Sexual orientation and gender identity change efforts (so-called "conversion therapy")

Background

So-called "conversion therapy" or "reparative therapy" refers to any form of intervention, such as individual or group, behavioral, cognitive, or milieu/environmental operations, that attempts to change an individual's sexual orientation or sexual behaviors (sexual orientation change efforts [SOCE]) or an individual's gender identity (gender identify change efforts [GICE]).[1] Practitioners of change efforts may employ techniques including:[2]

- Aversive conditioning (e.g., electric shock, deprivation of food and liquids, smelling salts and chemically-induced nausea)
- Biofeedback
- Hypnosis
- Masturbation reconditioning

Underlying these techniques is the assumption that any non-heterosexual, non-cisgender identities are mental disorders, and that sexual orientation and gender identity can and should be changed. This assumption is not based on medical and scientific evidence. Professional consensus rejects pathologizing sexual and gender identities. In addition, empirical evidence has demonstrated a diversity of sexual and gender identities that are normal variations of human identity and expression, and not inherently linked to mental illness. However, the unfounded misconception of sexual orientation and gender identity "conversion" persists among some health, spiritual and religious practitioners.[3]

According to the UCLA Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy, as of 2019, almost 700,000 lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) adults in the U.S. had received "conversion therapy;" in addition, an estimated 57,000 youths will receive change efforts from religious or health care clinicians before they turn 18 years old.[4] In a national survey of over 35,000 LGBTQ youth ages 13–24, 13% of respondents reported being subjected to "conversion therapy," with 83% reporting it occurred when they were under18.[5]

Another study found that nearly 18% of middle-aged and older men who have sex with men reported experiencing "conversion therapy."[6]

1. John Bancroft, et al., *Peer Commentaries on Spitzer,* 32 Archives Sexual Behav. 5, 419-68 (Oct. 2003); Carl Streed, et al., *Changing Medical Practice, Not Patients — Putting an End to Conversion Therapy,* 381 New Eng. J. Med. 6, 500-02 (Aug. 2019).
2. American Psychological Association, Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Aug. 2009).
3. Jack Drescher, *Ethical issues in treating gay and lesbian patients,* 25 Psychiatric Clinics N. Am. 3, 605-21 (Sep. 2002).
4. Christy Mallory, Taylor Brown & Kerith Conron, The Williams Institute on Sexual Orientation and Gender Identity Law, UCLA School of Law, Conversion Therapy and LGBT Youth Update (Jun. 2019).
5. The Trevor Project, National Survey on LGBTQ Mental Health 2021 (May 2021), *available at* https://www.thetrevorproject.org/wp-content/uploads/2021/05/The-Trevor-Project-National-Survey-Results-2021.pdf.
6. Steven Meanley, et al., *Characterizing Experiences of Conversion Therapy Among Middle-Aged and Older Men Who Have Sex with Men from the Multicenter AIDS Cohort Study (MACS),* Sexual Res. & Soc. Pol'y (published online Jun. 2019).

AMA AMERICAN MEDICAL ASSOCIATION

GLMA Health Professionals Advancing LGBTQ Equality

The study also identified racial inequity: Black and Hispanic Black men were more likely to experience "conversion therapy" compared to non-Hispanic white men.[7] This racial disparity was similarly observed in a another survey, which additionally noted double the rate of conversion therapy reported by transgender/nonbinary youth compared to their cisgender counterparts.[8]

Health implications for LGBTQ individuals

Evidence does not support the purported "efficacy" of SOCE in changing sexual orientation.[9] To the contrary, these practices may cause significant psychological distress.[10] One study showed that 77% of SOCE participants reported significant long-term harm, including the following symptoms:[11]

- Depression
- Anxiety
- Lowered self-esteem
- Internalized homophobia
- Self-blame
- Intrusive imagery
- Sexual dysfunction

Participants also reported significant social and interpersonal harm, such as alienation, loneliness, social isolation, interference with intimate relationships and loss of social supports.[12]

SOCE may also increase suicidal behaviors in a population where suicide is prevalent. In young adults between 15 and 24 years old, suicide has been the second leading cause of death since 2011, and LGBTQ young adults are more than twice as likely to report a history of suicide attempts in comparison to their heterosexual peers.[13] Similarly, LGB adults are three to five times more likely to have a suicidal attempt in comparison to their heterosexual counterparts.[14] Young LGBTQ adults who report higher levels of parental and caregiver rejection are 8.4 times more likely to report having attempted suicide.[15] One study found nearly 30% of individuals who underwent SOCE reported suicidal attempts.[16] In a Trevor Project survey, LGBTQ youth subjected to conversion therapy reported twice the rate of suicide attempts compared to those who were not.[17]

