

An Exploration of Conversion Therapy Practices in Ireland



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Content Guidance

Readers should note that this report presents the findings from a research study about individuals' experiences of conversion practices which some people might find upsetting.

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Brief Summary Report

Introduction

Conversion therapy is an umbrella term that describes a range of practices which specifically aim to change or suppress an individual's sexual orientation or gender identity expression (Mendos, 2020). While there was some anecdotal evidence that the practice exists in Ireland, there was no robust evidence that provides a clear understanding of the prevalence or nature of conversion therapy practices. Considerable research has largely concluded that sexual orientation change efforts are pseudo-scientific, ineffective, and harmful to the individual being 'treated' (Jowett et al., 2021). The American Psychological Association (APA, 2021b, 2021a) have denounced such practices and recommended affirmative, supportive treatment instead. Although conversion therapy and other sexual orientation change efforts have been widely discredited, they remain legal in most jurisdictions and continue to be practiced on members of the LGBTI+ community (Haldeman, 2022). The National LGBTI+ Inclusion Strategy 2019-2021 (Government of Ireland, 2019) outlined the Irish Government's commitment to investigate the methods and prevalence of conversion therapy in Ireland and review international best practice and legislative responses to same. In preparation for any subsequent policy and legislation in the area of conversion therapy, a study was commissioned to gain an understanding of the forms and extent of conversion therapy practices in Ireland. This summary document provides an overview of the findings from a research study, which sought to explore conversion therapy practices in the Republic of Ireland.

Aims and objectives

The overall aim of this study was to explore the practice of conversion therapy in Ireland. Specifically, the research sought to establish:

- a definition of conversion therapy and conversion practices as they operate in Ireland (including what conversion practices are used, what signifiers are used and how people consent or assent)
- who is subjected to conversion practices (minority sexual orientation/minority gender identity)
- if there are longer term consequences of such practices for the individual
- if there are any support needs for people who have been subjected to conversion therapy.

Research Approach

Given the aims and objectives of the research, data were collected from a review of the literature, a survey administered to the LGBTI+ community and in-depth individual interviews with individuals who experienced conversion practices.

Findings

Twenty three (n=23) research papers published between January 2020 and July 2022 were included in the literature review. Two hundred and seventy eight (278) participants completed the survey. Survey findings revealed that 70 participants stated that they were offered conversion practices and 38 participants stated that they were exposed to conversion practices. Seven participants who were exposed to Sexual Orientation Change Efforts [SOCE] or Gender Identity Change Efforts [GICE] which occurred in Ireland (n=5) or in another country (n=2) were interviewed. An overview of the findings related to the research objectives can be reviewed in table 1.

Table 1:
Summary findings addressing research question

Research objectives	Response
How is conversion therapy defined?	Within the research literature there are moves to use the terms Sexual Orientation Change Efforts [SOCE] and Gender Identity Changes Efforts [GICE] often combined as SOGICE. The participants in this study who were interviewed, used the term conversion therapy to describe their experiences and generally meant it as religious or professional attempts to change or modify minority sexual orientation or gender identity.
What conversion practices are used?	In the context of SOCE the findings suggest that a combination of cognitive, behavioural, psychoanalytical and religious/spiritual methods are used which focus on reducing same sexual behaviour. Corresponding increases in heterosexual behaviour were signifiers of 'success'. In terms of GICE, the findings suggest that similar strategies are used although interactions with therapists who created barriers to gender affirming care or closed down discussions about gender identity were interpreted as a form of conversion therapy. One participant who identified as trans and intersex argued that the surgery that she had to assign gender when she was born was a form of conversion therapy. Two participants stated that they were encouraged to seek out SOCE abroad.
How did individuals consent or assent?	The five gay men who were interviewed were clear that they voluntarily accessed and sourced SOCE themselves although this needs to be taken in the context of the internal, religious and societal pressures that encouraged them to seek conversion practices in the first place. In the survey, the majority of the participants stated that they did not provide consent and in some cases there were indications that it was provided against the participants will. Five of the seven trans participants indicated that they did not provide consent.

Table 1:
Summary findings addressing research question (continued)

Research objectives	Response
Who is subjected to conversion practices?	Individuals with minority sexual orientation and minority gender identity were exposed to conversion practices in this study. Five individuals in the survey stated that they were intersex or had an intersex variation and were exposed to conversion practices. Eleven (n=11) participants stated that they had experience SOGICE in the last one to five years. At least two participants stated that they were still undergoing SOGICE.
Are there longer term consequence of such practices?	For both the survey and interview participants there were both short and long term harmful consequences for those exposed. These harms were marked and enduring for those participants who had been exposed to formal practices over a longer timeframe to the extent that some had not resolved some of the issues at the time of interview. These harms extended to spouses and children where participants had been encouraged to marry. The combined evidence from the literature and the study is clear that conversion practices pose a significant risk to mental health. In addition, conversion practices delay acceptance of sexual orientation or gender identity. For people of faith, the lack of 'success' may exacerbate guilt and perpetuate internalised homophobia or transphobia.
What are the support needs for people who have been subjected to conversion therapy?	There was limited discussion about support needs within the literature with only one paper sourced specifically looking at the area. Among the interview participants, those who were adversely affected by conversion practices resolved their distress by navigating informal and formal supports. Recovery was contingent on recognising that mental health had been affected and where necessary, sourcing therapy that affirmed their sexual orientation or gender identity was accessed. For some, accessing an LGBTI+ affirmative church or faith based organisation was also central to recovery.

Implications

1. Given the range of practices described, policy and legislation must be clear about the definition of conversion therapy while also explicitly describing what those practices are (Human Rights Council, 2020).
2. Negative societal attitudes towards LGBTI+ individuals were described in both the survey and by the interview participants. These attitudes and beliefs can delay acceptance of LGBTI+ identities and cause individuals to modify their behaviour and in that way align with conversion practices. Measures to promote LGBTI+ individuals' visibility and inclusion, equality, health and safety

as advocated by the National LGBTI+ Inclusion Strategy (Government of Ireland, 2019) will go some way to addressing some of these issues.

3. Legislation to ban conversion therapy will also support safety and health by ensuring that those who experience distress about their sexual orientation or gender identity because of homophobia or transphobia are unable to access formal conversion practices which have the potential to cause further harm.
4. Raising awareness of the harms associated with conversion practices as well as highlighting the evidence that it is ineffective will also help to prevent it from being advocated as a legitimate course of action for those who experience distress about their sexual orientation or gender identity.
5. Those working with LGBTI+ individuals need to be aware that SOCE and GICE are ineffective and harmful and that people who seek out these practices need to be given clear and accurate information about their ineffectiveness and their potential for harm.
6. Interventions that perpetuate stigma, oppression and exclusion and seek to change, suppress or modify sexual orientation or gender identity expression such as the ones described by the participants in this study do not correspond with affirmative practices.
7. According to the UN Special Rapporteur on freedom of religion or belief, a person's sexual orientation or gender identity should not be 'treated' using practices that harm. The right to believe religious scripture about the nature of sexuality and gender identity is protected by international human rights legislation. The right to inflict potential harm based on religious teachings to change or suppress sexual orientation and gender identity or for other faith-based reasons is not.
8. Even when consenting adults seek out conversion practices, these practices are inherently debasing as they pathologize and stigmatise LGBTI+ individuals promoting the belief that they are somehow inferior to their heterosexual and cisgender counterparts which is tantamount to discrimination (Boulos & González-Cantón, 2022). Countries, therefore, have an obligation to enact legislation that protects and upholds the full range of human rights for LGBTI+ individuals (Human Rights Council, 2020).

Chapter 1

Introduction



1.1 Background and context

Conversion therapy is an umbrella term that describes a range of practices which specifically aim to change or suppress an individual's sexual orientation or gender identity expression (Mendos, 2020). The practice is rooted in the medicalisation of homosexuality and gender identity and the belief that being heterosexual and cisgender are the only 'natural' or 'healthy' expression of sexual orientation and gender (Drescher, 2015).

Conversion therapy is also associated with religious beliefs, especially strongly held beliefs that sexual orientations and gender identities that fall outside heterosexuality or cisgender are sinful (Jones et al., 2018). This standpoint is typically grounded in beliefs that non-heterosexual orientations are caused by trauma, are not innate and can be changed through prayer or therapy (Jones et al., 2018). Similarly held convictions about gender and biological sex support the suppression of trans identities and the non-acceptance of gender expression where it does not match the gender assigned at birth. While commonly known as 'conversion therapy', it has been referred to as Sexual Orientation and Gender Identity and Expression Change Efforts or SOGIECE among other terms (Goodyear et al., 2021). Information about the practices and prevalence of conversion therapy in Ireland is scarce, although in the United States and Canada it is reported to affect between 3-18% of LGBT+ people (Goodyear et al., 2021). A survey of LGBTI+¹ people in the United Kingdom found that 2% of the total respondents (n=107,850) reported that they had undergone conversion therapy, with 5% stating they had been offered it (Government Equalities Office, 2018). In the same survey, transgender respondents were more likely to have undergone conversion therapy or to have been offered it (13%) than cisgender respondents (7%) (Government Equalities Office, 2018).

There is evidence that conversion therapy is practiced worldwide, although the nature and specifics related to it are less well understood (Adamson et al., 2020). While there was some anecdotal evidence that the practice exists in Ireland, there was no robust evidence that provides a clear understanding of the prevalence or nature of conversion therapy practices. A survey completed by McCann and Sharek (2014) on the experiences of LGBT people of the mental health services in Ireland reported that 13% (n=92) of the participants received advice that their sexual orientation could be changed to

1 We have used the acronym LGBTI+ to refer to Lesbian, Gay, Bisexual, Transgender, Intersex and other communities outside of heteronormative and cisgender identities who may be vulnerable to or have experienced conversion therapy.

heterosexual. While this provides some evidence about the beliefs associated with conversion therapy, more research is required.

The underlying philosophy associated with conversion therapy is the belief that being LGBTI+ is wrong and that efforts to change sexual orientation or suppress gender expression are legitimate ways to address this (Blosnich et al., 2020; Drescher et al., 2016). This has led to both physical and psychological approaches being used with little if any robust evidence of their effectiveness available. In the past, electroshock aversion therapy and medications were used frequently and continue to be used in some cases (International Rehabilitation Council for Torture Victims (IRCT), 2020). Physical approaches have mostly been replaced with talking therapies that align more with conventional psychotherapy, although the primary aim is the same (Grace, 2008). Prayer, incantations and sometimes exorcisms have also been reported and in some cases, internment and rape have been used² (IRCT, 2020; Mendos, 2020). The lack of empirical evidence to support conversion therapy and greater understanding of the nature of sexual orientation and gender identity has led to it being discredited. Many mainstream, accredited health and wellbeing providers have taken steps to issue statements that oppose the practice of conversion therapy. For example, a memorandum of understanding on conversion therapy in the UK (2017) has been signed by 17 organisations including The British Psychological Society and The British Psychoanalytical Council among other counselling and healthcare organisations which called for the ending of conversion practices, calling them harmful and unethical. In Ireland, the Psychological Society of Ireland (2019) also condemned the practice of conversion therapy in the context of sexual orientation, referring to it as pseudoscience and having no place in modern society. Harm is apparent in the numerous studies that report the negative consequences of conversion therapy. A review completed by the American Psychological Association (American Psychological Association (APA), 2009) found that conversion practices rarely achieved enduring changes in sexual orientation and that it was unlikely that increases in opposite sex attraction could be achieved. However, there were reports of harm including depression, anxiety, and suicidality. Where benefits were recorded, these related to assisting individuals live their lives in accordance with their faith or assisted them to ignore or tolerate their attraction to the same sex (APA, 2009).

Considerable research has largely concluded that sexual orientation change efforts are pseudo-scientific, ineffective, and harmful to the individual being treated (Jowett et al., 2021). As a result of findings like these, the APA (2021a, 2021b) have denounced such practices and recommended affirmative, supportive approaches instead. Although conversion therapy and other sexual orientation change efforts have been widely discredited, they remain legal in most jurisdictions and continue to be practiced on members of the LGBTI+ community (Haldeman, 2022). Indeed, the turn of the millennium has seen an increase in the visibility of gender nonconforming and transgender individuals, and likewise there has been a similar rise in conversion efforts (Haldeman, 2022).

² A range of conversion therapy practices were documented in the IRCT (2020) report, and many did not resemble therapy, supporting GALOP's assertion that the term conversion practices is more appropriate.

In the first half of the previous century, conversion efforts were the foremost ‘treatment’ provided to individuals with a minority sexual orientation (Haldeman, 2022). The societal values of the time, namely that homosexuality was immoral, criminal, and pathological (American Psychiatric Association, 1952) were such that efforts to change sexual orientation through mental health treatments were sought to avoid discrimination and legal penalties (Drescher, 2015). Yoshino (2001) discussed conversion therapy in three distinct phases, the Freudian Age, the ‘Gilded Age’ and the ‘Post-Stonewall Age’. The ‘Freudian Age’ presented conversion therapy through the lens of psychotherapy, with (Freud, 1958) and von Krafft-Ebing (2011) theorising that hypnotic suggestion was a possible ‘treatment’ for homosexuals. However, what was conceived as successful treatment by Freud did not entail the elimination of homosexual feelings, but simply the possibility of heterosexual feelings (Freud, 1958). In fact, Freud concluded that methods of conversion were largely ineffective as the individuals being treated generally did not wish to change (Freud 1958). Post-Freud, the ‘Gilded Age’ from the 1940s to the 1960s was characterised by a sharp increase in conversion therapy being voluntarily sought (Drescher, 2002). This was due in part to the American Psychiatric Association (1952) listing homosexuality as a psychopathology in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) (American Psychiatric Association, 1952). The medical and helping fields have a similar history of pathologizing trans and nonbinary individuals, with the inclusion of gender identity disorders in previous editions of the DSM (Haldeman, 2022).

