Sexual Orientation and Gender Identity Change Efforts are Unethical and Harmful

See also Green et al., p. 1221.

Sexual orientation and gender identity change efforts (SOGICE)—sometimes called "conversion" or "reparative" therapy—refer to practices that attempt to repress and alter a person's sexual orientation from lesbian, gay, or bisexual to heterosexual or gender identity from transgender to cisgender. Major professional organizations oppose SOGICE (e.g., the American Medical Association, the American Psychological Association). With substantial evidence of serious harms associated with exposure to SOGICE,[1] particularly for minors,[2] 21 states (and multiple cities and counties) have passed bipartisan laws or regulations prohibiting SOGICE.

Adolescents are uniquely susceptible to exposure to SOGICE. Given their emotional and financial dependence on parents, adolescents are subject to parental influence or pressure to engage in SOGICE. There are fundamental ethical concerns about whether youths consent to SOGICE and whether they understand the inherent risks to their short- and long-term mental health.[1] Furthermore, identity development, including the development of one's sexual and gender identity, is a hallmark of adolescence[3]; adolescence is also a critical period for the onset of several mental health problems and substance use behaviors.[4] Thus lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) adolescents are distinctly vulnerable to the negative consequences of exposure to SOGICE.

Findings from Green et al. (p. 1221), in this issue of *AJPH*, offer the latest evidence that SOGICE exposure among LGBTQ youths is unethical and dangerous. With data from a large nationwide survey of LGBTQ youths, the authors found that 4.2% of their sample had been exposed to SOGICE in their lifetime. Furthermore, compared with LGBTQ youths with no exposure, those exposed to SOGICE showed 1.76 times greater odds of seriously considering suicide, 2.23 times greater odds of having attempted suicide, and 2.54 times greater odds of multiple suicide attempts in the previous year.

Notably, estimates accounted for other risk factors for suicide that are specific to LGBTQ youths, including LGBTQ-related discrimination and physical threats or harm. Yet SOGICE were the most influential factor in risk for suicide ideation, attempt, and multiple attempts. The authors point out that SOGICE have been identified as a potentially harmful practice, with characteristics consistent with definitions of adverse childhood experiences.[5] Furthermore, the pattern of results is consistent with evidence that childhood trauma is associated with severity in mental health challenges.[6] Specifically, SOGICE had markedly stronger statistical associations with increasing severity of suicidality (i.e., the strongest effect was on multiple suicide attempts).

The findings are compelling, and several strengths of the study contribute to existing evidence of the mental health correlates of SOGICE, particularly among youths.[1,2] The findings by Green et al. are strengthened through the use of a contemporary, nationwide survey of LGBTQ youths. The authors found that rates of past-year suicide attempt are consistent with those documented in the Centers for Disease Control and Prevention's 2017 Youth Risk Behavior Survey, providing confidence that the findings from this survey are not inconsistent with population-based samples.

This study comes at a time when more cities and states are considering ordinances or laws that would ban the use of SOGICE on minors, with the most recent ban implemented in Virginia, the first Southern state to do so. It is important to recognize, however, that these bans are specific to licensed mental health care providers and thus do not provide protection against SOGICE by others, including unlicensed providers and faith leaders (e.g., clergy). Education is needed to warn parents about the serious harms associated with efforts by clergy and unlicensed professionals who subject minors to SOGICE. The findings presented by Green et al. further support the harmful and unethical nature of SOGICE and emphasize the importance of legislation that bans SOGICE, given the compelling interest by governments to defend the health and well-being of minors. The impact of these legislative bans is twofold: they protect LGBTQ youths from SOGICE but also raise awareness of the harms caused to those who are exposed to it.

An important issue that is left unexplored in the study by Green et al. is that exposure to and impacts of SOGICE may differ

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for sexual minority compared with gender minority youths. Our unscientific impression is that most of the public think of efforts to change sexual orientation (lesbian, gay, or bisexual identity) when they think of these practices, yet there is growing concern about practices aimed to change the gender expression and identity of transgender or nonbinary children. Although the motivation for sexual orientation change efforts is likely rooted in the nonconforming gender expression of youths who are gay, lesbian, or bisexual, there are important differences to consider in how SOGICE may be experienced by youths based on their sexual orientation or gender identity.

First, there may be differences related to developmental timing. Some but not all transgender and gender-diverse youths exhibit gender-nonconforming behaviors or assert a desire to be another gender early in childhood, whereas sexual identity development may begin in childhood but is typically understood to be associated with the developmental changes linked to adolescence.[7] Inasmuch as transgender youths may exhibit behaviors that do not conform with their sex assigned at birth in early childhood, they may be susceptible to experiences of SOGICE earlier in the life course and for longer periods of time. Earlier and prolonged exposures likely have differential effects on later mental health and suicide risk. By contrast, sexual minority youths often first report feeling different and attribute that difference to sexuality around the start of adrenarche, which could delay their exposure to SOGICE until early to middle adolescence (or later).

Second, there are different developmental processes, cultural meanings, and interpersonal experiences associated with the developmental of a same-sex sexual orientation compared with a gender identity different from one's sex assigned at birth. It is likely that attempts to change a young person's sexual orientation compared with their core sense of gender may have very different meaning and salience, as well as distinct sequelae. Thus, developmental timing or focus on gender versus sexual orientation may make a difference for how SOGICE are experienced by a young person. We note the bitter irony of pointing to ways to advance research on practices that are at their core unethical and harmful; yet empirical studies should consider these distinctions when assessing factors that put youths at risk for SOGICE at different points in the life course and the subsequent implications for mental health and risk for suicide.

Given the evidence of serious harm caused by SOGICE, we also suggest an end to the use of the language of "reparative" or "conversion" therapy by scientists to describe these practices. The authors use the words "conversion efforts" in their title, and indeed the terminology of "conversion therapy" or "reparative therapy" is understood in the public and was part of the wording of the survey question. Their choice of wording is understandable on those terms. However, these practices are not therapeutic, are not reparative, and do not offer the possibility of conversion (the implication that LGBTQ people need repair or conversion is itself demeaning). We argue that such language risks legitimizing unethical and harmful practices as "therapy" and promulgates stigma. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

REFERENCES

1. American Psychological Association. Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. 2009. Available at: https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf. Accessed May 9, 2020.

2. Ryan C, Toomey RB, Diaz RM, Russell ST. Parent-initiated sexual orientation change efforts with LGBT adolescents: implications for young adult mental health and adjustment. *J Homosex*. 2020;67(2):159–173.

3. Russell ST, Fish JN. Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annu Rev Clin Psychol*. 2016;12:465–487.

4. National Academies of Sciences, Engineering, and Medicine. *The Promise of Adolescence: Realizing Opportunity for All Youth*. Washington, DC: National Academies Press; 2019.

5. Mercer J. Evidence of potentially harmful psychological treatments for children and adolescents. *Child Adolesc Social Work J*. 2017;34(2):107–125.

6. Oral R, Ramirez M, Coohey C, et al. Adverse childhood experiences and trauma informed care: the future of health care. *Pediatr Res*. 2016;79(1–2):227–233.

7. Fish JN, Baams L, McGuire JK. Sexual and gender minority mental health issues among children and youth. In: Rothblum E, ed. *Oxford Handbook of Sexual and Gender Minority Mental Health*. New York, NY: Oxford University Press; 2020: 229–243.