---

7. *Id.*
8. The Trevor Project, *supra* note 5.
9. American Psychological Association, *supra* note 2.
10. *Id.*
11. Ariel Shidlo & Michael Schroeder, *Changing Sexual Orientation: A Consumers' Report,* 33 Professional Psychology: Res. & Practice 3, 249-59 (2002).
12. *Id.*
13. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 10 Leading Causes of Death by Age Group, United States, *available at* https://www.cdc.gov/injury/wisqars/LeadingCauses.html; Andrea Miranda-Mendizábal, et al., *Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis,* 211 Brit. J. Psychiatry 2, 77-87 (Aug. 2017).
14. Travis Hottes, et al., *Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis,* 106 Am. J. Pub. Health 5, e1-e12 (May 2016).
15. Caitlin Ryan, et al., *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults,* 123 Pediatrics 1, 346-52 (Jan. 2009).
16. 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 (published online Sep. 2019).
17. The Trevor Project, *supra* note 5.

GICE, with an estimated lifetime prevalence of 13.5–20% in a transgender population, may cause similar long-term harm as SOCE.[18] Analysis of the 2015 National Transgender Survey found that recalled exposure to GICE was significantly associated with increased severe psychological distress and increased lifetime suicide attempts compared to transgender persons who reported that they saw a therapist but were not exposed to "conversion therapy."[19] In addition, exposure to GICE prior to age 10 was significantly associated with an increased risk of lifetime suicide attempts.[20] Among those subjected to "conversion therapy," 42% reported that they had attempted to commit suicide while suicide attempts were reported by 5% of those not subjected to "conversion therapy."[21]

Sexual orientation and gender identity change efforts (SOGICE) also exert a significant economic burden on patients and society at large. An economic evaluation published in JAMA Pediatrics estimated that LGBTQ youth subjected to SOGICE incur $83,366 in lifetime excess health care costs, primarily associated with suicidality, anxiety, severe psychological distress, depression and substance abuse.[22] The total economic burden associated with SOGICE was estimated to be $9.23 billion annually, including $650 million in health care costs in 2021 alone.[23] In contrast, the total potential savings from the provision of affirmative therapy—psychotherapy that validates the positive expression of sexual and gender identities—instead of SOGICE was estimated to be nearly $6.19 billion each year.[24]

Ethical concerns

All leading professional medical and mental health associations reject "conversion therapy" as a legitimate medical treatment. Yet, an estimated 36.5% of LGBTQ people, including 90% of transgender people, who have received SOCE/GICE received this therapy from a health care clinician.[25] In addition to the clinical risks associated with the practice, the means through which clinicians or counselors administer SOGICE violate many important ethical principles, the foremost of which is: "First, do no harm."

A health care clinician's nonjudgmental recognition of and respect for patients' sexual orientations, sexual behaviors and gender identity are essential elements in rendering optimal patient care in health, as well as in illness. This recognition is especially important to address the specific health care needs of people who are or may be LGBTQ as these patients often experience disparities in access to care. Yet administering change efforts is an inherently discriminatory practice often administered coercively and fraught with ethical problems, such as:[26]

- Uninformed consent (change efforts are often prescribed without full descriptions of risks and disclosure of lack of efficacy or evidence)

18. Jack L. Turban, et al., *Psychological Attempts to Change a Person's Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015,* 109 Am. J. Pub. Health 10, 1452-1454 (Oct 2019); Ilan H. Meyer, et al., The Williams Institute on Sexual Orientation and Gender Identity Law, UCLA School of Law, LGBTQ People in the US: Select Findings from the Generations and TransPop Studies (2021).
19. Sandy E. James, et al., National Center for Transgender Equality, The Report of the 2015 U.S. Transgender Survey (2016).
20. *Id.*
21. The Trevor Project, *supra* note 5.
22. Anna Forsythe, et al., *Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States,* JAMA Pediatrics (published online Mar. 2022).
23. *Id.*
24. *Id.*
25. Meyer, *supra* note 18.
26. Jack Drescher J, et al., *The Growing Regulation of Conversion Therapy,* 102 J. Medical Regulation 2, 7-12 (Jan 2016).