During the ‘Golden Age’, there were still dissenting voices in the scientific community regarding conversion efforts, with Hooker (1958) and Szasz (1970) among others questioning the idea that homosexuality was abnormal. These efforts and anti-conversion sentiment accelerated post-Stonewall in 1969, culminating in the removal homosexuality as a mental disorder from the DSM-II (American Psychiatric Association, 1973). In its stead, however, was Sexual Orientation Disturbance (SOD), which regarded homosexuality as an illness if a ‘same sex attracted’ individual was distressed by their feelings (Drescher, 2015) thereby continuing the justification of conversion therapy. SOD was later replaced by Ego Dystonic Homosexuality (EDH) in the DSM-III (American Psychiatric Association, 1980), which was characterised by an individual whose sexual orientation was at odds with their idealised self-image, causing anxiety and a desire to change one’s orientation, again justifying conversion therapy (Drescher, 2015). In addition, the DSM-III introduced the diagnostic categories of transsexualism within a diagnostic group called ‘gender identity disorders’, suggesting that sex-gender incongruence placed an individual at risk of poor mental health outcomes (APA, 1980). Subsequently, EDH was removed from the DSM-III-Revised (American Psychiatric Association, 1987) and the phrase ‘sexual disorder not otherwise specified’ was included, meaning that mental health professionals could still provide conversion therapy (Wyatt-Nichol, 2014). It was not until the publication of the DSM-5 (American Psychiatric Association, 2013) that diagnostic criteria for an individual’s sexual orientation was not included, but gender dysphoria as a form of gender discordance was, further misrepresenting those who identify as a gender different to that which they present as having a mental illness (Haldeman, 2022).

In their extensive review of Conversion Therapy, Jowett et al. (2021) presented conversion techniques in three distinct themes, spiritual, psychoanalytic and cognitive/behavioural. They detail spiritual therapies as including ‘prayer ‘healing’ (including exorcising spirits), confession, repentance, faith

declarations, fasting, pilgrimages, Bible reading and attending religious courses’ (Jowett et al., 2021, p. 21), psychoanalytic as including ‘exploring ‘causes’ through a discussion of childhood trauma, psychodrama, emotional-release work, ‘father-son style holding’ and altering gender-role behaviour’, (Jowett et al., 2021, p. 21), while cognitive/behavioural therapies include ‘reframing desires, redirecting thoughts, avoiding ‘triggers’, abstaining from masturbation or masturbatory reconditioning, journaling, accountability buddies/groups, behaviour modelling, covert aversive methods (e.g. snapping a rubber band on the wrist)’ (Jowett et al., 2021, p. 21). The authors noted that the academic literature mainly represented experiences from ‘the global North and North America in particular (Jowett et al., 2021, p. 20) however, they detail that the grey literature presented data on more extreme forms of conversion therapy, including electric shock aversion therapy and corrective rape in research from parts of Africa, Asia and the Middle East. The frameworks compiled by Jowett et al., (2021) are presented in Table 1.1.

The literature is conclusive that claims of conversion therapy being effective are baseless (APA, 2009; APA 2021a; APA 2021b). Despite this, there are studies reporting some positive aspects associated with conversion therapy, such as increased social support (Shidlo & Schroeder, 2002), being provided with hope (Beckstead & Morrow, 2004) and improving relationships with family (Bradshaw et al., 2015). It is noted that these benefits could be experienced through alternative therapeutic approaches and are not unique to conversion therapy (Jowett et al., 2021). As well as being ineffective, there is a growing body of evidence suggesting that exposure to conversion therapy is associated with poor mental health outcomes, with depression (Ryan et al., 2020), distress (APA, 2009), forced isolation (Flentje et al., 2014) and suicidal behaviour (Blosnich et al., 2020) commonly cited in the literature. Ultimately, conversion therapy has been consistently observed to place an individual under severe mental strain, creating internal conflicts as opposed to resolutions and reinforcing non-positive stigma associated with minority sexual orientations and gender identities (Jowett et al., 2021).

Table 1.1.

Overview of conversion therapy frameworks (Jowett et al., 2021 p. 21)

Framework	Features
Religious/ Spiritual	Premise: Same-sex attractions and transgender identities are caused by evil spiritual forces, sins of previous generations or are a test from God. Same-sex sexual behaviour or cross-dressing are sinful/immoral. Techniques include: Prayer ‘healing’ (including exorcising spirits), confession and repentance, faith declarations, fasting, pilgrimages, Bible reading, attending religious courses. Setting: Within a religious community, in places of worship, at religious conferences and festivals, on religious conversion therapy courses. Provider: A religious leader (e.g. vicar/priest, youth pastor), other members of the church or faith community, a religious therapist.
Psychoanalytic	Premise: Same-sex attractions and transgender identities are developmental disorders resulting from a variety of familial (e.g. distant relationship with a parent), social (e.g. rejection by childhood same-sex peers) or traumatic (e.g. childhood sexual abuse) factors. Techniques include: Exploring ‘causes’ through a discussion of childhood trauma, psychodrama, emotional-release work, ‘father-son style holding’, altering gender-role behaviour. Setting: One-to-one or group therapy/pastoral counselling, conversion therapy weekend retreats or courses. Provider: A group or organisation (often religious), therapist, life coach or pastoral counsellor (with or without any formal training).
Cognitive/ Behavioural	Premise: Same-sex attractions and transgender identities are a behavioural problem similar to an addiction or compulsive behaviour. Techniques include: Reframing desires, redirecting thoughts, avoiding ‘triggers’, abstaining from masturbation or masturbatory reconditioning, journaling, accountability buddies/groups, behaviour modelling, covert aversive methods (e.g. snapping a rubber band on the wrist). Setting: One-to-one/group therapy or pastoral counselling, weekend retreats or courses, AA-style mutual aid groups (sometimes alongside people who suffer from addictions and/or sexual problems). Provider: A therapist, life coach or pastoral counsellor (with or without any formal training) and/or a group or organisation.

Despite denouncements from the United Nations Human Rights Council (2020), professional bodies and survivors, combined with calls for legislative advocacy to prohibit conversion therapy, as of 2022 there are only 14 countries with outright bans on conversion therapy (Stonewall, 2022). Within the European Union, Malta, Germany, France and Greece have banned these practices, with several other member states, including Ireland, engaged in the legislative process to follow suit (DeGroot, 2022). In the United Kingdom, a partial bill that only bans sexual orientation change efforts for minors and non-consenting adults is being proposed³. Following on from the referendum on marriage equality in 2015, the Prohibition of Conversion Therapies Bill (2018) was drafted and presented to Seanad Éireann. The Bill, which has been at stage three of ten before being enacted into law since September 2020, seeks to place an outright ban on conversion therapy in Ireland (Houses of the Oireachtas, 2018). Subsequently, objective 8(b) of the LGBTI+ National Youth Strategy (Department of Children & Youth Affairs, 2018) outlined the intention to prohibit the promotion or practice of conversion therapy by health professionals in Ireland. Following on from this, the National LGBTI+ Inclusion Strategy 2019-2021 (Government of Ireland, 2019) outlined the joint commitments to investigate the methods and prevalence of conversion therapy in Ireland and review international best practice and legislative responses to same. In preparation for any subsequent policy and legislation in conversion therapy, a study was commissioned to gain an understanding of the forms and extent of conversion therapy practices in Ireland. This document sets out the findings of a research study which sought to explore conversion therapy practices in the Republic of Ireland.

1.2 Aims and Objectives

The overall aim of this study was to explore the practice of conversion therapy in Ireland. Specifically, the research sought to establish

- a definition of conversion therapy and conversion practices as they operate in Ireland (including what conversion practices are used, what signifiers are used and how people consent or assent),
- who is subjected to conversion practices (minority sexual orientation/minority gender identity),
- if there are longer term consequence of such practices for the individual,
- if there are any support needs for people who have been subjected to conversion therapy.

3 <https://www.pinknews.co.uk/2022/10/03/liz-truss-conversion-therapy-ban-video/>

Chapter 2

Research Approach



2.1 Introduction

Given the aims and objectives of the research, this study followed a descriptive multi-phase mixed methods design with the qualitative arm being the dominant phase. There were three phases, each one overlapping in terms of how they met the aims of the research study allowing for triangulation of findings and a more comprehensive account of the phenomena under study.

Data collection for this study was proceeded by ethical approval from the Research Ethics Committee at the Faculty of Health Sciences, Trinity College Dublin. A research advisory group was formed which had representatives from the Department of Children, Equality, Disability, Integration and Youth [DCEDIY]; LGBT Ireland; Gay Project [Cork]; Transgender Equality Network Ireland (TENI) and the psychotherapy services. They provided guidance on the survey design, the interview guide, dissemination of the survey and participant recruitment for the interviews. An article was prepared for Gay Community News [GCN] which provided an overview of the study and a link to the survey⁴ and the launch of data collection was preceded by a press release from the DCEDIY.⁵ A study email address was used [conversiontherapy@tcd.ie] and all communication about the study was channelled through this email address.

2.2 Data Collection and Analysis⁶

Literature review

Given that a rapid evidence assessment (REA) had been recently conducted by Jowett and colleagues and published online in October 2021 (Jowett et al., 2021) it was not the intention of this review to repeat work that had already been completed. The aim of that review was to ascertain what forms conversion therapy takes, who experiences conversion therapy and why and what are the outcomes of conversion therapy. We conducted a similar approach, systematically searching for any new research papers that were published since 2020. In addition, the current review also searched for research

4 <https://gcn.ie/lgbtq-survey-conversion-therapy-ireland/>

5 <https://www.gov.ie/en/press-release/9aaa1-minister-ogorman-announces-research-into-conversion-therapy-that-will-inform-ban-on-the-practice/>

6 Supplemental material, search strategy, survey and interview guide are available on request.

papers and extracted information specifically about the long-term effects of conversion therapy and the support needs of those people who have been exposed to it. This element of the review was limited to peer reviewed research papers. To supplement the review and to make it culturally relevant, a search of grey literature was also conducted. This search was limited to grey literature published in Ireland and focused on the lived experience of conversion therapy which aimed to help enrich the survey and interview data collected as part of phase two and three of the study. The review followed a narrative approach using the PRISMA statement (Page et al., 2021) and the team worked closely with a librarian who is an expert in data base searching, retrieval and management of search outcomes. In addition, Dr Jowett who was involved in the review conducted in the UK, also advised on the construction of search terms and the screening, selection and analysis of the retrieved papers. Papers were assessed for inclusion against the inclusion and exclusion criteria presented in table 2.1.

Table 2.1:
Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
• Studies that are peer reviewed • Studies that explore the experience of conversion therapy. • Studies that explore the impact (positive or negative) of conversion therapy. • Studies that explore the support needs of people exposed to conversion therapy. • Quantitative, qualitative or mixed methods studies • Systematic reviews	• Discussion papers • Conference proceedings • Editorials • Case studies • Books and book chapters

The software package *Covidence*⁷ was used and following the data base searches, the titles and abstracts were screened against the inclusion criteria by two members of the team with any conflicts being resolved by both reviewers. The same process was followed for the full text screening process. Once all papers were identified they were subjected to a quality appraisal using the Mixed Method Appraisal Tool (MMAT)⁸ (Hong et al., 2018) which is a critical appraisal tool that was specifically designed for mixed studies systematic reviews. Quality appraisal was also completed by two members of the research team. The MMAT does not use a scoring system and excluding studies based on low methodological quality is discouraged. Therefore all papers progressed to the extraction phase of the

⁷ <https://www.covidence.org/>
⁸ http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

review. A data extraction template was designed and imported into Covidence where pertinent data related to the aims of the review was extracted from each paper. Once completed a summary table was populated with the pertinent data and summarised to reflect the aims of the study (see chapter 3).

Cross sectional survey of LGBT+ community

Phase two of this research involved the administration of an anonymous online survey to the LGBTI+ community. The purpose of the survey aimed to establish if respondents:

- Have ever been offered conversion therapy
- Have ever had conversion therapy;
- Who offered the conversion therapy;
- Who conducted the conversion therapy;
- When they had the conversion therapy;
- Why they had the conversion therapy;
- The types of ‘therapies’ they experienced
- The extent to which undergoing conversion therapy was their decision.
- Perceived usefulness and harm following exposure to conversion therapy

The survey also collected some demographic details including age, gender identity, sexual orientation, relationship status and religion. Questions for the survey were drawn from or adapted from the literature (Flentje et al., 2014; Global Interfaith Commission on LGBT+ Lives, 2022; Government Equalities Office, 2018; Meanley et al., 2020) and was hosted by Qualtrics.

The representatives on the research advisory group used their networks to connect with other national and local organisations to maximise responses for both the survey and the qualitative interviews. LGBT Ireland had recently appointed a campaign officer for their *Ban Conversion Therapy Campaign* who created a steering committee which also supported the recruitment of participants and promoted the research. The study was also promoted through social media. Data for the survey was collected over six weeks with reminders about the research sent frequently via GCN and social media. Data collection began on the 8th of July 2022 and closed on the 24th August 2022. Data was downloaded to SPSS and descriptive statistics computed in line with the aims and objectives of the study.

Individual interviews with people who experienced conversion

Semi structured in-depth interviews were conducted with LGBTI+ people who experienced conversion therapy sometime over the last 25 years. The decision to recruit within this timeframe stemmed from the desire to capture more recent experiences considering shifting societal attitudes, the general move away from a medical or deviant conceptualisation of homosexuality and gender identity and the decriminalisation of homosexuality. In addition, this approach attempted to capture conversion

therapy as a set of practices which persist despite it being discredited. Some older people may have experienced conversion therapy when it was a standard medical practice, and this may not be representative of how it is practiced today. Face to face interviews took place in a private location that was convenient for the participants with two interviews taking place via zoom. While the interviews were semi-structured, they were narrative in nature, allowing the participants to tell their own personal story in their own way. An interview guide was constructed to support the interviews which focused on the participants initial engagements with conversion therapy, their experiences and perceptions of the process, the nature of the approach, and the perceived usefulness and or negative effects of exposure to conversion therapy. Where the participant reported harmful or traumatic experiences, their perceptions of their support needs at that time and now was also ascertained.

The interviews were conducted sensitively at a pace dictated by the participants and conducted by an experienced researcher who was used to engaging with individuals about subjects that are sensitive in nature. Prior to conducting the interviews, there was consultation with the research advisory group to ensure that the interview guide was appropriate and met the needs of the research in a sensitive way. Dr Jowett who led the UK research on conversion therapy also advised on the interview guide. Interviews were audio recorded and once the interview was completed the recording was transcribed by a transcription company used frequently by the School of Nursing and Midwifery. A number of strategies were used to recruit participants. On completion of the survey, participants who indicated that they had experienced conversion therapy were redirected to a secure webpage that provided information about the interviews, where they could leave their contact details if they wished to take part. Once they did a member of the research team contacted them to chat with them about their experiences, answer any question that they had and recruit them to the study if they still wished to take part. Potential participants could also contact the team directly using the study email address and information about both the survey and the interviews were disseminated widely through social media and with posters displayed in LGBTI+ organisations and meeting places.

