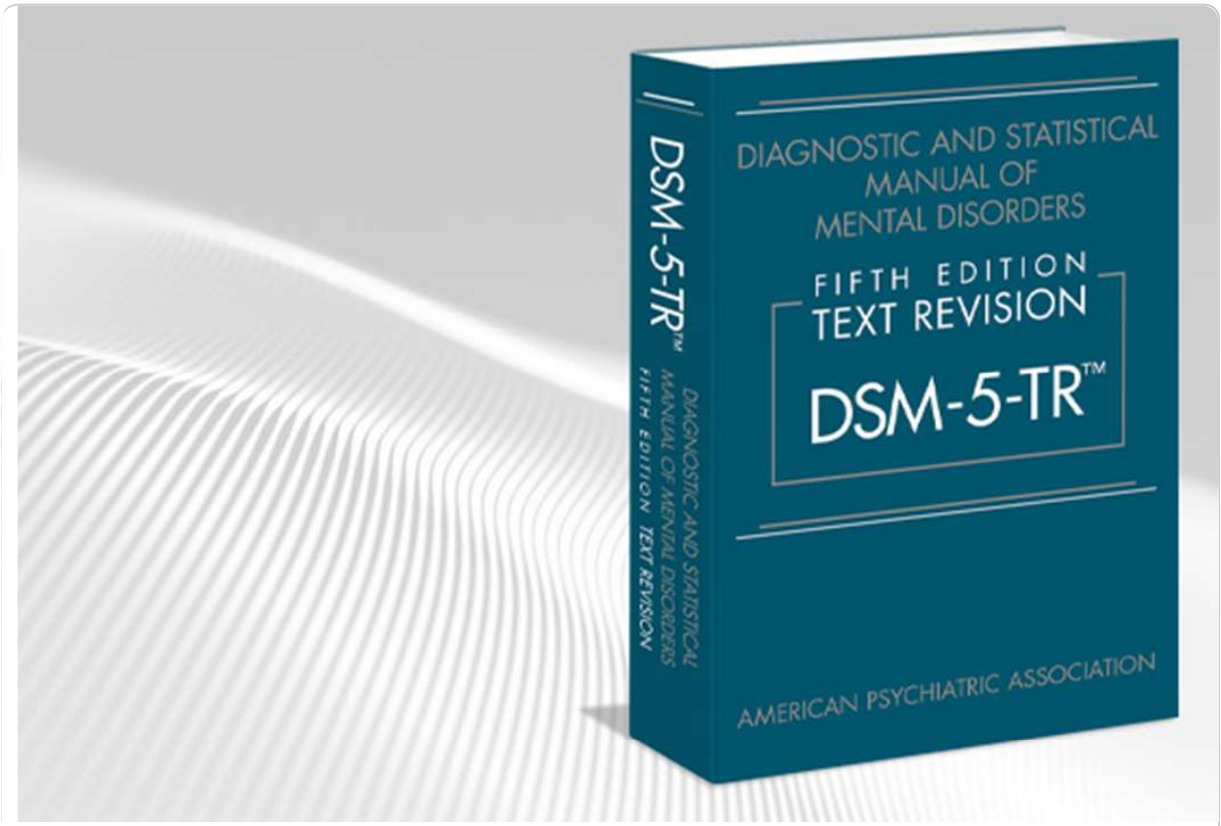

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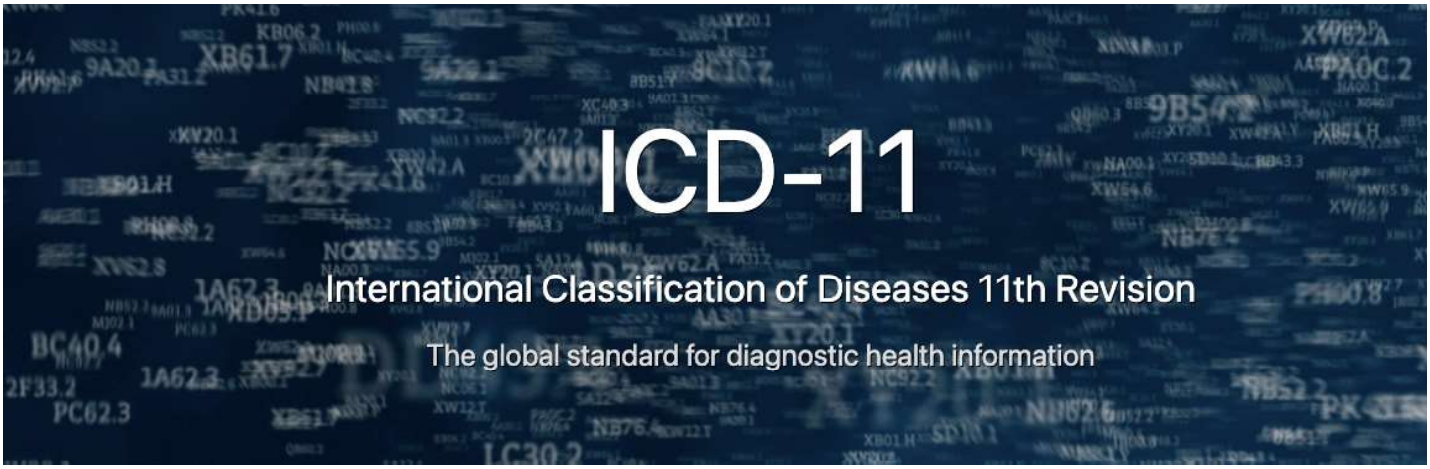

ICD-11 Homepage

ICD serves a broad range of uses globally and provides critical knowledge on the extent, causes and consequences of human disease and death worldwide via data that is reported and coded with the ICD. Clinical terms coded with ICD are the main basis for health recording and statistics on disease in primary, secondary and tertiary care, as well as on cause of death certificates. These data and statistics support payment systems, service planning, administration of quality and safety, and health services research. Diagnostic guidance linked to categories of ICD also standardizes data collection and enables large scale research.

For more than a century, the International Classification of Diseases (ICD) has been the basis for comparable statistics on causes of mortality and morbidity between places and over time. Originating in the 19th century, the latest version of the ICD, ICD-11, was adopted by the 72nd World Health Assembly in 2019 and came into effect on 1st January 2022.

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ICD purpose and uses

As a classification and terminology ICD-11:

- allows the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or regions and at different times;
- ensures semantic interoperability and reusability of recorded data for the different use cases beyond mere health statistics, including decision support, resource allocation, reimbursement, guidelines and more.

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Uses of the ICD are diverse and widespread and much of what is known about the extent, causes and consequences of human disease worldwide relies on use of data classified according to ICD. See below just a few examples:

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ICD-11 Webinar - A focus on Occupational Health