- Breaches of confidentiality (content of treatment, sexual orientation and gender identity may be shared with family, school or religious leaders without proper consent)
- Patient discrimination (change efforts reinforce bias, discrimination and stigma against LGBTQ individuals)
- Indiscriminate and improper treatment (change efforts are recommended regardless of evidence)
- Patient blaming (the failure of treatment may be blamed on the patient)

It is clinically and ethically inappropriate for health care clinicians to direct mental or behavioral health interventions, including SOCE and GICE, with a prescriptive goal aimed at achieving a fixed developmental outcome of a child's or adolescent's sexual orientation, gender identity or gender expression.[27]

State laws

As of April 2022, 20 states (California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, Nevada, New Hampshire, New Jersey, New Mexico, New York, Maine, Massachusetts, Oregon, Rhode Island, Utah, Vermont, Virginia and Washington) and the District of Columbia have enacted laws banning "conversion therapy" for minors. Importantly, these laws do not prohibit counseling and therapies that help patients struggling with sexual or gender identity to develop coping and self-acceptance skills. While an additional five states have a partial ban on conversion therapy, three states are under a preliminary federal circuit injunction that prevents enforcement of conversion therapy bans, and the remaining 22 states—where an estimated 32% of the LGBTQ population reside—have no laws protecting minors against such therapy.[28]

Medical society and other health care association positions

The American Medical Association and GLMA: Health Professionals Advancing LGBTQ Equality (GLMA) oppose the use of reparative or conversion therapy for sexual orientation or gender identity. Other medical societies have policies or statements similarly opposing these policies, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American College of Physicians and the American Academy of Pediatrics.[29] Other health care associations have similar policies, including the American Association for Marriage and Family Therapy, the American Counseling Association, the American Psychoanalytic Association, the American Psychological Association, the National Association of Social Workers, the American School Counselor Association, the American School Health Association, the World Psychiatric Association and the Pan American Health Organization: Regional Office of the World Health Organization.[30]

27. Policy and Position Statements on Conversion Therapy, Human Rights Campaign, *available at* http://www.hrc.org/resources/policy-and-position- statements-on-conversion-therapy.
28. Conversion Therapy Laws, Movement Advancement Project, *available at* https://www.lgbtmap.org/equality-maps/conversion_therapy.
29. See, American Psychiatric Association, Commission on Psychotherapy by Psychiatrists, *Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies),* 157 Am. J. Psychiatry 10, 1719-21 (Oct. 2000); American Academy of Child and Adolescent Psychiatry, The AACAP Policy on "Conversion Therapies" (Feb. 2018); Hilary Daniel & Renee Butkus, American College of Physicians, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians,* 163 Annals Internal Med. 2, 135-7 (July 2015); American Academy of Pediatrics, Committee on Adolescence, *Homosexuality and Adolescence*, 92 Pediatrics 4, 631-4 (1993).
30. Human Rights Campaign, *supra* note 27.

AMA policy

The following is a list of relevant AMA policy:

D-515.978, Ban Conversion Therapy

Our AMA will develop model state legislation and advocate for federal legislation to ban "reparative" or "conversion" therapy for sexual orientation or gender identity. (Res. 10, I-19)

H-160.991, Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity. (emphasis added)

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18)

GLMA policy

The following is relevant GLMA policy:

GLMA 099-97-114 Reparative or Conversion Therapy

GLMA: Health Professionals Advancing LGBTQ Equality condemns the behavioral and psychological interventions known as "reparative" or "conversion" therapies that attempt to change sexual orientation and gender identity. (Approved 1997; Amended & Reaffirmed 2018)

AMA model state legislation

The AMA has developed model state legislation, the Protecting Minors from Conversion Therapy Act, to assist with state advocacy efforts to ban the practice of "conversion therapy." The model act defines "conversion therapy," prohibits the practice of "conversion therapy" on a minor by a health care professional and establishes that violations of the Act are unprofessional conduct and subject to disciplinary action by the appropriate licensing board. The model state legislation also exempts practices, treatments and counseling that provide support for an individual's identity exploration, facilitate coping and social support, or address unlawful conduct or unsafe sexual practices. The Protecting Minors from Conversion Therapy Act is available from the AMA Advocacy Resource Center.

For additional information or assistance with legislation to ban conversion therapy in your state, please contact Annalia Michelman, JD, senior legislative attorney, AMA Advocacy Resource Center, at annalia.michelman@ama-assn.org or (312) 464-4788.

AMA AMERICAN MEDICAL ASSOCIATION

GLMA Health Professionals Advancing LGBTQ Equality

AMERICAN PSYCHIATRIC ASSOCIATION

News Releases

Nov 15, 2018

APA Reiterates Strong Opposition to Conversion Therapy

Washington, D.C. – In the wake of recent popular entertainment portrayals of conversion therapy, the American Psychiatric Association (APA) today reiterates its long-standing opposition to the practice. APA made clear with its 1998 position statement that "APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation."