A descriptive thematic analysis was conducted following the steps outlined by Braun and Clarke (2022). An overview of this process is contained in Table 2.2. Following transcription, each transcript were read and re-read to assist the researchers to become familiar with the participant's story. The transcripts were then coded, and similar codes applied across transcripts with an iterative approach of coding, recoding and collapsing codes taking place until themes and subthemes were developed. Themes were supported by verbatim quotations from the transcripts to highlight important points and to provide examples of the participant's experiences. The qualitative analysis told the collective story of the participants experiences and provide a clear description of their engagement with conversion therapy, the structure and process of conversion therapy, issues of consent or assent and the perceived harm or benefits attributed to conversion therapy. Two researchers were involved in the qualitative data analysis to enhance the rigor of the process. Each researcher independently coded interview transcripts and developed an initial coding framework. Once the themes were developed, all team members reviewed the findings and checked their quality against the criteria outlined by Braun & Clarke (2022).

Table 2.2:
Overview of thematic analysis (Braun & Clarke, 2022)

1. Familiarising yourself with the dataset	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Coding	Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Generating initial themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Refining, defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Writing up	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

2.3 Ethical considerations and general data protection regulations (GDPR)

Ethical approval was sought from the Research Ethics Committees of the Faculty of Health Sciences in Trinity College Dublin. All involved with the study are bound by national and international codes of good practice in research, and by professional standards within their disciplines. The rights and dignity of participants were respected throughout by adherence to models of good practice related to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice. The rights of the participants and their well-being were given precedence over data collection. Information sheets were designed for each phase of the study to allow the participants to make an informed choice about whether to take part in the study or not. For the survey, participants were informed of the voluntary nature of participation and that completion on the survey was seen

as implied consent. The survey data was anonymous so participants were advised not to include any information that might identify them. Withdrawal from the study following completion of the survey was not possible following online submission due to the data being anonymous and this was clearly stated in the participant information leaflet (PIL). Any information that might have revealed the identity of the survey respondents was not reported.

For those participants who experienced conversion therapy, detailed information about the study was provided and participants were contacted by the researchers once they indicated their interest in taking part through the survey, LGBTI+ organisations or other avenues. They had the opportunity to ask questions about the research and at least one week to think about taking part. Permission to follow up with the potential participant was obtained and the same researcher contacted them to further ascertain their interest in taking part and to arrange for the interview to take place. The voluntary nature of participation was clearly stated in the PIL and reiterated verbally. In addition, the participants freedom to withdraw their consent without prejudice was also be clearly indicated. The interview took place at a time and location convenient to the participant and written informed consent was obtained following the reiteration of the study information. From the onset participants were clear about the nature of the interview and that some of the questions were sensitive and that they may cause upset at the retelling of past experiences. If the participants believed that it might be too distressing to talk about their experiences of conversion therapy, then they were advised not to take part and this information was contained in the PIL and reiterated verbally. Every effort was made to put the participants at ease and allow them to tell their story in their own way. All the team are experienced researchers and clinicians and are very familiar with interviewing participants about sensitive topics. Strategies to manage distress during the interviews were also in place but were not required. A contact number for a confidential listening and support service and an instant messaging service provided by LGBT Ireland was provided as a source of support for those who might be distressed following the interview and participants were encouraged to access this if they feel they were affected.

2.4 Data Protection

The researchers are aware of their responsibilities and obligations under the General Data Protection Regulations (GDPR) and all team members have undergone GDPR training provided by Trinity College Dublin and Coventry University. Within Trinity College Dublin, ethical approval was contingent on the review of a Data Protection Impact Assessment (DPIA) by the Data Protection Officer (DPO). The DPIA detailed the data protection and data security provisions that were planned and ensured that study materials such as the survey, PIL and consent forms were fit for purpose and contained the appropriate information to render them GDPR compliant. In addition, the impacts of a data breach were assessed and a plan was in place should one occur. All data is stored on a doubly encrypted online folder that only the researchers have access to. Survey data did not contain any

personal data. For those participants who were interested in taking part in the interviews, their survey questions were submitted anonymously and then they were redirected to a webpage where they could submit their contact details so they could be contacted about the interviews. This allowed their survey responses to remain anonymous. For the interviews, personal data was only collected to allow the researchers to contact the potential participants to schedule the interviews and to provide them with a transcript of the interview should they require one. This personal data was deleted once recruitment and data collection was completed. Interview transcripts were made confidential and audio files deleted following transcription. Interviews were assigned a code number that did not identify the participant. Any information that could possibly identify the participant was removed from the transcript. Dr Jowett was provided with an honorary position so that he could have TCD credentials which allowed him to access study materials in a secure manner.



Chapter 3

Findings from the Systematic Review

3.1 Research Papers 2020 – 2022

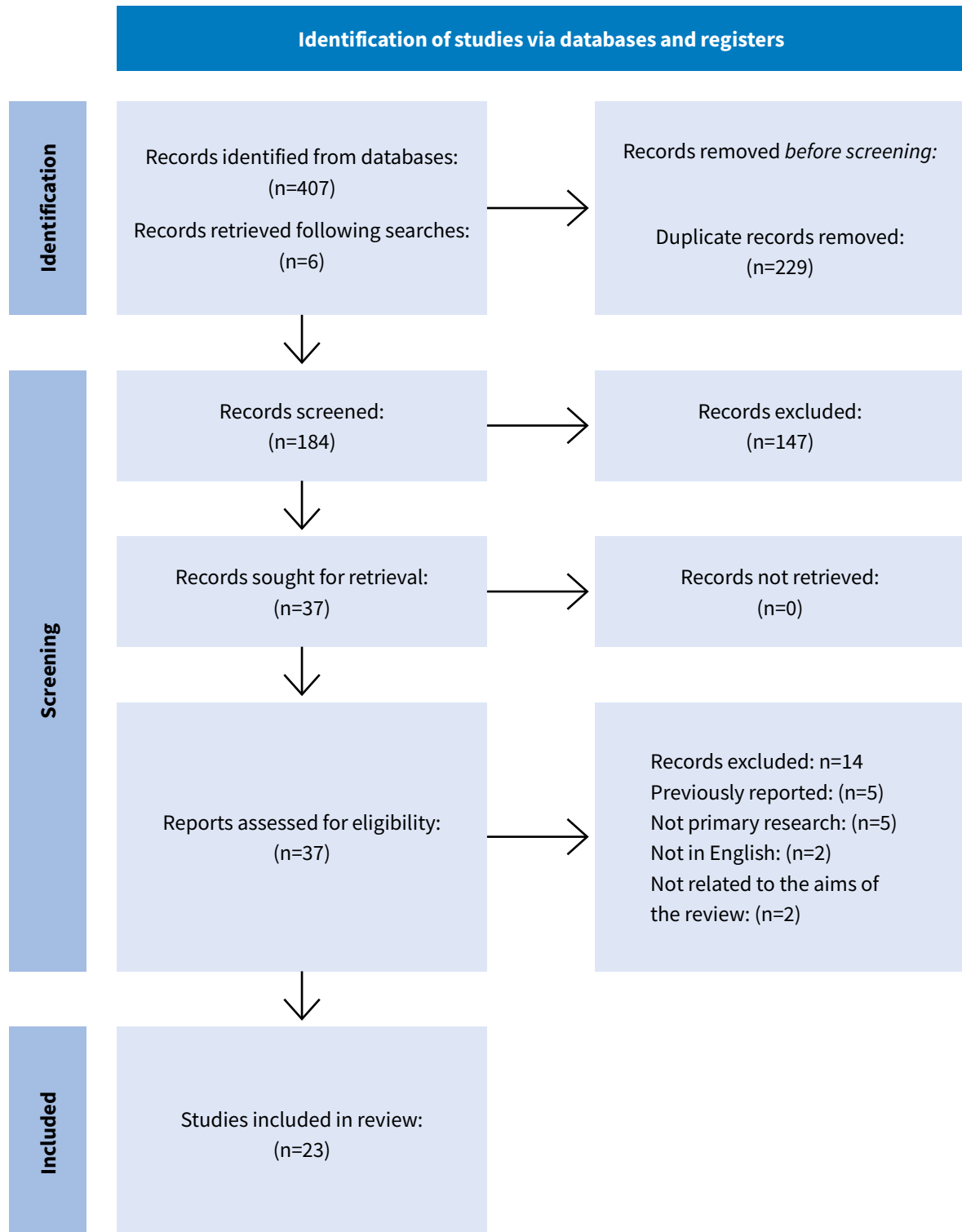
Using an adapted version of Jowett et al's (2021) search strategy, library databases were searched for relevant peer reviewed papers in May 2022. Figure 3.1 provides an overview of the results using the PRISMA statement (Page et al., 2021). In summary 407 papers were imported following the searches with 229 duplicate papers removed leaving 178 for title and abstract screening.

Following initial screening against the inclusion criteria 147 papers were removed leaving 31 papers for full text review. At this point 14 papers were excluded because two were not in English, two were unrelated to the aims of the review and five were not primary research studies. As the focus was on new papers, a further five were excluded as they were already included in Jowett et al.'s (2021) rapid evidence assessment. A PhD dissertation exploring the experiences of 'corrective' rape was also included (DeWee, 2017). As this is a rapidly expanding evidence base in the weeks following our initial data base search, we came across several papers that were subsequently published which met the criteria for inclusion. In the interest of timely completion of the review, no further papers were added after July 2022. In total 22 papers and one dissertation were included in the review. An overview of the included papers (n=23) is available in Appendix two.

- Seventeen of the papers reported results from quantitative studies and six reported qualitative studies.
- Two papers were a reanalysis of previously available data sets.
- Eight of the papers were from the United States, five were from Canada, three were from Australia, two from South Korea and one from Hong Kong, Columbia, Nigeria, South Africa, and New Zealand. One paper was a multi-county study and included data from the United States, Canada, United Kingdom and Ireland.⁹
- Ten of the papers focused on Sexual Orientation Change Efforts (SOCE), three focused on Gender Identity Change Efforts (GICE) with the remaining papers exploring both SOCE and GICE (SOGICE).

⁹ The Irish participants in this study were not exposed to conversion practices.

Figure 3.1:
Overview of the review process following PRISMA guidelines
 (Page et al., 2021)



3.2 Quality appraisal

The Mixed Methods Appraisal Tool (MMAT) was used to assess the quality of the papers that were included in the review (Hong et al., 2018). The MMAT consists of two general screening questions and then five questions related to the specific methodology of the paper. All papers were appraised by two assessors and consensus reached. Many of the quantitative papers used cross sectional methods with non-probability samples which limits their generalisability and potential to make a causal inference (Wang & Cheng, 2020). The quantitative studies were mostly retrospective and relied on self-report and may be vulnerable to recall bias, which may be further hampered by the challenges of both understanding and defining conversion practices, a point highlighted by both Salway et al. (2021) and del Río-González et al. (2021), among others. Like the studies included by Jowett et al. (2021), there were no randomised controlled trials or longitudinal studies and the conversion practices discussed in many of the studies were not standard which also makes drawing conclusions difficult. While the qualitative papers were rated positively from a methods point of view, cisgender gay men were overrepresented generally with a lack of representation from women and trans participants. As recommended by the authors of the MMAT, no score was given to the papers, and they were all included in the final review.

3.3 Definition, Practices, and Issues of Consent/Assent

The papers use the terms Sexual Orientation Change Efforts [SOCE] or Gender Identity Change Efforts [GICE] and conversion therapy. Conversion therapy practices is specifically referred to by Salway et al., (2021) and Jones et al., (2021). The term sexual orientation and gender identity change efforts was used where the papers explored the prevalence or experience of both. This was generally abbreviated to SOGICE except by Goodyear et al., (2021), Kinitz et al., (2021) and Salway et al., (2021) who refer to Sexual Orientation and Gender Identity and *Expression* Change Efforts [SOGIECE] which is a slight variation with the inclusion of the word 'expression'. Most of the papers discuss SOCE/GICE or SOGICE as an umbrella term for a variety of practices and efforts to change someone's sexual orientation to heterosexual or gender identity to the one that aligns with gender assigned at birth (cisgender). In addition, in many of the definitions, there is an emphasis on deterring, suppressing, managing, discouraging or avoiding adoption of non-heterosexual sexual orientations and gender identities not assigned at birth rather than actually changing them (Blais et al., 2022; Chan et al., 2022; Goodyear et al., 2021; Heiden-Rootes et al., 2022; Jones et al., 2021; Kinitz et al., 2021; Salway et al., 2021). In one of the papers SOGICE is described as a treatment (del Río-González et al., 2021) although the focus of the paper concentrates on the harm it can cause. DeWee (2017) writing about corrective rape describes the goals of this sexual violation as curative, perpetrated with the goal of 'curing the lesbian woman of her emotional and sexual attraction to another woman' (p.9). Earley et al. (2020) describes SOCE as a disputed therapeutic approach where its proponents promise 'gay to straight' outcomes

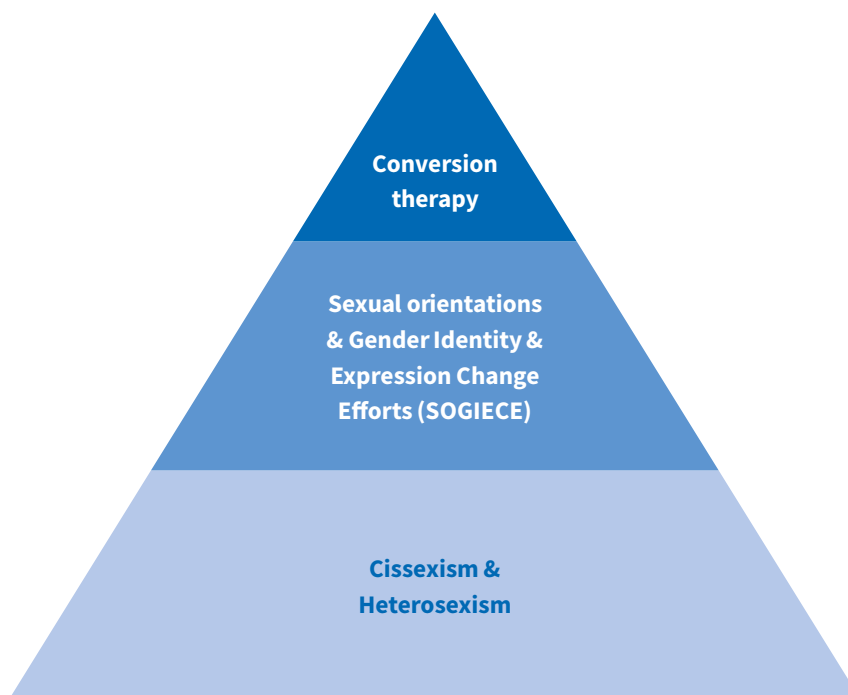
for clients. Ogunbajo et al. (2021) refer to sexual orientation conversion therapy and describe it as a dangerous and discredited practice. The papers from Australia (Jones et al., 2021, Jones et al., 2022a, 2022b) discuss conversion practices in terms of an ideology where LGBTQA+¹⁰ identities are perceived as broken, sinful and in need of fixing. This conversion ideology, often rooted in religious beliefs, champions the notion that heterosexual and cisgender identities are the ideal.