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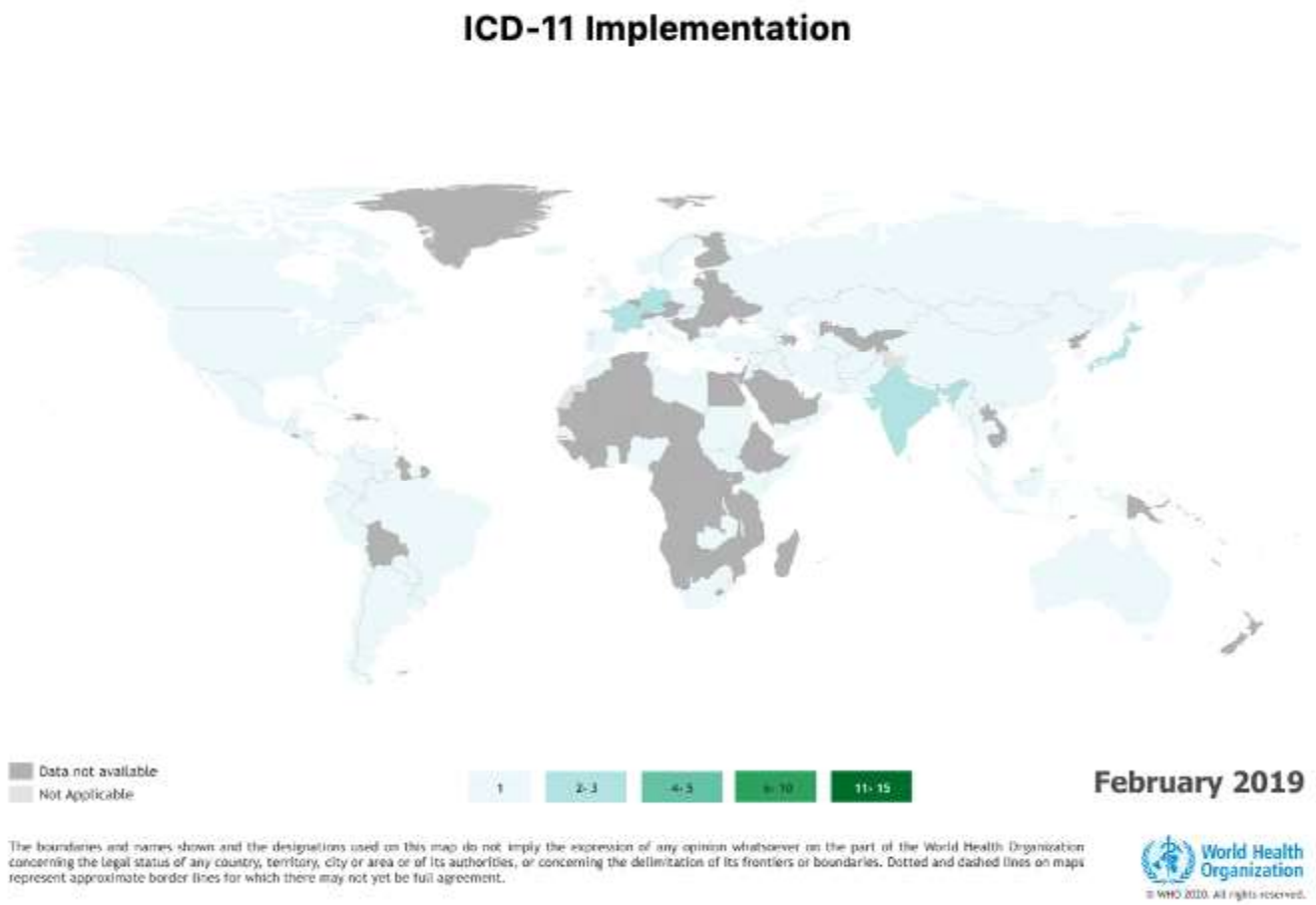

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ICD-10

All Member States are committed to using the most recent version of ICD. 2022 is the first year where ICD-11 is officially in effect.

- ICD-10 Browser (Latest version, 2019)
- ICD-10 Training
- List of Official ICD-10 Updates
- FAQ on ICD

- ICD-10 Update platform (Archive)

Previous online versions of ICD-10:

- ICD-10 Browser (Latest version, 2019)
- ICD-10 2016
- ICD-10 2015
- ICD-10 2014
- ICD-10 2010
- ICD-10 2008

ICD History

First World Health Assembly

Convention of 30 April 1948

The Delegates entrusted WHO, as one of its functions, with the task of establishing and revising the necessary international nomenclatures of diseases and causes of death, giving the World Health Assembly authority to adapt regulations in respect, such as nomenclatures, for consideration and action, the International Statistical Classification of Diseases, Injuries and Causes of Death and accompanying recommendations, destined to improve international uniformity and comparability of statistics of morbidity and mortality.

ICD revisions under the auspices of WHO

ICD Revision	ICD Coming into effect	ICD Adoption
6th Revision	into effect 1948	adopted 1948 (WHA1.36)
7th Revision	into effect 1 Jan 1958	adopted May 1956 (WHA9. 29)
8th Revision	into effect 1 Jan 1968	adopted May 1966 (WHA19.44)
9th Revision	into effect 1 Jan 1979	adopted May 1976 (WHA29.34)
10th Revision	into effect 1 Jan 1993	adopted May 1990 (WHA43.24)
11th Revision	into effect 1 Jan 2022	adopted May 2019 (WHA72.15)

Ethical Principles of Psychologists and Code of Conduct

Ethics (https://www.apa.org/search?query=ethics)

Including 2010 and 2016 Amendments

- **Section 9: Assessment**
- **Section 10: Therapy**
- **History and Effective Date**
- **Amendments to the 2002 "Ethical Principles of Psychologists and Code of Conduct" in 2010 and 2016**