APA expanded on that position with a statement in 2013: "The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed."

Conversion therapy is banned in 14 states as well as the District of Columbia. The APA calls upon other lawmakers to ban the harmful and discriminatory practice.

American Psychiatric Association

The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 37,800 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.

Media Contacts

Glenn O'Neal, 202-459-9732
press@psych.org

Erin Connors, 202-609-7113
econnors@psych.org

800 Maine Avenue, S.W., Suite 900, Washington, DC 20024
202-559-3900 apa@psych.org

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Conversion Therapy

Variations in sexual orientation and gender expression represent normal and expectable dimensions of human development. They are not considered to be pathological; therefore, they are not included in the Diagnostic and Statistical Manual of Mental Disorders, and other accepted nosological systems (1). Health promotion for all youth encourages open exploration of all identity issues, including sexual orientation, gender identity, and/or gender expression according to recognized practice guidelines (2). This fosters healthy development, especially for sexual and gender diverse youth, as they integrate their sexual orientation, gender identity, and/or gender expression, into their overall identity without any pre-determined outcome.

"Conversion therapies" (or "reparative therapies") are interventions purported to alter same-sex attractions or an individual's gender expression with the specific aim to promote heterosexuality as a preferable outcome (3, 4). Similarly, for youth whose gender identity is incongruent with their sex anatomy, efforts to change their core gender identity have also been described and more recently subsumed under the conversion therapy rubric (5). These interventions are provided under the false premise that homosexuality and gender diverse identities are pathological. They are not; the absence of pathology means there is no need for conversion or any other like intervention. Further, there is evidence that "conversion therapies" increase risk of causing or exacerbating mental health conditions in the very youth they purport to treat (2-5).

Comprehensive assessment and treatment of youth that includes exploration of all aspects of identity, including sexual orientation, gender identity, and/or gender expression is not "conversion therapy" (2). This applies whether or not there are unwanted sexual attractions and when the gender role consistent with the youth's assigned sex at birth is non-coercively explored as a means of helping the youth understand their authentic gender identity. In the presence of gender dysphoria (distress related to the incongruence between gender identity and sex assigned at birth), the standard of care may involve exploration of living in a different gender role (appropriate to the child or adolescent's developmental understanding of gender) and/or potential use of affirming gender transition interventions to align anatomical features with one's gender identity for appropriately assessed pubertal adolescents (6, 7). This follows recognized standards of care and is not considered "conversion therapy."

The AACAP Policy on "Conversion Therapies"

The American Academy of Child and Adolescent Psychiatry finds no evidence to support the application of any "therapeutic intervention" operating under the premise that a specific sexual orientation, gender identity, and/or

gender expression is pathological. Furthermore, based on the scientific evidence, the AACAP asserts that such "conversion therapies" (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful. As a result, "conversion therapies" should not be part of any behavioral health treatment of children and adolescents. However, this in no way detracts from the standard of care which requires that clinicians facilitate the developmentally appropriate, open exploration of sexual orientation, gender identity, and/or gender expression, without any pre-determined outcome.

Developed by AACAP's Sexual Orientation and Gender Identity Issues Committee

References:

1. American Psychiatric Association, Diagnostic and statistical manual of mental disorders: DSM-5. 2013.
2. Adelson, S. L., & the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 51, 957– 974. http://dx.doi.org/10.1016/j.jaac.2012.07.004.
3. American Psychiatric Association Commission on Psychotherapy by Psychiatrists. Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies). Am J Psychiatry. 2000; 157(10):1719-1721.
4. APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Washington, DC: American Psychological Association.
5. Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
6. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): International Journal of Transgenderism.
7. Hembree, W. C., Cohen-Kettenis, P., Gooren, L. J., Hannema, S.E., Meyer, W.J., Murad, M.H., Rosenthal, S.M., Safer, J.D., Tangpricha, V., and T'Sjoen, G.G. (2017). Endocrine treatment of Gender dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. The Journal of Clinical Endocrinology & Metabolism, 102(11), 1-35. doi: doi:10.1210/jc.2017-01658.

#

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

Approved by Council February 2018

Sexual Orientation & Homosexuality

LGBTQ (https://www.apa.org/search?query=lgbt)

Introduction

Since 1975, the American Psychological Association has called on psychologists to take the lead in removing the stigma of mental illness that has long been associated with lesbian, gay and bisexual orientations. The discipline of psychology is concerned with the well-being of people and groups and therefore with threats to that well-being. The prejudice and discrimination that people who identify as lesbian, gay or bisexual regularly experience have been shown to have negative psychological effects. This pamphlet is designed to provide accurate information for those who want to better understand sexual orientation and the impact of prejudice and discrimination on those who identify as lesbian, gay or bisexual.