Sullins (2022) and Sullins et al. (2021) also writing in the context of SOCE refer to it as therapeutic activities or programmes that aim to change or reduce unwanted same sex attraction. Rosik et al (2022a) refers to 'sexual orientation distress' and in the context of psychotherapy the term SOCE is not used. Instead, strategies that aim to affirm sexual orientation, discourage homosexuality/bisexuality and those that are neutral are discussed. Neutral strategies were those that could be perceived as helpful regardless of theological perspective or sexual orientation. Given the definitions already discussed, strategies that discourage non-heterosexual identities can fall into the category of SOCE.

In terms of conversion practices, not all the papers described the practices in any detail and where they were mentioned they were only described briefly. Apart from DeWee (2017) they do not generally deviate from the frameworks described earlier by Jowett et al. (2021). Chan et al. (2022), Jones et al. (2022a), Meanley et al., (2020), Kinitz et al., (2021) and Rosik et al. (2022a) provide the most comprehensive descriptions of the practices that those who were exposed to or subjected to SOGICE experienced. In Chan et al.'s (2022) study most participants were exposed to religious methods, (e.g., prayer, fasting and exorcism) with some participants also receiving psychological approaches, including attending sexual orientation change courses. These approaches were coupled with more behavioural approaches aimed at participants suppressing their feelings, abstaining from same sex relationships, or developing heterosexual relationships. A minority sought medication although there is no detail provided about this approach. There is overlap here with Jones et al.'s (2022a) study although their participants also mentioned being forced into heterosexual marriages and rape. Many of the participants who had engaged in formal conversion practices had also been involved in spiritual or religious practices as well (Jones et al., 2022a). In Meanley et al.'s (2020) study, most participants who experienced SOCE had individual or group therapy and religious based approaches with gender role reinforcement, aversion therapy and pharmacological approaches which were less frequently reported. Kinitz et al. (2021) describe a sexual orientation and gender identity and expression change efforts pyramid (figure 3.2).

10 Lesbian, Gay, Bisexual, Transgender, Queer and Asexual.

Figure 3.2:
SOGIECE Pyramid (Kinitz et al., 2021 p444)



At the base of the pyramid, the participants in the study described informal and insidious SOGIECE from family members, friends, the religious community, or health care professionals which are referred to as cissexism and heterosexism. This involved pressure on the participants to suppress their non-heterosexual orientations or non-cisgender identities or general unsupportive and non-affirming attitudes towards them. This included advice to gay men to marry someone of the opposite sex for example or encouraging others to repress their gender identity. SOGIECE was conceptualised as non-formal albeit overt attempts to change a person's sexual orientation or gender identity including prayer and exorcisms or where health professionals denied gender affirming care. Conversion therapies were conceptualised as structured and formal approaches that ranged from individual and group therapy with mental health professionals and religious leaders, psychoanalysis, intensive prayer sessions, gender reinforcement to suppressing and avoiding non-heterosexual outcomes or engaging in masculine activities for gay men. These 'therapies' were underpinned by beliefs that early life trauma, an absentee father or domineering mother and other discredited theories resulted in 'same sex attraction' (Kinitz et al., 2021).

Rosik et al. (2022a) focused on SOCE in psychotherapy although they did not use that term to describe them. In their paper they describe 33 different outcomes within psychotherapy that might result in a reduction in 'sexual orientation distress'. Rosik (2016) writing for the *Alliance for Therapeutic Choice and Scientific Integrity (ATCSI)*¹¹, supports a move away from the term SOCE suggesting that 'sexual

¹¹ ATCSI was formally known as the National Association for Research and Therapy of Homosexuality who were known for advocating SOCE <https://www.glaad.org/blog/ex-gay-group-narth-rebrands-dangerous-mission>

attraction fluidity exploration in therapy’ or SAFE-T is a more accurate term. This, according to the ATCSI, infers that SOCE are sometimes client centred, sexual orientation is fluid and that exploratory approaches such as SAFE-T can address and be helpful to those with ‘unwanted same sex attraction’ (Rosik, 2016). Strategies that discouraged homosexuality and bisexuality were interventions that promoted religious and traditional interpretations of relationships and sexuality and those that supported the suppressing and resisting of sexual desires.

DeWee’s (2017) exploration of corrective rape, while outlining the ‘curative’ motives behind the sexual assault also describes how the violation was also meant to humiliate and punish victims for their sexual orientation and identity. Ogunbajo et al.’s (2021), Jones et al. (2021) and Sullins et al.’s (2021) all focused on SOGICEs that were religious in nature. Where it was discussed, there was a tendency to talk generally about SOGICE with little emphasis on the differences, if any, between SOCE and GICE. Where GICE was the sole focus of the paper (Heiden-Rootes et al., 2022; Lee et al., 2022; Veale et al., 2021) there is limited detail on the practices that the participants were exposed to, although Heiden-Rootes et al. (2022) found that participants were more likely to be exposed to non-religious means and Veale et al. (2021) focused specifically on GICE administered by mental health professionals.

Consent was mentioned in eight of the papers (Blais et al., 2022; Chan et al., 2022; Goodyear et al., 2021; Jones et al., 2022a; Kinitz et al., 2021; Meanley et al., 2020; Ogunbajo et al., 2021; Sullins et al., 2021). Generally, the participants attended SOCE or GICE voluntarily, but this voluntariness was set against an atmosphere of coercion where SOGICE was advised or recommended by family or religious leaders and supported by the participants awareness of the negative societal attitudes towards homosexuality and trans identities (Chan et al., 2022; Goodyear et al., 2021; Jones et al., 2022a; Kinitz et al., 2021). In Chan et al.’s (2022) paper, over half of the participants attended SOCE to fulfil other people’s expectations and Kinitz et al. (2021) reports that some of their participants sought out gender affirming care but had SOGICE forced on them instead. Chan et al. (2022) divides their participants into those who sought out SOCE themselves and those who were advised by others to have SOCE. Of those who sought it out themselves, more than half had their first engagement with SOCE on or before the age of eighteen (Chan et al., 2022). Over half of the participants in Blais et al.’s. (2022) study attended voluntarily but many didn’t know what they were volunteering for and in some cases other people were involved in the decision-making process. There were also participants who volunteered to attend because they felt they couldn’t say no or they feared negative outcomes if they refused (Blais et al., 2022). Jones et al. (2022a), in the context of religious SOCE, describes participants who were tricked or coerced into attending which exacerbated the trauma they experienced. Ogunbajo et al.’s (2021) paper specifically mentions religious practices being forced on the participants (‘I have been forced to participate in a prayer service or traditional ceremony to turn me straight’ p.7) but there is no detail beyond that. Meanley et al. (2020) asked their participants how much it was their decision to seek conversion therapy with just under 43% indicating that it was completely or mostly their decision to attend. Sullins et al.’s (2021) specifically refers to the voluntary nature of SOCE and the deeply religious men in their paper were highly motivated to seek SOCE given the conflicts it had with their religious beliefs. Where the papers included participants that were under the age of 18 (Chan et al., 2022; Green et al., 2020; Jones et al., 2021; Veale et al., 2021) issues of consent or assent are not discussed specific to this age group.

3.4 Consequences of Conversion Practices

Consequences of conversion practices refer to the participants' perceptions of the effectiveness of SOGICE, any perceived benefits or usefulness of attending, the harms that attending SOGICE caused and any support needs that were reported following exposure to SOGICE. In terms of SOGICE having its desired outcomes, only one paper (Sullins et al., 2021) refers to partial changes in sexual orientation for between 45% - 69% of the participants and reports a 14% total reduction in same sex sexual attraction and identification using a self-report retrospective pre and post survey designed by the researchers.¹² In Chan et al.'s (2022) paper, none of the participants said that it was somewhat or very effective which conflicts with the one person in that study who reported that their sexual orientation changed from non-heterosexual to heterosexual. In that study six participants reported that they had some short-term changes to heterosexual but were non-heterosexual now. These short-term changes are likely due to repressing or resisting same sex relationships or activity rather than actual change. In Earley et al.'s (2020) study, all the men who were exposed to SOCE identified as non-heterosexual at the time of publication. One person in Goodyear et al.'s (2021) study reported some benefits of attending SOGICE in terms of the religious affirmation he received but was clear that it was ineffective in terms of changing his sexual orientation. One person in Jones et al.'s (2022a) paper recalls being excited about finding a group of people who were also dissatisfied with their sexual orientation like they were, but with the benefit of hindsight regretted their enthusiasm now.

Returning to Sullins et al.'s (2021) paper which reported some effectiveness of SOCE, the authors drew on data from what were described as 125 deeply religious men which was a secondary analysis of data collected in 2011. While about 14% (n=18) indicated that they experienced complete diminishing of their unwanted 'same sex attraction' a larger proportion experienced no change and the most common change reported was to bisexuality and not heterosexuality. The many reported limitations of the paper (in addition to the age of the data and that many of the participants were still undergoing the 'treatment' at the time of data collection) mean that even these small changes cannot be directly related to SOCE. In addition, respondents did not receive the same interventions which makes measurement challenging. As reported, the highly religious participants' self-reported changes may have been fuelled by their adherence to religious norms rather than changes associated with SOCE (Sullins et al., 2021). In Rosik et al.'s (2022a) paper, the psychotherapy approaches used were discussed in terms of how helpful or harmful they were. Participants were divided into two groups, those who identified as LGB and those who experienced same sex attraction at some point in their life but didn't identify as lesbian, gay or bisexual. In addition, their theological viewpoints were also captured. Participants' interpretations of the interventions' helpfulness and harmfulness was often associated with both their identity and religious orientation. For example, those who identified as LGB were more likely to find affirming strategies more helpful, while those who were religious and did not identify as LGB found strategies promoting religious and traditional values more helpful. However, the latter were perceived as harmful for those who identified as LGB (Rosik et al., 2022a).

12 <https://dataverse.harvard.edu/dataset.xhtml?persistentId=doi:10.7910/DVNRGNGNH>

There were some benefits of attending SOGICE, but it must be acknowledged that these perceived benefits could have been achieved in more affirmative and supportive ways. In Chan et al.'s (2022) and Earley et al.'s (2020) studies the benefits for some of the participants were associated with their ability to share their feelings and experiences even though in Chan et al.'s (2022) study many of the participants didn't have much faith in its ability to change their sexual orientation anyway. As briefly mentioned earlier, one participant in Goodyear et al.'s (2021) study described their experience favourably despite its ineffectiveness. In Sullins et al., (2021) and Sullins (2022), both studies report perceived benefits of exposure to SOCE. In Sullins et al., (2021) attendance at SOCE was associated with enhanced psychological well-being with about only 1 in 20 participants reporting negative effects. The limitations of this study have already been outlined.¹³ Sullins (2022) paper suggests that SOCE may have protective elements as it reduces the effects of minority stress and childhood adversity on suicide attempts, however these conclusions are contested.

3.4.1 Harms

Significant harms and negative consequences of SOGICE were documented in most of the papers that were reviewed. From the quantitative papers, participants exposed to SOCE or GICE were at greater risk of developing depression (Chan et al., 2022; Lee et al., 2021, 2022; Ogunbajo et al., 2021), panic disorder (Lee et al., 2022), anxiety (Jones et al., 2021) and other mental illnesses (Higbee et al., 2022; Jones et al., 2021) and severe psychological distress (Heiden-Rootes et al., 2022; Jones et al., 2021; Veale et al., 2021). Higbee et al. (2022) found that participants who were exposed to SOGICE before the age of 18 were significantly more likely to experience serious mental distress. In many of the studies, participants exposed to SOGICE were at greater risk of suicide ideation, suicide planning and suicide attempts (Chan et al., 2022; del Río-González et al., 2021b; Green et al., 2020; Heiden-Rootes et al., 2022; Jones et al., 2021; Lee et al., 2021, 2022; Ogunbajo et al., 2021; Veale et al., 2021). Green et al. (2020) found that when compared to those who did not have SOGICE, those who did were twice as likely to report having attempted suicide and having multiple suicide attempts. Similarly, in Jones et al. (2021) study, participants who attended SOGICE were two and a half times more likely to think about suicide, plan suicide and nearly four times more likely to attempt suicide than those who did not attend. Chan et al. (2022) reported that those who were exposed to SOCE developed shame, guilt, self-hatred and showed higher levels of internalised homonegativity. Exposure also disrupted their interpersonal relationships and sometimes impacted negatively on family relationships (Chan et al., 2022). Higher levels of internalised homophobia following exposure to SOCE was also reported by Ogunbajo et al. (2021). Salway et al. (2021) reported that the sexual minority men in their study reported more isolation and feeling left out as well reporting that they accessed mental health service services more often.

13 Another reanalysis of the same data was submitted to the same journal 'A re-analysis of data from Sullins, Rosik, and Santero (2021): are sexual orientation change efforts (SOCE) helpful for those who don't change? However this paper was rejected <https://f1000research.com/articles/11-580>

The qualitative papers offered some depth to the quantitative findings with the gay men in Earley et al.'s (2020) study describing how they were made to feel guilty about being gay which triggered anxiety. One person believed that his diagnosis of generalised anxiety disorder was related to SOCE. Taken together, the participants' experiences and the approaches that were used which were mostly shame based were perceived as unethical and harmful. Feeling of shame and guilt were also reported in Goodyear et al.'s (2021) paper where the participants experiences were described as damaging to their overall sense of wellbeing. The participants' experiences reinforced the feelings that they were broken and discredited their identities, making them feel like they didn't belong. Some of the participants felt that their later mental health difficulties were directly related to their exposure to SOGICE. DeWee's (2017) dissertation explores the issue of 'corrective' rape and recounts the experiences of four lesbians in South Africa. Although it is recognised as a practice that does exist it falls outside the strategies discussed generally. The trauma of the rape and the physical and psychological sequelae associated with this were exacerbated by discrimination and a general lacklustre response to their experiences, including not being believed and not being able to talk about their experiences or their identities. This led to symptoms of post-traumatic stress disorder, clinical depression, isolation and withdrawal, hopelessness, shame, anxiety, guilt, fear of being raped again, low self-esteem and self-blame. Jones et al (2022a) focuses on the harm that was caused from SOGICE that was religious based. While many of the harms have already been mentioned, the paper highlights the spiritual dimension where the participants relationships with their faith community were damaged. In addition, the faith that they had, which was important to them, created an internal conflict which often motivated them to seek out conversion practices.

