



Fact Sheet – Conversion Therapy

Background on Conversion Therapy

- **What does “conversion therapy” or “reparative therapy” entail?**

These “therapies” comprise interventions aimed at altering an individual’s same-sex attraction, gender identity, an/or gender nonconforming expression in order to promote heterosexuality or a gender expression/identity aligning with sex anatomy (1, 2). These interventions have historically included: talk therapy; aversive conditioning, such as electric shocks or induced nausea and vomiting; and other cognitive or behavioral therapy methods, such as hypnosis and biofeedback (1). They have been practiced by some licensed mental health professionals, as well as various clergy or religious advisors (3). Specific efforts to change individuals’ gender identity have also recently been considered conversion therapy (2).

- **How many Americans does “conversion therapy” impact?**

According to the UCLA Williams Institute (3), a think tank with expertise in sexual orientation and gender identity law and policy, an estimated:

- 698,000 LGBT adults (18-59 years old) have received conversion therapy, of which approximately 50% were adolescents when treated;
- 6,000 LGBT adolescents (13-17 years old) residing in states banning conversion therapy would have otherwise received it from a licensed professional, if not for the ban; and
- 57,000 adolescents (13-17 years old) nationally will receive conversion therapy delivered by a religious advisor before they turn 18.

The Evidence on Benefits vs. Harms

- **What is known about gender identity incongruence and variations in sexual orientation and gender expression?**

Variations in sexual orientation and gender expression are a normal part of human development. They are not considered to be pathological and are thus not included in the Diagnostic and Statistical Manual of Mental Disorders (4), in which homosexuality was declassified as a psychiatric disorder in 1973. It is also normal and healthy for children and adolescents to explore their sexuality and gender identity as they approach puberty and beyond. In a large sample of mostly white but geographically and socioeconomically diverse middle and high school students, 10.1% of males and 11.3% of females surveyed were

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“unsure” of their sexual orientation, while 1.5% of males and 1.1% of females stated they were “bisexual or predominantly homosexual.” Uncertainty decreased successively with older groups, suggesting that adolescence is a common time of exploration and experimentation (5).

- **Is there evidence showing the efficacy of “conversion therapies”?**

A systematic literature review conducted by the American Psychological Association in 2007 found significant and serious deficiencies in the research methodologies of studies on conversion therapy outcomes, thus concluding that there was little evidence of benefit and some evidence of harm from these interventions. High dropout rates, particularly with aversive interventions, suggested that individuals found these treatments harmful. This task force summarized its findings thus: “results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE [sexual orientation change efforts]” (1).

- **How might “conversion therapies” be harmful?**

Instead of being helpful, conversion therapies may cause harm in various ways. Studies of these interventions in adults have shown an increased risk of harm to self-esteem (6) or have been criticized for not adequately considering risks such as increased anguish, self-loathing, depression, anxiety, substance abuse, and suicidality (7). Indeed, a study of transgender people found those exposed to conversion therapy were more likely to be unemployed, have a lower household income, and have an increase in suicide attempts and lifetime history of suicidal ideation and mental distress (8). Further, conversion therapies may encourage family rejection, which plays a role in poor mental health and substance abuse outcomes. One study out of San Francisco State University found that “highly rejected” LGBTQ youth, as compared to those who were “not rejected” or “only a little rejected” by parents or caregivers, were about eight times as likely to have attempted suicide; six times as likely to report high levels of depression; three times as likely to use illegal substances; and three times as likely to be at high risk for HIV/sexually transmitted infections (9).

Efforts to Ban Conversion Therapy for Minors

- **State and Local Laws Regarding Conversion Therapy**

Currently, 18 states including, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Maine, New Jersey, New Hampshire, New Mexico, New York, Nevada, Oregon, Rhode Island, Vermont, and Washington, as well as the District of Columbia and Puerto Rico, have laws or regulations banning conversion therapies for youth to various extents. Cities and counties across the country, have also implemented policies against conversion therapies for youth. Both Republican as well as Democratic governors and mayors have signed such bills.

- **Court Decisions**

In April 2019, the United States Supreme Court declined a petition to hear a challenge to New Jersey’s ban on conversion therapy. Two previous petitions to the Supreme Court challenging New Jersey’s ban were also not considered in 2015 and 2016.

AACAP Policy Statement

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, 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.

References

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