Pamphlets in English and Spanish may be purchased in bundles of 25 for $4.00 plus shipping by calling (800) 374-2721 or by email (mailto:order@apa.org) (the others are only available electronically at this time).

- **What is sexual orientation?**
- **How do people know if they are lesbian, gay, or bisexual?**
- **What causes a person to have a particular sexual orientation?**
- **What role do prejudice and discrimination play in the lives of lesbian, gay, and bisexual people?**
- **What is the psychological impact of prejudice and discrimination?**
- **Is homosexuality a mental disorder?**

- **What about therapy intended to change sexual orientation from gay to straight?**
- **What is "coming out" and why is it important?**
- **What about sexual orientation and coming out during adolescence?**
- **At what age should lesbian, gay or bisexual youths come out?**
- **What is the nature of same-sex relationships?**
- **Can lesbians and gay men be good parents?**
- **What can people do to diminish prejudice and discrimination against lesbian, gay and bisexual people?**
- **Where can I find more information about homosexuality?**
- **Suggested Bibliographic Citation**

Date created: 2008

(javascript:toggleCitation();) (#) (javascript: openSocialShare('https://twitter.com/share?url=https%3a%2f%2fwww.apa.org%2ftopics%2flgbtq%2forientation&via=APA&text=Answers+to+your+questions+for+a+better+understan

Related Resources

Transgender People, Gender Identity and Gender Expression

APA LGBT Resources and Publications

The pamphlet also is available as a PDF download in the following

languages:

- Arabic (PDF, 286KB)
- Simplified Chinese (PDF, 307KB)
- Traditional Chinese (PDF, 453KB)
- English (PDF, 132KB)
- Russian (PDF, 205KB)
- Spanish (PDF, 277KB)

"Therapies" to change sexual orientation lack medical justification and threaten health

Washington, D.C., 17 May 2012 (PAHO/WHO) — Services that purport to "cure" people with non-heterosexual sexual orientation lack medical justification and represent a serious threat to the health and well-being of affected people, the Pan American Health Organization (PAHO) said in a position statement launched on 17 May, the International Day against Homophobia. The statement calls on governments, academic institutions, professional associations and the media to expose these practices and to promote respect for diversity.

Twenty two years ago, on May 17, the World Health Assembly removed homosexuality from the list of mental disorders when it approved a new version of the World Health Organization's International Classification of Diseases (ICD-10).

"Since homosexuality is not a disorder or a disease, it does not require a cure. There is no medical indication for changing sexual orientation," said PAHO Director Dr. Mirta Roses Periago. Practices known as "reparative therapy" or "conversion therapy" represent "a serious threat to the health and well-being—even the lives—of affected people."

The PAHO statement notes that there is a professional consensus that homosexuality is a natural variation of human sexuality and cannot be regarded as a pathological condition. However, several United Nations bodies have confirmed the existence of "therapists" and "clinics" that promote treatment intended to change the sexual orientation of non-heterosexual people.

The document notes that no rigorous scientific studies demonstrate any efficacy of efforts to change sexual orientation. However, there are many testimonies about the severe harm to mental and physical health that such "services" can cause. Repression of sexual orientation has been associated with feelings of guilt and shame, depression, anxiety, and even suicide.

As an aggravating factor, there have been 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.

"These practices are unjustifiable and should be denounced and subject to sanctions and penalties under national legislation," said Dr. Roses. "These supposed conversion therapies constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional agreements."

To address the problem, PAHO makes a series of recommendations for governments, academic institutions, professional associations, the media, and civil society, including:

- "Conversion" or "reparative" therapies and the clinics offering them should be denounced and subject to adequate sanctions.
- Public institutions responsible for training health professionals should include courses on human sexuality and sexual health in their curricula, with a focus on respect for diversity and the elimination of attitudes of pathologization, rejection, and hate toward non-heterosexual persons.
- Professional associations should disseminate documents and resolutions by national and international institutions and agencies that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation.
- In the media, homophobia in any of its manifestations and expressed by any person should be exposed as a public health problem and a threat to human dignity and human rights.
- Civil society organizations can develop mechanisms of civil vigilance to detect violations of the human rights of non-heterosexual persons and report them to the relevant authorities. They can also help to identify and report people and institutions involved in the administration of "reparative" or "conversion therapies."