Sullins' (2022) paper reanalyses data that was reported by Blosnich et al. (2020) which found that exposure to SOCE increased the odds of lifetime suicidal ideation, planning and attempts when compared to sexual minorities who were not exposed to SOCE. Criticisms of the Blosnich et al.'s (2020) paper raised by Rosik et al (2021) were refuted by the authors in their response (see Blosnich et al., 2021). Sullins' (2022) reanalysis argues that those exposed to SOCE were no more likely to be affected by increased levels of psychological distress including suicidality as most suicidal morbidity occurred prior to SOCE. However, in response Meyer and Blosnich (2022) argue that the reanalysis is misleading for several reasons. Sullins used data on the last exposure to SOCE when research typically shows that most people engage with SOCE multiple time making it difficult to ascertain if suicidal ideation or attempt preceded SOCE (Meyer & Blosnich, 2022). In addition, suicidality was measured one year prior to the study interview rather than lifetime suicidality. For these reasons, according to Meyer and Blosnich (2022), Sullins' (2022) reanalysis is misleading and the conclusions invalid.

3.5 Support Needs Following SOGICE

While support needs were mentioned briefly in a couple of papers (Earley et al., 2020; Veale et al., 2021), only Jones et al. (2022b) provides a description of the strategies that SOGIECE survivors used to support their recovery following exposure. The participants who had experienced religious based SOGIECE talked about how they needed time to recover and sometimes recovery took a long time

and was complicated by mental health difficulties. Strategies used included finding a support network that was affirmative and where formal approaches were used, professionals needed to be attuned to the needs of the participants as well as understanding why participants might have engaged with conversion practices in the first place. Furthermore, professionals needed to understand the role of faith in the participants lives.

3.6 Systematic reviews

While several systematic reviews and a discourse analysis have been conducted since the American Psychological Association's (2009) landmark work (Forsythe et al., 2022; Przeworski et al., 2021; Robinson & Spivey, 2019; Serovich et al., 2008; Wright et al., 2018), including Jowett et al's (2021) rapid evidence assessment, we have chosen to focus on two new reviews that were published in 2021 and 2022 (Forsythe et al., 2022; Przeworski et al., 2021). Forsythe et al.'s (2022) paper focuses on youth and sources 28 papers with over 190,000 participants. Twelve percent (range 7% - 23%) of the participants were exposed to SOGICE with a mean duration of 26 months. The analysis discovered that:

Relative to LGBTQ individuals who did not undergo SOGICE, those who did undergo SOGICE experienced severe consequences, including serious psychological distress (47% vs 34%), depression (65% vs 27%), problematic substance use (67% vs 50%), attempted suicide (58% vs 39%; odds ratio, 2.27 [95% CI, 1.60-3.24; $P < .001$]), and attempted suicide causing moderate or severe injury (67% higher odds; odds ratio, 1.67 [95% CI, 0.76-3.64]) (p497)

Forsythe et al. (2022) also estimated that in 2021, 508,892 youths were at risk of being exposed to SOGICE in the US, with the cost of SOGICE and associated harms totalling over nine billion dollars. Przeworski et al.'s (2021) review stretches back to the 1960s and includes 35 papers that explore the efficacy, harmful effects and ethical issues associated with SOCE. From a historical perspective, this review provides a timeline of how 'treatments' have changed over time and the effect that the move away from the medicalisation of homosexuality had on SOCE. For example, the earlier papers included in the review such as MacCulloch et al. (1965) and Fookes (1969) used approaches such as anticipatory avoidance learning and aversion therapy to achieve changes in sexual orientation suggesting that they were effective with little detail on how outcomes were measured. In terms of efficacy, many of the papers that reported changes in sexual orientation were methodologically flawed or conflate reported behavioural changes with changes in sexual orientation. Studies may report that participants abstained from same sex relationships or entered heterosexual relationships, which speaks more to suppression or resisting outcomes from SOCE rather than actual sexual orientation change. In addition, many of the studies recruited devoutly religious men who are more likely to report favourable changes and align their relationships with traditional religious interpretations of gender and sexuality (Przeworski et al., 2021).

The litany of psychological harms reported in the review have mostly been reported in the primary research papers already. However, there is some detail about how the SOCE practices fuelled internalised homonegativity, further damaging the participants self-esteem and increasing their sense of self-loathing. For example, some participants were told that gay men were promiscuous, could never be masculine and would eventually contract HIV and AIDS. Others reported being told that homosexuality was a mental illness and grouped them alongside paedophiles and other sexual deviants. In addition to the harm caused directly to the participants, families were also affected especially where participants had entered opposite sex relationships or marriages (Przeworski et al., 2021). The paper makes the point that because there is a large amount of data available which demonstrates that SOCE is ineffective and harmful, the practice is therefore unethical.

3.7 Grey Literature and other media

We were unsuccessful in finding any research literature that was published in Ireland. We searched Gay Community News (GCN) an Irish LGBTI+ interest magazine/newspaper which was first published in 1988. Hard copies were sourced from the TCD library and hand searched for articles that reported any lived experiences of SOCE or GICE. An investigation conducted in 2010 (issue 249) tells the experiences on one young gay man who attended a ‘Courage’ meeting undercover after seeing it advertised in an edition of Alive!¹⁴ magazine. Courage¹⁵, a religious organisation, is dedicated to helping those with ‘same sex attraction’ live chaste lives in keeping with Catholic interpretations of sexuality. The story references a book called ‘Coming Out Straight: Understanding and Healing Homosexual Wounds’ by Richard Cohen which was given to the reporter by way of an introduction to the group. The book carries familiar discredited psychoanalytical theories and stereotypes about the nature of masculinity while promoting harmful anti LGBTI+ rhetoric. The group meeting, held in Dublin, was spiritual but not compassionate and encouraged chastity, emphasising that gay men and lesbians were broken and could never find happiness (GCN, 2010).

In 2017, Hot Press an Irish music and current affairs magazine, ran a story about a gay man who had been exposed to conversion therapy in Portlaoise. The young man in the story (‘David’) had been tricked into visiting a faith/religious ‘healer’ by his conservative parents who were shocked and distressed when David had told them he was gay. David managed to record the conversation with the ‘healer’ where he was told that he could change his sexual orientation through prayer, confession and attending mass.¹⁶ David acknowledges the trauma of the incident but believed that his relative maturity and acceptance of his sexual orientation had given him some protection against additional stress. However, his experience further damaged his relationship with his parents and in the article, he talks about how similar situations could be much worse for individuals, especially young people, who may not have had an opportunity to process their feelings in an affirmative way. David’s mother had been referred to the faith healer through informal networks which explains in some part how

14 Alive! is a free catholic newspaper published monthly.

15 According to the Courage International website there are no chapters in Ireland <https://couragec.org/>

16 The healer in the story, when confronted about the incident, denied ever meeting David despite the recording.

these practices occur under the radar. Searches were also conducted in the Irish Times archive (1995-2022) and the Irish Newspapers Archive.¹⁷ While it is acknowledged that the searches we completed were rudimentary, much of the information that we gleaned were news, opinion pieces or discussed conversion therapy in other jurisdictions including Northern Ireland.¹⁸ A short documentary called 'Converted' made in 2018 was also reviewed¹⁹ where four people share their experience of conversion therapy in the context of SOCE. In this documentary some of the discredited theories about the 'causes' of homosexuality and some of the practices, including exorcism are presented. The film also features Mike Davidson from Core Issues Trust, a religious organization that supports people with 'unwanted same sex attraction'²⁰ and a person from Northern Ireland who has chosen celibacy because his Christian faith conflicts with his sexual orientation.

3.8 Summary Points from the Literature Review

- Current data about SOGICE in Ireland are anecdotal in nature and no empirical studies were in the literature.
- Sexual Orientation Change Efforts (SOCE) and Gender Identity Change Efforts (GICE) are the most common terms associated with conversion practices although the term 'conversion therapy' is used as well. The papers mostly discuss practices that aim to change sexual orientation and/or gender identity however in papers that are more supportive of SOCE the term 'unwanted same sex attraction' and 'sexual orientation distress' have been used. The term 'sexual attraction fluidity exploration in therapy' (SAFE-T) was also noted as an intervention to address these issues. The narrative associated with these terms is that sexual orientation can change or can be suppressed and that individuals who do not want to be gay or lesbian can and should be permitted to try. In addition, it may be also seen as an attempt to shift the narrative away from their relationship with conversion therapy, legitimising the practices which have been widely discredited. These practices tend to focus on people who are religious and seek to change their sexual orientation to align with religious interpretations of sexuality.
- Multiple definitions of SOGICE are presented and there is overlap in terms of what constitutes SOGICE. While changing an individual's sexual orientation or gender identity expression is the stated objective within many definitions, SOGICE includes practices which seek to deter, suppress, manage, discourage or avoid adoption of non-heterosexual sexual orientations and gender identities not assigned at birth.
- Most of the papers focus on sexual orientation change efforts and gay men are overrepresented in the studies. However, all sexual and gender minorities are vulnerable to SOGICE. Only three papers specifically focused on GICE. In some of the papers, analysis demonstrated that transgender, nonbinary, indigenous and ethnic minority individuals were more vulnerable to SOGICE exposure.

17 Contains 63 full text Irish Newspapers including Northern Ireland.

18 There is a feature in the Irish Times from 2019 which interviews Mike Davidson from Core Issues Trust which is based in Northern Ireland and advocates therapy for 'unwanted same sex attraction'.

19 <https://www.rte.ie/player/movie/converted-s1-e1/113693735989>

20 <https://www.core-issues.org/>

- The practices mentioned in the papers are generally a combination of religious, psychological, behavioural, and cognitive interventions that have been mostly described previously in the literature (see Jowett et al., 2021). The experiences of ‘corrective rape’ were documented in one dissertation and rape was also mentioned by Jones et al. (2022a). Kinitz et al., (2021) differentiates between different levels of SOGICE; heterosexism and cissexism which can occur in everyday interactions with a range of actors; SOGIECE which are overt but informal conversion practice such as prayer and other spiritual activities and conversion therapy which are formal approaches that can be administered by a health professional but often have a prayer or spiritual dimension to them as well.
- The research studies that were reviewed primarily examined the negative impact of SOGICE on people who were exposed to it. The literature adds to the growing body of evidence that finds SOGICE harmful and provides evidence of long-term harms. In the qualitative studies some of the participants were able to draw a line between their experiences of SOGICE and current mental health difficulties. One paper specifically focuses on the spiritual harm that was caused by exposure to SOGICE (Jones et al., 2022a). Most of the studies were quantitative and more qualitative studies are warranted.
- There is less emphasis on the efficacy of SOGICE across these papers (i.e., do SOGICE effect any change). Where there is mention that changes have occurred (i.e., moves towards heterosexuality), the papers are methodologically flawed. This point has been made previously in the reviews by both Jowett et al. (2021) and Przeworski et al. (2021) among others. For the most part SOGICE are discussed in the context of being discredited practices that are ineffective and harmful.
- Where consent was discussed, many of the participants indicated that they attended voluntarily. However, this was often in the context of implicit or explicit coercion placed on the participants from multiple sources. It was also in the context of a power imbalance where the participants felt they had no option but to attend or attended to avoid negative outcomes or where they had limited information. There are reports of individuals who were forced to attend or were administered conversion practices against their will. Many individuals sought out SOGICE themselves because their minority sexual orientation or gender identity conflicted with their religious beliefs.
- Only one paper explored the support needs of people who have experienced SOGICE and provides some detail about how the needs of people can be met through affirmative practices.



Chapter 4

Findings from the Survey and Individual Interviews

4.1 Overview of the study participants

In total 340 participants started the survey and many provided comments, but on subsequent analysis this reduced to 278 valid responses.²¹ An overview of the survey participants is provided in table 4.1. The majority of the participants were cisgender (n=182) with 27 indicating they were trans, and 35 identifying as nonbinary, genderqueer, agender or genderfluid.

The participants mean age was 37.9 years and they ranged from 18 to 77 years old. Just under 32% (n=89) said that they were gay with 18.6% (n=52) stating that they were lesbian. There were a sizable number of bisexual participants (22%; n=60) and just under 11% (n=30) stated that they were heterosexual. Fourteen participants indicated that they identified as intersex or have an intersex variation (n=14; 5.4%). Almost 64% (n=178) stated that they had no religion with just under 16% (n=43) stating that they were Roman Catholic. The remaining participants were either Church of Ireland, Presbyterian, Muslim or Orthodox Christian (n=25). Twenty eight participants selected 'other' with paganism the belief system most frequently referenced here.

Seven participants who were exposed to Sexual Orientation Change Efforts [SOCE] or Gender Identity Change Efforts [GICE] which occurred in Ireland (n=5) or in another country (n=2) volunteered to be interviewed. Given the small sample size, limited information is provided about the participants to ensure that their confidentiality is protected. A code is also used to identify the interviewers experiences [P1, P2 etc]. The participants mean age was 38 and the most recent exposure to SOGICE was three years ago for one of the participants with another participant ending his engagement with SOCE about five years ago. While the terms 'SOCE' or 'GICE' (collectively SOGICE) are used, the interview participants generally refer to the term 'conversion therapy'. The findings are supported by extracts from the survey open ended questions and interview transcripts. Extracts from the survey are labelled as 'Extract from survey comments' and extracts from the interview comments are labelled with the participant's code.

21 Some participants who consented did not answer any questions, several participants indicated that they were under the age of 18 and some people didn't answer the questions asked and used the space to provide commentary that was not the focus of the survey.

Table 4.1:
Overview of the survey participants

Demographic variables			
Age (N=277)	Mean 37.9	Range 18-77	SD 13.1
Gender Identity (N=278)	N %		
Woman	88 (31.7%)		
Man	94 (33.8%)		
Trans woman	17 (6.1%)		
Trans man	10 (3.6%)		
Nonbinary/genderqueer/agender/genderfluid	35 (12.6%)		
If you prefer to use your own term, please provide this here	24 (8.6%)		
Prefer not to say/don't know	10 (3.6%)		
Sexual Orientation (N=279)	N %		
Gay	89 (31.9%)		
Bisexual	60 (21.9%)		
Lesbian	52 (18.6%)		
Heterosexual/Straight	30 (10.8%)		
I prefer to use my own term	31 (11.1%)		
Prefer not to say/Unsure	16 (5.8%)		
Intersex or have an intersex variation	N % 14 (5.4%)		

Of the total sample (n=278), 70 (just over 25%) indicated they were offered SOGICE and 38 (13.7%) indicated that they were exposed to SOGICE. The characteristics of the participants who were offered and experienced SOGICE can be reviewed in table 4.2.