Date created: March 2017

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Additional Resources

- 2018 APA Ethics Committee Rules and Procedures (PDF, 197KB)
- Revision of Ethics Code Standard 3.04 (Avoiding Harm)
- APA Ethical Principles of Psychologists and Code of Conduct (2017) (PDF, 272KB)
- 2016 APA Ethics Committee Rules and Procedures
- Revision of Ethical Standard 3.04 of the "Ethical Principles of Psychologists and Code of Conduct" (2002, as Amended 2010) (PDF, 26KB)
- 2010 Amendments to the 2002 "Ethical Principles of Psychologists and Code of Conduct" (PDF, 39KB)
- Compare the 1992 and 2002 Ethics Codes

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Research and analysis

An assessment of the evidence on conversion therapy for sexual orientation and gender identity

Published 29 October 2021

Contents

This publication is available at https://www.gov.uk/government/publications/an-assessment-of-the-evidence-on-conversion-therapy-for-sexual-orientation-and-gender-identity/an-assessment-of-the-evidence-on-conversion-therapy-for-sexual-orientation-and-gender-identity

1. Executive summary

This report summarises the international evidence on the nature, quality and quantity of evidence on conversion therapy to change sexual orientation, and to change gender identity. This is to help inform the development of options for ending conversion therapy.

This assessment supplements the rapid evidence review and research on conversion therapy (https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study) carried out by Coventry University.

1.1 About the evidence

The evidence base for conversion therapy to change sexual orientation has been growing for over 20 years. The evidence base for gender identity is much newer, with the earliest study done in 2018. As a result, the literature is dominated by evidence on conversion therapy for sexual orientation.

The main topics of the studies into conversion therapy for sexual orientation were:

- participants' experiences of conversion therapy
- the outcomes of conversion therapy

For conversion therapy for gender identity, the main topics covered were:

- the scale of conversion therapy among transgender people
- participants' experiences of conversion therapy
- the outcomes of conversion therapy

Articles were reviewed using a standardised assessment approach, with each study scored on a spectrum from 'high' to 'average' to 'low', including points in between. Most of the studies were assessed as being of around average quality.

However, the quality of the overall evidence base is lowered by the lack of robust sampling and design in the quantitative studies. This is because a sample frame of people who have undergone conversion therapy does not exist.

There were a small number of studies for conversion therapy for gender identity and these were assessed as being stronger in design than those for sexual orientation. This was due to the fact that 2 of the studies were based on large-scale national surveys, which helps to reduce some sample limitations.

1.2 Main findings

The main findings from the studies were that:

- there is no robust evidence that conversion therapy can achieve its stated therapeutic aim of changing sexual orientation or gender identity
- the types of practices tend to be similar for conversion therapy for sexual orientation and for gender identity – for example, talking therapies delivered by faith groups or mental health professionals

- conversion therapies were associated with self-reported harms among research participants who had experienced conversion therapy for sexual orientation and for gender identity – for example, negative mental health effects like depression and feeling suicidal
- there is indicative evidence from surveys that transgender respondents were as likely or more likely to be offered and receive conversion therapy than non-transgender lesbian, gay or bisexual (LGB) respondents

1.3 Issues for consideration

Based on the reported aims of studies, it was possible to categorise them by their focus on conversion therapy for sexual orientation or for gender identity.

However, some of the studies targeted at changing sexual orientation also included changing people's social identities, which could affect their gender identity. As a result, a number of studies have suggested that practitioners of conversion therapy can conflate sexual orientation and gender identity in practice.

This assessment also found this area of research faces some inherent methodological challenges which are highlighted throughout. This limits the ability to say definitively what the impact of conversion therapy is.

However, this report has noted that the quality of evidence reviewed is likely to be the highest possible given inherent constraints. More methodologically-robust research designs, such as randomised control trials, are not possible.

While the evidence is based on self-reporting, consistent patterns were found which enable conclusions to be drawn. These are that there is no robust evidence that conversion therapy can change sexual orientation or gender identity, and that conversion therapy is frequently associated with harm.

2. Introduction

The National LGBT Survey 2017 (https://www.gov.uk/government/publications/national-lgbt-survey-summary-report) had a self-selecting sample of around 108,000 lesbian, gay, bisexual, and transgender (LGBT) respondents in the UK. The survey found that:

- 5% of respondents said they had been offered conversion or reparative therapy in an attempt to cure them of being LGBT
- a further 2% said they had undergone the therapy

These figures were higher for transgender respondents, with 13% saying they had undergone or been offered conversion therapy, compared with 7% of non-transgender UK respondents. In 2018, the government said it would explore options for ending conversion therapy in the UK.