PAHO, which celebrates its 110th anniversary this year, is the oldest public health organization in the world. It works with its member countries to improve the health and the quality of life of the people of the Americas. It also serves as the Regional Office for the Americas of WHO.

Links:

- PAHO Position Statement "Cures" for an illness that does not exist (/hq/index.php?option=com_docman&task=doc_download&gid=17703&Itemid=270&lang=en)
- PAHO/ Promotion of Sexual Health (/hq/index.php?option=com_content&task=blogcategory&id=2500&Itemid=2429&lang=en)
- www.paho.org/paho110/ (/paho110/)
- www.paho.org (https://www.paho.org)
- facebook (https://www.facebook.com/PAHOWHO)
- youtube (https://www.youtube.com/pahopin)
- twitter pahowho (https://twitter.com/pahowho)
- twitter opsoms (https://twitter.com/pahowho)

Media Contacts:

Leticia Linn, linnl@paho.org (mailto:linnl@paho.org), Tel. + 202 974 3440, Mobile +1 202 701 4005, Donna Eberwine-Villagran, eberwind@paho.org (mailto:eberwind@paho.org), Tel. +1 202 974 3122, Mobile +1 202 316 5469, Sonia Mey-Schmidt, maysonia@paho.org (mailto:maysonia@paho.org), Tel. + 1 202 974 3036, Mobile +1 202 251 2646, Knowledge Management and Communications, PAHO/WHO—www.paho.org

(https://www.facebook.com/PAHOWHO) (https://www.youtube.com/pahopin) (https://www.flickr.com/photos/pahowho/albums)

american-health-organization)

format=feed&type=rss)

Sitemap

- Home (/hq/index.php?option=com_content&view=featured&Itemid=1&lang=en)
- Topics (https://www.paho.org/en/topics)
- Media (https://www.paho.org/en/resources-journalists)
- Publications (https://www.paho.org/en/publications)
- Data (https://www.paho.org/data/index.php/en/)
- Countries & Centers (https://www.paho.org/en/countries-and-centers)
- Governing Bodies (/hq/index.php?option=com_content&view=article&id=42&Itemid=419&lang=en)
- About PAHO (https://www.paho.org/en/who-we-are)

Help and Services

- Doing Business with PAHO (https://www.paho.org/en/doing-business-paho)
- Employment (https://www.paho.org/en/careers-paho)

Resources

- PAHO Digital Library (IRIS) (http://iris.paho.org/xmlui)
- Virtual Health Library (http://bvsalud.org/en/)
- Virtual Campus for Public Health (http://www.campusvirtualsp.org/?q=en)

AMERICAN ACADEMY OF PEDIATRICS | OCTOBER 01 1993

Homosexuality and Adolescence

COMMITTEE ON ADOLESCENCE

Pediatrics (1993) 92 (4): 631–634.
https://doi.org/10.1542/peds.92.4.631

Pediatricians should be aware that some of the youths in their care may be homosexual or have concerns about sexual orientation. Caregivers should provide factual, current, nonjudgmental information in a confidential manner. These youths may present to physicians seeking information about homosexuality, STDs, substance abuse, or various psychosocial difficulties. The pediatrician should ensure that each youth receives a thorough medical history and physical examination (including appropriate laboratory tests), as well as STD (including HIV) counseling and, if necessary, appropriate treatment. The health care professional should also be attentive to various potential psychosocial difficulties and offer counseling or refer for counseling when necessary.

The American Academy of Pediatrics reaffirms the physician's responsibility to provide comprehensive health care and guidance for all adolescents, including gay and lesbian adolescents and those young people struggling with issues of sexual orientation. The deadly consequences of AIDS and adolescent suicide underscore the critical need to address and seek to prevent the major physical and mental health problems that confront gay and lesbian youths in their transition to a healthy adulthood.

Topics: homosexuality, acquired immunodeficiency syndrome, sexually transmitted diseases

This content is only available via PDF.

You do not currently have access to this content.

Comments

0 Comments

Comments (0)

Sign in

Don't already have an account? Register

Create Account

Individual Login

Institutional Login

Sign in via OpenAthens

Pay-Per-View Access $25.00

Buy This Article

View Your Tokens

FROM THE AMERICAN ACADEMY OF PEDIATRICS | POLICY STATEMENT | OCTOBER 01 2018

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents FREE

Jason Rafferty, MD ✉;
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH;
COMMITTEE ON ADOLESCENCE;
SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS;
Michael Yogman, MD; Rebecca Baum, MD; Thresia B. Gambon, MD; Arthur Lavin, MD;
Gerri Mattson, MD; Lawrence Sagin Wissow, MD; Cora Breuner, MD;
Elizabeth M. Alderman, MD; Laura K. Grubb, MD; Makia E. Powers, MD;
Krishna Upadhya, MD; Stephenie B. Wallace, MD; Lynn Hunt, MD;
Anne Teresa Gearhart, MD; Christopher Harris, MD; Kathryn Melland Lowe, MD;
Chadwick Taylor Rodgers, MD; Ilana Michelle Sherer, MD

Address correspondence to Jason Rafferty, MD, MPH, EdM, FAAP. E-mail: Jason_Rafferty@mail.harvard.edu

POTENTIAL CONFLICT OF INTEREST: The author has indicated he has no potential conflicts of interest to disclose.