Table 4.2:
Overview of participants offered and exposed to SOGICE

Demographic variables of participants who were offered or experienced SOGICE			
Age	Mean	Range	SD
<i>Offered SOGICE (n=70)</i>	35.3 ²²	18-73	14.0
<i>Experienced SOGICE (n=38)</i>	38.5	18-73	14.4
Gender Identity	N %		
Woman			
<i>Offered SOGICE</i>	12 (17.1%)		
<i>Experienced SOGICE</i>	8 (21.1%)		
Man			
<i>Offered SOGICE</i>	24 (34.3%)		
<i>Experienced SOGICE</i>	13 (34.2%)		
Trans woman			
<i>Offered SOGICE</i>	5 (7.1%)		
<i>Experienced SOGICE</i>	5 (13.2%)		
Trans man			
<i>Offered SOGICE</i>	5 (7.1%)		
<i>Experienced SOGICE</i>	2 (5.3%)		
Nonbinary/genderqueer/agender/genderfluid			
<i>Offered SOGICE</i>	11 (15.7%)		
<i>Experienced SOGICE</i>	1 (2.6%)		
I prefer to use my own term			
<i>Offered SOGICE</i>	9 (12.9%)		
<i>Experienced SOGICE</i>	6 (15.8%)		
Prefer not to say/don't know			
<i>Offered SOGICE</i>	4 (5.7%)		
<i>Experienced SOGICE</i>	3 (7.9%)		
Intersex or have an intersex variation	N %		
<i>Offered SOGICE</i>	7 (10%)		
<i>Experienced SOGICE</i>	5 (13.2%)		

²² Based on n=69 as one participant did not provide their age.

Table 4.2:
Overview of participants offered and exposed to SOGICE (continued)

Sexual Orientation	N %
Gay	
<i>Offered SOGICE</i>	22 (31.4%)
<i>Experienced SOGICE</i>	12 (31.6%)
Bisexual	
<i>Offered SOGICE</i>	11 (15.8%)
<i>Experienced SOGICE</i>	5 (13.1%)
Lesbian	
<i>Offered SOGICE</i>	12 (17.1%)
<i>Experienced SOGICE</i>	7 (18.4%)
Heterosexual/Straight	
<i>Offered SOGICE</i>	8 (11.4%)
<i>Experienced SOGICE</i>	7 (18.4%)
I prefer to use my own term	
<i>Offered SOGICE</i>	12 (17.1%)
<i>Experienced SOGICE</i>	3 (7.9%)
Prefer not to say/don't know	
<i>Offered SOGICE</i>	5 (7.2%)
<i>Experienced SOGICE</i>	4 (10.6%)

4.2 Pathways to SOGICE, motivations for attending and consent.

Generally, there were four pathways to attending SOGICE for the participants; they were either offered it by somebody and then took up the offer, or they sought it out themselves. In addition, there were some participants who were exposed to it against their will or it emerged as part of a therapeutic process. Of the 70 participants who were offered SOGICE, parents and guardians or other family members were the most likely to offer SOGICE to the participants (Table 4.3).

Table 4.3:
Individual or organisation who offered SOGICE

Individual or Organisation who offered SOGICE	N
Parent, guardian or other family member	21
A Priest, Imam, rabbi or other religious minister	16
Faith organisation, group or charity	19
Healthcare provider or medical professional [e.g., counsellor, psychotherapist, psychiatrist, nurse, doctor]	19
A teacher	6
Person from the community where I live [e.g., friend or neighbour]	8
Prefer not to say	3
Other	6

In the interviews all the participant who engaged in sexual orientation change [SOCE] efforts actively pursued the process themselves and this happened following some form of consultation or meeting, most often with a faith leader. They were then either advised to contact a third party to discuss the process further or sought out people themselves. For example, P1 spoke to a religious leader who then provided a phone number which he rang and was given the contact details of another person who he eventually met for the sessions. In contrast, after discussing his sexual orientation with the leaders of the faith organisation he was a member of, P7 sought out individuals and groups who offered SOCE online or through the literature he was reading at the time.

Other participants suggested that it wasn't offered and that they had no choice, or they didn't know that they being exposed to SOGICE. In terms of gender identity change efforts, two contrasting experiences were described by the interview participants. P4 talked about their experiences of being intersex and trans. When they were born, the medical staff assigned their gender and performed a surgical operation to align physical appearance with the assigned gender. However, this assigned gender, did not correspond with their gender identity and P4 believed that this is a type of conversion therapy and one that continues to be practiced in Ireland and elsewhere. For P4, this has led to significant health problems. Despite knowing from an early age that their gender identity did not align with the one that was assigned at birth, P4 was not permitted to live in an authentic way and was severely punished by their parents when they expressed anything other than the gender that was assigned to them. Efforts to live in an authentic way were seen as P4 making a choice. These experiences were described as traumatic and had lasting impact on their mental health, resulting in suicidal thoughts and behaviour.

I grew up very much like Cinderella. While, ironically being punished for having female preferences. So choosing female clothing I would be bullied and beaten for and physically abused. So basically any of my preferences I tend to have pretty girly preferences I like girly [], I like, I own a lot of pink sparkly []. But, yeah, basically any of my choices, any of the things I wanted to do, any things that I drew, any things I would get punished for [P4]

P4 believed that there was a lot of shame and stigma attached to being intersex and this motivated them to try and act more masculine and to try and fit in which was reflective of the dominant heterosexist and cissexist attitudes that exist and which were experienced as oppressive. Another participant [P6] described how he acknowledged to himself that he was experiencing gender dysphoria when he was around 13 years old, although he did not have the language to describe this at that time. When he was 17 and attending a mental health service for reasons that were intertwined with his gender identity, he talked about his gender dysphoria and he describes his encounter in the following quotation:

And I was attending [] at the time. So [mental health professional] kind of brought me in there and I told them what was going on and I had thought, you know because there was like posters in the waiting room and whatever saying you know if you're transgender you know you can talk to us about it. And you know we support trans kids or something, I can't remember exactly what the poster said but I felt like that made me a bit safe. But the first thing that came out of the [mental health professional's] mouth was like you know are you sure this isn't just a fashion phase, and you will just grow out of this you know. And I kind of, that really put me into a sense of shock I suppose you know, yeah. [P6]

In the context of therapy or professional support, other participants also wrote about how they had attended therapy for a specific reason unrelated to their gender identity and believed that the therapist focused too much on this aspect of their lives, rather than their presenting issue. For example, one survey participant wrote how the therapy seemed to focus on the issue of trans identity rather than the issues at hand which was perceived as a warning sign that the therapist was not gender affirming. A similar thing happened to another survey participant who described a sense of being dismissed when, as part of therapy, they talked about being non-heterosexual and felt belittled when feelings about their gender identity were not taken seriously and explained as mental illness:

When I expressed that I didn't feel like the gender other people identified me as and expressed feelings of (what I now recognise as) dysphoria, they told me that what I described made no sense and wasn't possible, and that I must just be afraid of 'becoming an adult.' I felt so belittled I never mentioned it again to anyone for more than a decade. [Extract from survey comments]

For this participant, the therapist's lack of knowledge and expertise in LGBTI+ issues were seen as the root cause for the approach taken. It was also noted that the therapist was not consciously trying to change the person's gender identity. However, this was not everyone's perception and some participants ceased their interactions and sought out a more affirming therapist:

I cancelled upcoming sessions when I realised what the therapist's view of transgender identity was. I'm happy with my gender, I only went to therapy for depression and anxiety. [Extract from survey comments]

Similarly, in another example, a participant attended therapy for issues unrelated to their gender identity. However, the therapist focused on their gender identity, and asked questions about gender and gender inequality, and suggested that all trans people should attend therapy:

I went to one [a therapist]. There were two assessment sessions, one being focused fully on gender. I did not ask for this and didn't want help with my gender identity. I was asked for my birth name, my thoughts about gender inequality and a lot of general questions about gender. The therapist said that all trans people should get therapy and that their gender identity might change after therapy. [Extract from survey comments]

Other participants described resisting the offer of SOGICE even though they were not sure what it entailed. This sometimes happened in school where teachers spoke about counselling which would help the participants with their 'confusion'. This is highlighted in the following excerpt and the participants acknowledge the buffer that a supportive family provided:

I didn't accept the offer, and reported the incident to my Year Head, who said there wasn't much that could be done. It was clear that the purpose was to 'correct' my thinking as I was obviously 'confused' about 'admiring/looking up to' women v. finding them attractive. I knew how I felt was correct and not immoral or confused and was lucky enough to be raised in a family that is very queer friendly with a cousin and uncle who were out and accepted. [Extract from survey comments]

Another participant refused to attend SOCE as they were comfortable with their sexual orientation and knew that it wouldn't work. In a response to a request to attend a religious based approach a participant wrote that:

I said no and/or got angry, upset, scared. I felt unsafe and isolated. I think it has happened so often that I am numb to it a bit but it is a trauma especially when you're going about your day and don't expect it. [Extract from survey comments]

4.3 Motivations for attending

Thirteen (34.2%) of the survey participants stated that the purpose of attending SOGICE was to change their sexual orientation, with 10 (26.3%) stating that the purpose of attending was to change their gender identity. Seven participants (18.4%) stated that the reason they attended was to change both their sexual orientation and their gender identity. Five survey participants who stated that they were intersex or had an intersex variation were exposed to SOGICE. Of these one person stated that the purpose was to change their sexual orientation and another person stated that the purpose was to change both their sexual orientation and their gender identity. In the qualitative arm of the study, five of the interview participants attended for SOCE with two of the participants being exposed to GICE.

Table 4.4:
What was the purpose of the therapy, treatment or intervention?

What was the purpose of the therapy, treatment or intervention? (n=38)	N %
To change my sexual orientation	13 (34.2%)
To change my gender identity	10 (26.3%)
Both of the above	7 (18.4%)
Other	4 (10.6%)
Prefer not to say	1 (2.6%)
Did not respond	3 (7.9%)

Some of the participants were raised in an environment that was not LGBTI+ friendly and they themselves subscribed to the belief that they were somehow broken and needed to be ‘cured’ or ‘fixed’. This desperation to be ‘straight’ or heterosexual was often fuelled by the belief that their religious values and their ‘different’ sexual orientation or gender identity were incompatible. In the context of sexual orientation, when the participants were told that they could change their sexual orientation, it was often something that they wanted to hear. Furthermore, for the gay men in this study, their distress at being gay emerged from the strong heteronormative messages that they received while growing up and which were then amplified as part of religious services. While these messages were not necessarily homophobic, they emphasised the ‘traditional family’ and framed relationships outside this interpretation of the family as sinful. The spiritual language that was sometimes used provided a sort of legitimacy to the process especially for people of faith and might be hard to understand for a person who did not have this upbringing or background:

The environment that I was part of did not support a healthy view of LGBT people. We were seen as broken and needing healing. Because I accepted this view, I also accepted what others said would be good for me e.g. prayer, deliverance, counselling. I wouldn't say I consented because I felt compelled and had no choice. I was brought up to believe that you could not be gay and Christian and so any opportunity to not be gay was something that I actively pursued. [Extract from survey comments]

I accepted it at the time as I was desperate to not be gay. [Extract from survey comments]

She [therapist] used to talk about oh you know God has got you on an elastic band and you know he'll only let you go so far before that band will flip you back to him. And you know you can't ever, you know engage in anything that, the minute you have sex with a man you're kind of going to open up the door to more demonic possession and you know. It was really kind of very convincing stuff when you are a person of faith. I think if you're not a person of faith it would be hard to root any of this in other than maybe mental health and psychiatry or something. [P5]

In addition to the spiritual language that was used, people in positions of leadership including people who were perceived as mental health professionals²³ also spoke with authority about the practices as legitimate. In addition, 'success stories' were discussed which further motivated attendance:

You believed everything. I believed everything anyway. And then you see they say it but then you see if you read the likes of Nicolosi²⁴ we mentioned a minute ago when you read what they have to say that backs it up anyway so you are going well psychologists can see the same. So it gets very twisted together you know. [P7]

In the interviews four of the participants also talked about growing up in Ireland as part of a family where religion had varying levels of importance. For one such participant, the thought of being gay filled him with fear. While this was something that emerged from religious belief, he also associated being gay with weakness and emasculation:

I felt like the religious thing was important for me, it always was kind of part of my identity, you know growing up I was a good boy, you know God believing and all of that, not in a, probably in a way a bit more so than my family. But I was essentially distressed when I went to the priest and looking for kind of forgiveness you know. And to be told I wasn't going to hell which is what I had been kind of stressing and worrying about you know. [P1]

²³ It was not always clear if those who were providing conversion practices were licensed professionals.

²⁴ Joseph Nicolosi, founder and president of the National Association for Research and Therapy of Homosexuality (NARTH) advocated and practiced 'reparative therapy' a type of conversion therapy. Author of 'Reparative therapy of male homosexuality: A new clinical approach'.

For these reasons, he did not want to be gay and when he confided in a religious leader that he didn't want to be gay he was clear that he didn't want to attend a therapist that was just going to tell him to accept that he was gay:

And I do recall that I was very much against just going to someone who would tell me to accept my sexuality because that's not something that I felt I could do at that point in time, you know I was dealing with a lot of shame and self-loathing I guess you know around my sexual orientation. [P1]

P2 did not want to be gay either as it did not align with his faith and he also sought help from a religious leader. Likewise, when P3 discovered he was gay, he sought help from a religious leader when he realised that being gay was not compatible with the beliefs of the faith organisation he had joined, despite initially having accepted his sexual orientation. P5 was raised in a deeply religious household and was acutely aware that his sexual orientation had to align with his faith community or he risked rejection. P7 joined a religious organisation when he was twelve years old where there were very strict interpretations of religious texts and being gay was just not an option for him as part of this organisation. Religious norms were not just limited to heteronormative views on sexuality but also permeated every aspect of life with traditional conservative perceptions on the role of men and women within society. These views underpinned the participants' desires to be straight which would allow them to 'fit in':

But what I desperately wanted was to not be gay because to be gay meant that it was always a blockage between me and my faith and me and God and me and my Christian community which I was so entrenched in. [P5]

4.4 Agency over and consent to SOGICE

In the survey, participants were asked to consider their first experience with SOGICE and think about how much it was their own decision to seek it out. In response to this question, over half of the participants indicated that it was not their decision to seek out SOGICE (n=20; 52.6%) with most of the remaining participants indicating that they had some role in the decision making, ranging from completely their decision (n=5) to a little (n=12), with four participants not providing an answer (see table 4.5).