The Government Equalities Office (GEO) commissioned a further study, comprising a rapid evidence assessment and qualitative research (https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study), to improve understanding of the practice, experience and effect of conversion therapies.

This was undertaken by researchers at Coventry University and aimed to answer questions such as:

- what forms does conversion therapy take?
- who experiences conversion therapy and why?
- what are the outcomes of conversion therapy?
- what measures have been taken to end conversion therapy around the world?

GEO's assessment aims to distinguish between evidence on conversion therapy for sexual orientation and for gender identity. This analysis builds on the evidence review and findings generated by Coventry University. It does not replace it, but considers a further question:

- to what extent does the evidence vary for conversion therapy to change sexual orientation and gender identity, specifically in relation to its nature, quality, quantity and the findings?

This report summarises the findings from this analysis.

3. Approach

3.1 Search strategy

The research team at Coventry University found 46 articles in their rapid evidence assessment on conversion therapy. These articles are listed in Appendix 1.

These 46 studies were used as a starting point for the evidence search for this assessment. We used an academic database to look for any other relevant studies, using the terms:

- 'conversion therapy' or 'reparative therapy'
- 'sexual orientation' or 'gender identity'

We also did research to identify any further grey literature relating to this issue, but did not find any more studies.

3.2 Assessment

Full text articles were read and reviewed and their methodology assessed using the Mixed Methods Appraisal Tool (MMAT) (Pluye and others, 2009), which we felt gave a consistent set of questions across a broad range of methods. For example, compared with other tools, the MMAT specifically includes criteria for appraising mixed methods studies.

The MMAT can be used to appraise the quality of 5 categories of study:

- qualitative research
- randomised controlled trials
- non-randomised studies
- quantitative descriptive studies
- mixed methods studies

Systematic reviews cannot be assessed using the MMAT. Instead the methods and search strategies of the 3 systematic reviews found were reviewed for robustness independently.

The MMAT uses up to 5 different questions for each type of study. For example, for quantitative studies reviewers are asked to assess whether the statistical analysis used is appropriate. For qualitative studies, they are asked whether the conclusions taken from the data presented are rational. Each question is answered with a 'yes' or 'no', and an overall score is given. Reviewers also make notes about the studies' strengths and limitations. All of this contributes to an overall assessment of quality. This approach was in line with that taken in the Coventry University review.

For this exercise each study was scored in this way. Its quality was then labelled as one of the following:

- high
- above average
- average
- below average
- low

All full text articles were reviewed by one analyst using the relevant MMAT section. This gave an indication of the quality of each study. A random sample of 10% of the studies were also reviewed by a second analyst and these scores were compared for consistency and reliability.

A matrix was developed to catalogue the studies. Information was captured from each study under the following headings:

- coverage – for example, sexual orientation, gender identity or both
- geography – for example, country in which the study was carried out
- methodology – for example, comparison group, pre-post survey, qualitative
- overall assessment of quality – for example, how robust the study was
- topic or focus of the study – for example, experience or impact of conversion therapy
- main findings

We identified patterns from this exercise, such as the similarities and differences between the studies looking at conversion therapy for sexual orientation and gender identity. Main findings on the patterns in the evidence between conversion therapy for sexual orientation and gender identity are shown in the next 4 sections. A high-level summary using the matrix headings is shown in Appendix 2. The full assessment is available as a separate annex.

4. Overview of the evidence

46 studies were found relating to conversion therapy, including 26 from the USA and only 2 from the UK. This makes evaluating the evidence within a UK context challenging.

The evidence base for conversion therapy to change sexual orientation has been growing for over 20 years. The evidence base for gender identity is much newer, with the earliest study done in 2018. Given this, most studies in this assessment focus exclusively on conversion therapy for sexual orientation (41 out of 46).

4 studies looked exclusively at conversion therapy for gender identity, and one further study looked at experiences of conversion therapy on the basis of respondents' sexual orientation or gender identity.