FINANCIAL DISCLOSURE: The author has indicated he has no financial relationships relevant to this article to disclose.

Pediatrics (2018) 142 (4): e20182162.
https://doi.org/10.1542/peds.2018-2162

As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

Subjects: Developmental/Behavioral Issues, Psychosocial Issues

Topics: gender, transgender persons, gender identity, mental health

Introduction

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.[1,2] Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.[3]

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research and expert opinion from clinical and research leaders, which will serve as the basis for recommendations. It is not a comprehensive review of clinical approaches and nuances to pediatric care for children and youth that identify as TGD. Professional understanding of youth that identify as TGD is a rapidly evolving clinical field in which research on appropriate clinical management is limited by insufficient funding.[3,4]

Definitions

To clarify recommendations and discussions in this policy statement, some definitions are provided. However, brief descriptions of human behavior or identities may not capture nuance in this evolving field.

"Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels. Meanwhile, "gender identity" is one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (ie, not conforming to a binary conceptualization of gender). Self-recognition of gender identity develops over time, much the same way as a child's physical body does. For some people, gender identity can be fluid, shifting in different contexts. "Gender expression" refers to the wide array of ways people display their gender through clothing, hair styles, mannerisms, or social roles. Exploring different ways of expressing gender is common for children and may challenge social expectations. The way others interpret this expression is referred to as "gender perception" (Table 1).[5,6]

TABLE 1

Relevant Terms and Definitions Related to Gender Care

Term	Definition
Sex	An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels

Gender identity	A person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations
Gender expression	The external way a person expresses their gender, such as with clothing, hair, mannerisms, activities, or social roles
Gender perception	The way others interpret a person's gender expression
Gender diverse	A term that is used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex; gender-diverse individuals may refer to themselves with many different terms, such as transgender, nonbinary, genderqueer,[7] gender fluid, gender creative, gender independent, or noncisgender. "Gender diverse" is used to acknowledge and include the vast diversity of gender identities that exists. It replaces the former term, "gender nonconforming," which has a negative and exclusionary connotation.
Transgender	A subset of gender-diverse youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time; the term "transgender" also encompasses many other labels individuals may use to refer to themselves.
Cisgender	A term that is used to describe a person who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth
Agender	A term that is used to describe a person who does not identify as having a particular gender
Affirmed gender	When a person's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic
MTF; affirmed female; trans female	Terms that are used to describe individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine

FTM; affirmed male; trans male	Terms that are used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine
Gender dysphoria	A clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender; also, gender dysphoria is the psychiatric diagnosis in the *DSM-5*, which has focus on the distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth.
Gender identity disorder	A psychiatric diagnosis defined previously in the *DSM-IV* (changed to "gender dysphoria" in the *DSM-5*); the primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research.
Sexual orientation	A person's sexual identity in relation to the gender(s) to which they are attracted; sexual orientation and gender identity develop separately.

This list is not intended to be all inclusive. The pronouns "they" and "their" are used intentionally to be inclusive rather than the binary pronouns "he" and "she" and "his" and "her." Adapted from Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016. Adapted from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; FTM, female to male; MTF, male to female.

These labels may or may not be congruent. The term "cisgender" is used if someone identifies and expresses a gender that is consistent with the culturally defined norms of the sex that was assigned at birth. "Gender diverse" is an umbrella term to describe an ever-evolving array of labels that people may apply when their gender identity, expression, or even perception does not conform to the norms and stereotypes others expect of their assigned sex. "Transgender" is usually reserved for a subset of

such youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time. These terms are not diagnoses; rather, they are personal and often dynamic ways of describing one's own gender experience.

Gender identity is not synonymous with "sexual orientation," which refers to a person's identity in relation to the gender(s) to which they are sexually and romantically attracted. Gender identity and sexual orientation are distinct but interrelated constructs.[8] Therefore, being transgender does not imply a sexual orientation, and people who identify as transgender still identify as straight, gay, bisexual, etc, on the basis of their attractions. (For more information, *The Gender Book*, found at **www.thegenderbook.com**, is a resource with illustrations that are used to highlight these core terms and concepts.)