Table 4.5:
Decision to seek out SOGICE

Thinking of your FIRST experience with attempts to change your sexual orientation of gender identity, how much was it YOUR decision to seek SOGICE? (N=38)	N %
Not at all	20 (52.6%)
A little	2 (5.3%)
Somewhat	4 (10.5%)
Mostly	3 (7.9%)
Completely	5 (13.2%)
Prefer not to say	1 (2.6%)
Did not respond	3 (7.7%)

In the interviews five participants were clear that it was their decision to seek out SOCE with the remaining two stating that it happened without their request or consent. One participant reported that unbeknown to him and without his consent, he had been exposed to a religious ceremony that was intended to expel the ‘*evil spirits of homosexuality*’ that had possessed him. However, following this, he consented to attend a range of SOCE interventions which were motivated by his desire to align his sexual orientation with his religious beliefs. While the term consent is used here, it has to be considered in the context of the internal, societal and religious pressures to conform to a heteronormative view of sexuality that were exerted on the participant, by others who were sometimes in positions of power. This pressure also resulted in the person internalising this heteronormative script. Non-consensual practices were also discussed in the interviews and there were several responses in the survey that indicated that participants were coerced into it or that they attended against their will or without full knowledge of what was happening.

Didn't have much of a choice. [Extract from survey comments]

I was passive because well I was an innocent/naive 18 year old who was unsure of what was happening and what insinuations were being made about my sexuality to lead to a priest laying his hands on my head and praying. [Extract from survey comments]

I was brought to a faith healer/ ex man of priesthood in [location] to go to a counselling session and to be prayed with. I was not told where I was going- just brought on the 2.5 hour or so journey. [Extract from survey comments]

4.5 How long ago they attended SOGICE and conversion practices experienced

The participants mostly described being offered practices that were religious and practices that happened in the context of therapy or counselling.²⁵ Table 4.6 provides an overview of the individual or organisation who delivered the practice, type of therapy, intervention or treatment with religious organisation/individual (n=19) and health care provider (n=15) the main responses selected.

Table 4.6:
Individual or organisation who delivered SOGICE

Individual or organisation who delivered the practice, therapy, intervention, or treatment (n=38)	N
Healthcare provider or medical professional	15
Faith organisation, group or charity	10
A Priest, Imam, Rabbi, or other religious minister?	9
Parent, guardian or other family member	8
A teacher	2
Person from the community where I live [e.g., friend or neighbour]	2
Prefer not to say	2
Any other individual or organisation not listed above	3

Table 4.7:
How long ago did you undergo SOGICE

How long ago did you undergo SOGICE? (n=35)	N%
1-5 years ago	11
6-9 years ago	2
10 – 19 years ago	3
20-29 years ago	3
30-40 years ago	5
Still undergoing SOGICE	5 ²⁶
Prefer not to say	6

²⁵ One participant wrote that he had been forcibly given electro convulsive therapy (ECT) when he was 12 years old to change his sexual orientation and gender identity.

²⁶ Conflicts with a later response. Five participants indicated that they were still experiencing SOGICE, however in a later question, 2 participants indicated that they were still experiencing SOGICE [see table 4.8].

4.5.1 Experiences of attending SOGICE

For the interview participants who were exposed to sexual orientation change efforts, they detailed that their internalised homophobia and desire to be heterosexual provided motivation for continued engagement once they commenced the process. They were also told that their sexual orientation could change to align with their faith beliefs. In addition, being told that they could and should change their sexual orientation perpetuated their beliefs that it was wrong to be gay and further motivated their desire to change.

And I suppose because you see when, I mean I hope this doesn't sound like I'm blaming myself in any way, but you know I certainly was very clear that I didn't want to be gay. I mean I did have a lot of internalised homophobia. I think they played on that. [P7]

For two participants (P2 and P3), they were exposed to what can be described as SOGICE which was conversion therapy but delivered in a less formal way and revolved around prayer and spiritual ministry. P2 talked about the different prayers that he said, initially beginning with a formula prescribed by himself. However, as this was unsuccessful, he then moved to confiding in a religious leader who, although acting in a compassionate way, prescribed more prayer and devotions:

So I suppose my first thing was completely self-created and self-imposed conversion therapy of trying just different formulas of prayers and litanies and different devotions and things. Really just hoping that that would do it....but I was able then I suppose to utilise that skillset in finding I suppose a [religious leader] who I felt was sufficiently pious and spiritually powerful to take this gayness away from me but also being compassionate and gentle enough that I knew it would be treated in confidence. [P2]

This pattern of prayer and devotion continued over a period of 12 or 13 years. During that time, he was told by religious leaders that it was a phase he was going through and that it would pass:

And of course none of that works in terms of changing my innate personality or sexuality. They did have momentary effects in terms of celibacy but celibacy is not the same as changing what is, for me it's exactly the same as I love junk food and I cannot eat it, it doesn't mean I don't like KFC, I can go on a diet but. So it's the same thing in life, all diets come crashing down. It's the same really in terms of these conversion therapies. [P2]

P3's story shares similarities with P2 in that he was a member of a faith organisation for a long period of time and did not want to be gay for fear of being rejected by that organisation. He also sought support from a religious leader and was referred to another faith leader who had experience in this area. P3 attended two to three sessions with this person after an initial meeting where he had a

lengthy discussion about his family, his sexuality and other issues. As described, the sessions involved prayer and a 'spiritual practice':

I know there's kind of people had done maybe therapy, this was certainly more of a spiritual practice where there's kind of prayer used as a way to release something in you or to break a chain or to bring in the holy spirit or Jesus into your heart to make you better. [P3]

The faith leader explained to P3 that his 'same sex attraction' was the result of a generational sin or was a generational curse that had been passed on to him which could be resolved through ministry. As there were no changes in his sexual orientation, he stopped attending the sessions.

For the remaining participants, their exposure to SOCE comprised more formalised processes that combined religious and spiritual interventions and strategies influenced by psychotherapy to help modify behaviour and thought processes. These were delivered on a one-to-one basis or as part of a group. There were also retreats in other European countries which provided a more structured and intense experience on a residential basis. In the following quotation, P5 provides an overview of the processes that he engaged in which were mirrored by P1 and P7's experiences:

And I then discovered that there was this whole kind of like, you know therapeutic program that you could participate in that would see you straight at the end of it and so I did, I threw myself into that program. And it was a combination of kind of theology, psychobabble, psychotherapy, rooted in really strong beliefs about you know your sexuality being dysfunctional as a result of kind of various childhood experiences, whether its childhood trauma or you know dominant mother, weak father stuff. [P5]

P7 describes these approaches as 'pop-psychology' where the weak father figure and domineering mother were also floated as possible 'causes' of homosexuality. These ideas were reinforced and supplemented by the recommended reading:

The leader of the organisation came across this book called Homosexuality and Hope, by a Dutch psychiatrist called van den Aardweg. And he works on that basis that yes homosexuality is basically, that it's an immaturity, we haven't grown up in certain ways and it can be completely addressed and cured. And people can go on to live perfectly 'normal' excuse the expression, straight heterosexual married lives. So, they strongly recommended me to read it, now, it was a difficult read I remember it being a difficult read. Because it does imply that you are very deficient in many ways. [P7]

Other books that were mentioned were 'Setting Love in Order' by Mario Bergner; 'Healing the Homosexual' by Andy Comiskey; 'Crisis in Masculinity' and 'The Broken Image' both by Leanne Payne. These messages were absorbed by the participants who read them worsening the homonegativity that they were already experiencing.

The title was called the Broken Image, the idea was that you were split off from yourself in terms of your sexuality and that there's no such thing really as a healthy gay male, that in fact, somewhere along the line something went wrong somewhere in your development essentially. And that what you crave for in another man is what you lack in yourself or something, so for example your father didn't validate you or affirm you and that's why, that need, that legitimate need is then sexualised, you know in your development or whatever. Or your mother overpowered you and stuff like that. So you ran from the female into the arms of a male, this kind of stuff. [P1]

In the interviews, participants talked about how their sexual orientation was not perceived as an identity nor was there any emphasis on the relational, romantic or emotional aspects of sexual orientation. It was mainly seen as sexual behaviour and while different strategies and interventions were used, reductions in same sex activity and increases in heterosexual activity were viewed as measures of 'success'. This is explained by P2 and P7 in the following quotations:

And I've always thought it's really interesting in that it reduces your homosexuality or you being gay, you being lesbian, you being whatever to that act of penetrative sex with another man or. I think that cuts away so much of what it is to be gay and what it is to be straight, what it is to be lesbian or so many other layers of our identities [P2]

I feel as well that because of the exposure to the organisation it made, it, it made my sex life something very dirty. And being gay was very much linked completely to what I did in bed. It had actually nothing to do with any other form of sexually identity that could exist. So, it gave me a very poor perception of myself, of other men and vis-à-vis that you could have a relationship with another man. That you could have a loving fulfilling relationship. [P7]

The participants were advised not to think about their sexual orientation, and it was perceived as something that they could suppress or change by engaging in masculine activities. The participants were told that these approaches would work once they were committed to them which further reinforced the need for them to change and not engage in homosexual thoughts or activities:

I was told to try not to think about, yeah like sexual images or thoughts of men and things like that and to, you know not look at porn you know.I was encouraged to go for pints with my dad and talk about sports and you know to find something like that in common. I was encouraged to act like those that I respected in terms of being masculine and stuff like that. So, I remember like, or the idea that you were attracted to these people because you wanted to be them. So, I remember like I was encouraged to like, oh if you're attracted to like rugby players or I bought myself an Irish rugby jersey and stuff like this and you know was going around trying to be more masculine. [P1]

Participants were also told not to identify as gay because the perception was that they were not gay but had ‘same sex attraction’ which perhaps further served to pathologize their sexual orientation and perpetuate that it could be ‘cured’:

And there was a period of time in my early, very early 20s, I was probably about 21 or 22 and you know a lot of the focus of the therapy that I was involved in at the time really was like cognitive behavioural therapy, like behaviour management. And one of the things that the therapist talked to me about was not identifying, don't use the identity of gay, so you need to tell people that you're heterosexual, you're straight. And so I went through this phase of, I don't know why but I was telling everybody I was straight, oh yeah I'm straight. [P5]

[same sex attraction] which is the big phrase, because we are not gay, the gay doesn't exist. But people have same sex attraction. [P7]

For the participants who attended SOCE retreats, the activities here were more or less the same, with one participant describing how physical work was also incorporated into the activities as part of the process.

I went then to [] to do courses in the place where they are [faith organisation], which is all prayer, working in the fields, playing sports, building up your masculine side, all that kind of stuff. [P7]

P7 also talked about a psychiatrist, who was ‘heavily involved’ with the organisation who ran the retreats that he attended abroad. P7 started to see the psychiatrist as part of the SOCE and was prescribed psychotropic medications which impacted negatively on his ability to carry out everyday tasks and activities. P7 was also provided with a diagnosis which not only served to pathologize his sexual orientation but some of the side effects of the drugs reduced libido which he believes may have been their primary purpose in terms of why they were prescribed:

And he began to prescribe medication, initially it was things like the [drug name] that kind of you know relatively, antidepressants. But what I didn't realise, well what I now suspect is that the real reason I was being given these was because they are libido suppressants. It had nothing to do with their properties for any form of depression or any form of anything else. [P7]

P1's experience abroad was a little different as he attended a group session one evening a week in a European suburb while he was on university placement in that country. While the group processes were similar to what he had experienced in Ireland and the members were mostly there to change their sexual orientation, he made the following observation:

I do recall there was a guy in the group who shared with us, he was an [nationality] guy and he shared with us that he was there because he had abused or interfered with a child, you know. And I remember just thinking Christ am I that, am I in that category you know that kind of way. So that's kind of the category you were lumped in with of the broken and fallen because of course homosexuality would be equated with paedophilia and vice versa and stuff like that. [P1]

Four of the five interview participants who were exposed to SOCE were also encouraged to enter into a heterosexual relationship. P2 had convinced himself that he was in some part bisexual and that marriage may allow him to tap into that 'side' of his sexual orientation, so he followed the advice that was given from faith leaders and got married. However, marriage confirmed that he wasn't bisexual, and the marriage ended in divorce, a source of great distress and guilt for him. Some reported that they were told that heterosexual activity would help bring an end to the same sex attraction 'phase' that they were going through or that it would help 'shift' their sexual orientation to heterosexual. While two participants' heterosexual relationships were short lived, two got married with negative consequences for the participants, their spouses and for one his children. The rationale for entering a heterosexual relationship as advocated by the faith organisation is detailed in the following quotation:

And their advice to me was eh...not to enter the priesthood, but to find a girl and get married. That I could be cured of this. And it was completely possible to cure, change is possible. And I could be cured and the way to make me cured is to get married. I remember they were very clear on things like we'll say your libido is, my libido has been moved wrong that there's a right way for your libido to be and a wrong way. And every time I sin with another man, I'm putting my libido on a wrong track. And the best or most effective way to counteract that is to get married.[P7]

4.6 Impact of attending SOGICE

Table 4.8 outlines the survey results of those who attended SOGICE. While one person suggested that it worked for them, generally the participants stated that it didn't work for them with two participants stating that they were still undergoing it. Nine people stated that they were either unsure, preferred not to say or did not respond.

Table 4.8:
Result of undergoing SOGICE

What, if anything was the result of undergoing the attempts to change your sexual orientation or gender identity?	N %
It did not work for me and I do not believe it works for others	22 (57.9%)
Prefer not to say/Did not respond	6 (15.8)%
Not sure	3(7.9%)
It seemed to work for a while and then wore off	2 (5.3%)
It did not work for me but I do believe it does work for others	2(5.3%)
I am still undergoing it	2 (5.3%)
It worked completely	1 (2.6%)

The one person who stated that SOGICE worked completely stated that they had been provided with SOCE from a health care professional 19 years ago and that it had taken them away from ‘a toxic lifestyle’ and that they were ‘happily married now’. All the people who were interviewed stated that their exposure to SOCE was ineffective. Those who were committed to engaging with the processes suggested that while they were able to suppress their sexual orientation from a behavioural perspective in the short term, they were clear that there was no change to their sexual orientation.