Based on the reported aims of the studies, it is possible to categorise them by their focus on conversion therapy for sexual orientation or for gender identity. However, some of the studies targeted at changing sexual orientation also extended to changing people's social identities, which could affect their gender identity. This suggests in the evidence that practitioners of conversion therapy can mix sexual orientation and gender identity in practice.

The main topics of the studies reviewed were:

- the scale of conversion therapy and people's experiences of it (including their experiences within organisations promoting it)
- an assessment of how effective conversion therapy was at achieving its stated therapeutic aims (including any associated outcomes)

Using the MMAT approach the largest proportion of studies were assessed as being of around average quality (either average, or slightly above or below). Overall the quality assessment is lowered by the lack of robust sampling and design in the quantitative studies, 2 of the factors used in the MMAT scoring.

Studies on conversion therapy for gender identity were assessed as being stronger in design than those for sexual orientation, despite being fewer in number. This is felt to be due to their larger sample sizes, drawing on data from large-scale national surveys and appropriate or standardised measures, which can help to reduce sampling limitations.

The evidence base on conversion therapy as a whole is limited by clear methodological challenges – but more methodologically robust research designs such as randomised control trials are not possible. This is inherent with research in this topic area – more robust research designs would mean allocating some participants to a group who then went on to undergo conversion therapy, and comparing them to a group who did not. This would be practically and ethically impossible.

It is therefore important to note that the quality of evidence identified in this assessment will be the highest that is achievable, drawing on data from interviews and surveys in which participants reflect on their experiences and the impact conversion therapy has had on them.

5. Conversion therapy for sexual orientation and gender identity

Although the evidence base on conversion therapy is relatively limited, the findings from studies are generally consistent for both sexual orientation and gender identity.

Studies on conversion therapy for both sexual orientation and gender identity show that:

- there is no robust evidence that conversion therapy can change sexual orientation or gender identity
- the types of practices used tend to be similar (for example, talking therapies delivered by faith groups or mental health professionals)
- conversion therapies were associated with self-reported harms (such as mental health conditions like depression and feeling suicidal) in both sets of study participants

The only real difference in the evidence base for conversion therapy for sexual orientation and gender identity is that there is more evidence on sexual orientation because it has been studied for longer.

6. Conversion therapy for sexual orientation

The evidence on conversion therapy for sexual orientation comes from 41 studies:

- 33 from the USA
- 2 from South Africa
- 1 from each of Canada, China, Poland and the UK
- 2 systematic reviews of international evidence

Overall the largest proportion of studies were assessed as being of average or below average quality. The qualitative studies were assessed as being of higher quality due to the nature of the research topic. More rigorous quantitative studies of conversion therapy are hampered by the methodological challenges already discussed, meaning that the majority are based on self-reported evidence.

The majority of studies concentrated on participants' experiences of conversion therapy and the outcomes of conversion therapy.

Studies relating to conversion therapy for sexual orientation show that:

- there is no robust evidence that conversion therapy can change sexual orientation
- conversion therapy tended to be delivered by faith groups and mental health professionals and tended to use talking therapies
- there is consistent evidence of self-reported harms, such as negative mental health effects like depression and feeling suicidal
- people's motivations for seeking conversion therapy tended to be associated with conflict about sexual orientation

Given that there are more studies into conversion therapy for sexual orientation, there are fewer gaps. However, little evidence was found about the experiences of women and people from ethnic minority groups undergoing conversion therapy. Some studies included samples from these populations, but they were smaller compared with those for men from White ethnic groups. No studies were found which were based on the experiences of these groups specifically. As a result, we do not know whether and how their experiences might differ.

7. Conversion therapy for gender identity

The main evidence on conversion therapy for gender identity comes from 4 studies:

- 3 from the USA
- 1 systematic review of international evidence

There was no specific evidence focusing exclusively on conversion therapy for gender identity in the UK.

In general, the research from the USA was assessed as being of above average quality using the MMAT system. It consisted of 2 studies which analysed data from the large-scale Transgender Survey 2015, and a study which tested perceptions of different therapies (including non-affirming responses by therapists of gender identity) among 400 transgender participants. The systematic review is a robust

study of the available evidence on conversion therapy for gender identity, and access to transition-related healthcare in transgender people. However, it is limited by the lack of studies in this area to review.

In addition, the National LGBT Survey provides a snapshot estimate on the scale of conversion therapy among transgender respondents in the UK. The survey found that 13% of transgender respondents had been offered some form of conversion therapy for either sexual orientation or gender identity.