Epidemiology

In population-based surveys, questions related to gender identity are rarely asked, which makes it difficult to assess the size and characteristics of the population that is TGD. In the 2014 Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention, only 19 states elected to include optional questions on gender identity. Extrapolation from these data suggests that the US prevalence of adults who identify as transgender or "gender nonconforming" is 0.6% (1.4 million), ranging from 0.3% in North Dakota to 0.8% in Hawaii.[9] On the basis of these data, it has been estimated that 0.7% of youth ages 13 to 17 years (~150 000) identify as transgender.[10] This number is much higher than previous estimates, which were extrapolated from individual states or specialty clinics, and is likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining

"transgender" in a way that is inclusive of all gender-diverse identities.[11]

There have been no large-scale prevalence studies among children and adolescents, and there is no evidence that adult statistics reflect young children or adolescents. In the 2014 Behavioral Risk Factor Surveillance System, those 18 to 24 years of age were more likely than older age groups to identify as transgender (0.7%).[9] Children report being aware of gender incongruence at young ages. Children who later identify as TGD report first having recognized their gender as "different" at an average age of 8.5 years; however, they did not disclose such feelings until an average of 10 years later.[12]

Mental Health Implications

Adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide.[13,–20] Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder, but this association is not yet well understood.[21,22] In 1 retrospective cohort study, 56% of youth who identified as transgender reported previous suicidal ideation, and 31% reported a previous suicide attempt, compared with 20% and 11% among matched youth who identified as cisgender, respectively.[13] Some youth who identify as TGD also experience gender dysphoria, which is a specific diagnosis given to those who experience impairment in peer and/or family relationships, school performance, or other aspects of their life as a consequence of the incongruence between their assigned sex and their gender identity.[23]

There is no evidence that risk for mental illness is inherently attributable to one's identity of TGD. Rather, it is believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health

services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma, and social rejection.[24] This was affirmed by the American Psychological Association in 2008[25] (with practice guidelines released in 2015[8]) and the American Psychiatric Association, which made the following statement in 2012:

> *Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.... [Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.*[26]

Youth who identify as TGD often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. For example, many youth believe that they must hide their gender identity and expression to avoid bullying, harassment, or victimization. Youth who identify as TGD experience disproportionately high rates of homelessness, physical violence (at home and in the community), substance abuse, and high-risk sexual behaviors.[5,6,12,27–31] Among the 3 million HIV testing events that were reported in 2015, the highest percentages of new infections were among women who identified as transgender[32] and were also at particular risk for not knowing their HIV status.[30]

Gender-Affirmative Care

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience.

A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions while allowing questions and concerns to be raised in a supportive environment.[5] In a GACM, the following messages are conveyed:

- transgender identities and diverse gender expressions do not constitute a mental disorder;
- variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities;
- gender identity evolves as an interplay of biology, development, socialization, and culture; and
- if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.[27,33]

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families.[24] Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.[5] A specialized gender-affirmative therapist, when available, may be an asset in helping children and their families build skills for dealing with gender-based stigma, address symptoms of anxiety or depression, and reinforce the child's overall resiliency.[34,35] There is a limited but growing body of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.[24,36,37]

In contrast, "conversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as

transgender or to dissuade them from exhibiting gender-diverse expressions. The Substance Abuse and Mental Health Services Administration has concluded that any therapeutic intervention with the goal of changing a youth's gender expression or identity is inappropriate.[33] Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42] The AAP described reparative approaches as "unfair and deceptive."[43] At the time of this writing,[*] conversion therapy was banned by executive regulation in New York and by legislative statutes in 9 other states as well as the District of Columbia.[44]

Pediatric providers have an essential role in assessing gender concerns and providing evidence-based information to assist youth and families in medical decision-making. Not doing so can prolong or exacerbate gender dysphoria and contribute to abuse and stigmatization.[35] If a pediatric provider does not feel prepared to address gender concerns when they occur, then referral to a pediatric or mental health provider with more expertise is appropriate. There is little research on communication and efficacy with transfers in care for youth who identify as TGD, particularly from pediatric to adult providers.

Developmental Considerations

Acknowledging that the capacity for emerging abstract thinking in childhood is important to conceptualize and reflect on identity, gender-affirmation guidelines are being focused on individually tailored interventions on the basis of the physical and cognitive development of youth who identify as TGD.[45] Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level