Studies relating to conversion therapy for gender identity and transgender participants show that:

- there is no robust evidence that conversion therapy can change gender identity
- the types of practices used tend to be similar to those for conversion therapy for sexual orientation
- there was some robust evidence of self-reported harms (such as negative mental health effects like depression and feeling suicidal)
- there was indicative evidence that transgender respondents were as likely or more likely to be offered and receive conversion therapy than non-transgender respondents

Compared with conversion therapy for sexual orientation, little evidence was found on the detailed experiences of people who have gone through conversion therapy for gender identity, specifically in the UK (such as duration, frequency, and modalities and characteristics of approaches). There is also little evidence about the paths people have taken towards conversion therapy (for example, how voluntary and involuntary they were) and their subsequent experiences.

8. Conclusion

This assessment looked at the nature, quality and quantity of evidence on conversion therapy to change sexual orientation and gender identity exclusively. It found that the evidence base for conversion therapy for sexual orientation is long-established, extending over 20 years, while for gender identity the evidence base is newer. Despite being fewer in number, studies looking at conversion therapy for gender identity were assessed as being stronger in design than those for sexual orientation. This is largely due to their larger sample sizes which can help to reduce sampling limitations.

This assessment also found that research on conversion therapy is affected by methodological challenges. This limits the ability to say definitively what the impact of conversion therapy is. However, this report notes that the quality of evidence identified in this assessment is the highest that is achievable. While the evidence is predominantly based on self-reporting, consistent patterns were found which enable indicative conclusions to be found. These are that there is no robust evidence that conversion therapy can change sexual orientation or gender identity, and that conversion therapy is frequently associated with harm.

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11. Appendix 2. Summary findings from assessment of conversion therapy studies

	Sexual orientation (41 studies since 2000)	Gender identity (4 studies since 2018)	National LGBT Survey 2017
Geography	33 studies from the USA 2 from South Africa 1 each from Canada, China, Poland and the UK 2 systematic reviews of international evidence	3 studies from the USA 1 systematic review of international evidence	1 study from the UK

	Sexual orientation (41 studies since 2000)	Gender identity (4 studies since 2018)	National LGBT Survey 2017
Method	20 qualitative studies 19 quantitative studies 2 systematic reviews	3 quantitative studies, which include: 2 studies based on the Transgender Survey 2015, a non-random survey with of 28,000 transgender people in the USA, which explicitly covers conversion therapy for gender identity 1 study which tested perceptions of different therapy (including non-affirming responses by therapists of gender identity) among 400 transgender participants 1 systematic review	Non-random survey with approximately 108,000 LGBT respondents in the UK which identifies characteristics of those who have experienced or been offered conversion therapy Experience of conversion therapy may have related to at sexual orientation or gender identity
Quality	Majority of studies were assessed as being of average, or below average quality Majority of qualitative studies were assessed as being of average or above average quality Majority of quantitative studies were assessed as being average or below average quality, hampered by design	All studies assessed as being of above average quality	Assessed as being of average quality
Topic	Participants' experiences of conversion therapy The outcomes of conversion therapy	Scale of conversion therapy for gender identity among transgender people Participants' experiences of conversion therapy The outcomes of conversion therapy	Indicative estimate of scale of conversion therapy, among which groups, and who delivered it in the UK

	Sexual orientation (41 studies since 2000)	Gender identity (4 studies since 2018)	National LGBT Survey 2017
Summary of findings	No robust evidence that conversion therapy can change sexual orientation Tended to be delivered by faith groups and mental health professionals and tended to use talking therapies Consistent evidence of self-reported harms (such as negative mental health effects like depression and suicidality) associated with conversion therapy People's motivations for seeking conversion therapy tended to be associated with conflict about sexual orientation	No robust evidence that conversion therapy can change gender identity. Some evidence that therapy tended to use talking therapies Some robust evidence of self-reported harms (such as negative mental health effects like depression and suicidality) associated with conversion therapy Some evidence that transgender respondents are more likely to be offered and receive conversion therapy than non-transgender respondents	Transgender respondents more likely to be offered and receive conversion therapy than non-transgender respondents Limited but robust evidence from the UK tells us that approaches tended to be delivered by faith groups, health professionals or family members