4.7.1 Harmful effects of SOGICE

Most participants in the survey stated that their experiences of SOGICE were not useful and caused considerable distress. Some mentioned that they thought it was useful initially as they believed that they were working towards their goals of being heterosexual. One person stated that their exposure to SOGICE supported them to live their lives in line with their religious beliefs about sexual orientation. There were also some references to it being useful having someone to talk to about the difficulties they had with their sexual orientation or gender identity although these comments were in the minority. However as one person stated in the survey:

It served as a maladaptive coping mechanism that allowed me to believe I was working on myself without ever facing my real problems. [Extract from survey comments]

Overall, the participants wrote about the negative psychological effects of SOGICE using words such as ‘traumatising’, ‘destructive’, ‘anxiety provoking’, ‘horrendous’, ‘harmful’ and ‘damaging’. It not only affected the individual but also sometimes damaged their relationships with their family. It made them feel guilty about who they were and there were references to long term effects, ultimately delaying the self-acceptance that they needed. It also worsened the shame that they felt about themselves and there were references to self-hate and self-loathing. Exposure to SOGICE reinforced the belief that there was something wrong with the participants and as a result had adverse effects on their mental health. For some participants, it left them feeling isolated and alone. One participant wrote about how it was the worst time of their life. Other negative experiences are also detailed in the following excerpts from the survey:

It was the worst time of my life, I kept thinking that there was something wrong with me and every time I had thoughts that were not according to the religion’s point of view I would pray that it would go away and I would be “normal”. [Extract from survey comments]

Guilt, stifling. I spent two years after it trying to actually accept the truth and myself. It also affected my perceptions of my parents, my trust in them, and my relationship with them. [Extract from survey comments]

I attempted suicide, on multiple occasions. Ran away from home and eventually moved country. [Extract from survey comments]

It left me with trauma, from which I am still attempting to heal, it destroyed my self-worth, my sense of self and my health. [Extract from survey comments]

Being a maladaptive coping mechanism, I remained desperately uncomfortable in my skin and incapable of expressing my feelings to other people. [Extract from survey comments]

It was an horrendous experience and what was told to me about my being a lesbian was wrong and damaging to me. [Extract from survey comments]

One participant wrote about the long-term effects of being exposed to SOGICE and the host of mental health difficulties that it caused. The impact it had on another participant’s education and health is also mentioned while another participant wrote about how they still struggle to accept themselves and their sexuality:

It destroyed my mental health, self-esteem and self-efficacy, leaving me with a host of mental disorders that have to date proven untreatable by conventional means. [Extract from survey comments]

My education and my health suffered due to my high levels of stress. [Extract from survey comments]

I still struggle with accepting myself and my sexuality. [Extract from survey comments]

While there was recognition that SOGICE did not or would not work and that you couldn't 'pray the gay away', participants also reported feeling guilty when they couldn't achieve the standards that were set for them. Some participants, struggled to live the life that their respective faith mandated and, in some ways, the SOCE set them up to fail by creating standards of behaviour that were unachievable and went against their core feelings:

When I inevitably had gay sex, or watched gay porn, or masturbated whilst thinking about men again, it would increase the feelings of failure, inadequacy and uncleanliness. [Extract from survey comments]

And you know obviously, you know when I look back on it now I think when you're immersed in that it's so convincing that you underestimate the harmful impact it has on you and your mental health. Because effectively what you're doing is setting yourself up to just fail all the time. [P5]

For some of the trans participants, exposure to GICE also had harmful consequences with one participant writing about how it increased their dysphoria while for another it delayed them accessing the health care that they required ultimately affecting their mental health as well as relationships with family members.

Increased my dysphoria. [Extract from survey comments]

They prevented me from accessing the proper channels to undergo transition at the time, they worsened my mental health, they discouraged my mother from referring to me by my chosen name and pronouns and made subversive comments about my appearance, identity and personality. [Extract from survey comments]

A couple of participants also indicated that their negative interactions with health services influenced their decisions to open up about their gender identity or to engage with health professionals in the future. For one participant, they found their interaction with the health services anxiety provoking, and that they felt that they had to prove themselves in order to access the health care that they required:

It provokes immediate scepticism in your identity instilling an immediate anxiety. You are led to believe that you must prove your identity to some unknown third party to be provided health care. The psychotherapy care in Ireland is barbaric. [Extract from survey comments]

Two participants specifically mentioned the impact their engagement with SOGICE had on their relationships with their faith community. For these participants whose faith was very important to them, their engagement with SOCE and the fact that it didn't work despite their commitment to it had a further negative effect on their mental health:

It compounded the fact that there was something wrong [with] me and led me to feeling unworthy, ashamed, unable to live a full Christian life, impacted on my relationship with others. [Extract from survey comments]

Whilst I feel I have now come to terms with my sexuality, the process has left deep scars - despite still believing in my faith, I do not pray or fast anymore because of a subconscious feeling of uncleanness, especially now that I live with my same-sex partner, it feels like the space is "polluted" and unfit for prayer or religious activities - to avoid my mental health spiralling I therefore avoid religious activities to avoid this feeling and the thought processes it provokes. [Extract from survey comments]

For the participants who were exposed to SOCE who attended for interview, especially those who had experienced more formal approaches, they talked in detail about the harm that it caused. All of the participants had internalised negative perceptions of being gay which caused them distress. For those who engaged in more formal approaches, interaction with SOCE worsened this distress by amplifying their beliefs about being 'broken'. The participants desperately wanted to be heterosexual and the messages that they received that they were 'not whole' or 'broken' and needed to be fixed were absorbed and assimilated and often fuelled their immersion in the conversion practices which were provided.

For two of the participants, SOCE led to a cycle of despair where periods of abstinence culminated in same sex activity which not only perpetuated the feeling that they were 'broken' but exacerbated feelings of guilt and shame for not being able to change or control their sexual orientation:

There was also the cycle I should say of you know, probably last 6 months right where, until I would go again and hook up with somebody and be back in the cycle of kind of guilt and shame and then back in repenting for being back in the same place again, just you know. So I'd say that's pretty much how it happened. You know I could get as far as 6 months probably and then I would sin again. [P1]

For P1, his anxiety about being gay and feelings of guilt and shame were worsened by SOCE and continue to the present day even though his experiences happened about 20 years ago. He also suggests that his college grades were negatively impacted at the time and that he was on a path towards clinical depression at the point when he disengaged from the process. However, when triggered by a distressing event, he continues to experience those internalised negative beliefs and similar feelings:

I think how it has affected me is at times, if I'm triggered, you know depression is triggered through stress or something like that, I go back into a dark place about all this stuff you know in a big way. All those messages, negative messages are still there. The stuff I absorbed, the kind of false beliefs and things, like I just believe the [] a lot more, a lot more than I do when I'm well and when I'm fine. So that's primarily the impact, the lasting impact of it as well as it is kind of, those beliefs and things that I just absorbed at that young and vulnerable age kind of erupt when I'm not in a good place in terms of my mood, you know. So that's something I've worked a lot on to try and kind of dislodge that and stuff like that. So that would be I think the primary impact, the kind of legacy impact of it. [P1]

P5 describes leading a double life while externally committing to the SOCE process and talking about his success living with 'same sex attraction'. However, internally he described himself as 'crumbling' and talked about his mental health being eroded which caused significant harm. P5 goes on to state that he was lucky as he recognised the harm that SOCE was having on his mental health and was able to 'get out' before it propelled him into a cycle of depression. P7 also talked about leading a double life which he described as a 'real life and a false life':

The saddest bit of what happens in conversion therapy is it pushes people into a closet, as far back as you can go. And you know in any which way erodes you, whether it erodes you through your own behaviour and you live this kind of double life, double standards that you say one thing but you live another way. For other people it has an impact on mental health. For other people you know it compounds loneliness. There's nothing healthy about conversion therapy, nothing you know there isn't. And the people that tell you that there is, they're lying, because I used to be one of those liars that would say oh yeah God is really working in my life. And you know he's really helping me stay celibate. But underneath it all I was crumbling, you know. [P5]

You know suicide wasn't something that I had ever kind of considered as a youngster but now suddenly I found myself thinking what's life worth, why is it, you know why is it worth living. [P5]

I felt I was living a real life and a false life. The problem was the life I thought was the false life was the real life, and the life I had was the false life. So I could never get it right because I was living two lives and I didn't identify which one was the real life. [P7]

For P7, his immersion into the process was exacerbated by the fact that he was married and had a family and he felt that he was unable to leave it for fear of the negative consequence that might impact them. While he was acutely aware of the harms it had on him personally, getting married and starting a family resulted in further feelings of helplessness and hopelessness that bound him tighter to the conversion practices fuelling his desire for them to 'work' despite all evidence to the contrary.

I felt that that was very difficult and then the other thing that was very difficult was that as the children started to come there was a sense in me of well this is it, I can't do anything now, I am responsible for these poor innocent beings. That have done nothing wrong. I have made my bed I have to lie in it. But there was an awful lot of pressure because I didn't know how I should act, and I was very conscious that I'd act as a good male role model to my children. That I'd be a good father, that I'd be a good husband. [P7]

Within this religious organisation, P7 talked about how there was a lot of open discussion about his sexuality and his sex life and this furthered his desire to be heterosexual and to seek out SOCE. His sense of responsibility to his family not only prolonged his engagement with SOCE which was also set in the context of preventing or minimising harm to his wife and children. Outside of the religious organisation he was a member of P7 was advised to seek out more healthy expressions of sexuality with other men. However, as this was not acceptable to his faith community, it was not seen as a viable option for him at that point.

P4 talked about the impact of their experiences and how they impacted negatively on every part of their life. These are related to both their experience of being intersex and trans with both physical and mental health challenges worsened by the lack of expertise and the difficulties associated with accessing specialist care. In addition, almost daily encounters with transphobia and the associated verbal and sometimes physical aggression was perceived as traumatic. Furthermore, transphobia also resulted in difficulties getting employment and accommodation adding further challenges:

I mean it's tough, I mean there's a lot of you know I look around and I think about a lot of even BS jobs I won't get because they want to hire someone they can talk about soccer with and somebody who, one of the reasons things are terrible people hire the people who will fit in with their culture rather than people who can do the job. I'm capable of doing a lot of things, I've run my own businesses for years, I'm capable of doing a lot of things. But I think I will be, especially with rising transphobia and that pushes me back. [P4]

P6's experiences of attempting to talk about his gender dysphoria with a mental health professional left him feeling alone, isolated and a feeling of being dismissed. This was experienced as a setback, delaying his access to appropriate care and making him feel hopeless for the future. These feelings were worsened by the fact that it was a person with authority who had suggested that it was a phase he was going through:

And I got like really depressed after that, like I wouldn't come out of my bed or anything, I couldn't do anything because I just felt so hopeless. Yeah and I just know that like, yeah whenever I tried to bring it up or tried to talk about you know pronouns or anything it would just get immediately shut down or like I was being told that I was taking it too fast or that you know, that I'd grow out of it I suppose you

know. Yeah and I suppose like the fact that the people that I was talking to, like an authority over me, that added a bit more pressure for me to, you know accept what they were telling me rather than going with my own thoughts and feelings I suppose.
[P6]

4.8 Support needs

The participants who attended SOCE voluntarily accessed support in a number of ways. This occurred in the context of recognising that their experiences were harming their mental health and that disengagement from SOCE was necessary for their recovery. In addition, accepting that their sexual orientation could not be changed provided a critical juncture which facilitated a healthier way to perceive their sexual orientation. Positive role models were important while seeing and meeting other gay men who were comfortable with their sexuality provided an opportunity for them to reflect on the accuracy of the negative images that had been presented and internalised. Recognition that their experiences had been harmful to their mental health and accessing formal and legitimate sources of support such as psychotherapy, were necessary for some. Formal supports that were affirming of the participants were essential and these relationships were often prolonged. Time was also perceived as healing with the participants able to look back on their experiences, often using humour, which demonstrated their resilience. The participants often expressed incredulity that they went along with the processes and that they believed what they were told not just about their sexual orientation but that the approaches that were recommended would work to change their sexual orientation. This perhaps speaks to a point that was made earlier by P5 where people of faith believe that religion can directly intervene, or that they must adhere to religious interpretations of sexuality and gender in order to achieve salvation. In addition, P5 talked about professionals working with people harmed by conversion practices needing to be aware of the relationship that the person may have with their religion and also how important faith is to them.

P4 talked about the lack of gender affirming care available and the challenges associated with being able to access this care where it is available. This they believe is a part of a systemic failure to meet the mental health needs generally, not just of trans people, but of other minority groups as well. P4's experience of being intersex has also led to multiple health problems but they believe that there is a lack of expertise specific to this area and while they acknowledge that their experience is unique, accessing gender affirming, specialist mental and general health care is a challenge.

But the whole system is designed to bully you back into the [] closet. When you meet a medical professional one very often you are looked down on as well they are the expert. But very rarely have any knowledge of intersex whatsoever but they still take this position that they are the all-knowing expert. [P4]

P6 who was a minor when he encountered his experience, talked about the importance of health professionals listening to people and acknowledging their feelings as valid. Knowledge of trans issues is important and recognising that non affirming interactions can be interpreted as discrediting and ultimately harmful. P6 recognised that accessing specialist, gender affirming care is also a challenge and that there is a lack of availability in Ireland. However within the context of therapy, being able to direct the discussion himself and being allowed to talk about his identity, and perhaps even explore social transitioning could have made his experience more positive:

Tell me that it was ok I suppose in the first place. And allowed me to kind of direct myself in exploring like even transitioning socially, you know because it didn't even have to be medical or anything, you know just to allow me to you know direct myself, to make my own decisions around what my identity was. But I felt like any time I tried to make an assertion like that it was shut down pretty quickly. [P6]

4.9 Participants' views on banning SOGICE

As part of the interviews the participants were asked about their views on banning SOGICE. P1, while he was clear that SOCE didn't work and caused harm, was unsure if he supported a general ban, although he supported a ban for minors. This was in the context of civil liberties and whether the government could stop adults from trying to change their sexual orientation, even though it was a discredited practice. Similarly, P2 also agreed that SOGICE didn't work but was concerned that a ban might affect religious freedom and that there needs to be space for people to talk to their faith leaders in a compassionate, non-intrusive way when they are concerned about how their minority sexual orientation or gender identity conflicts with their faith. However, P2 was clear that while this was the approach that he took, it was a specific journey that he was on at that time it was not for everyone, and a balance needed to be struck:

And I think maybe if there was non-directive and non-intrusive just space for faith leaders maybe to explore, maybe that's the balance to be struck, I don't know. For other people, look if you are genuinely bisexual and can sustain a relationship with a woman, maybe that's a better option than going down the route of tearing yourself apart with religious guilt like I have. I don't know, I was never in that position. For me I know it didn't work but I know it was part of my journey and I think it's difficult to kind of place myself back there but if at 18 the government would have been telling me I had to be gay and I wasn't entitled to kind of exercise my religious right to seek help, to pray it away, maybe I'd have just viewed that as huge western conspiracy to destroy, I don't know. [P2]

P3 supports the ban even though he was not exposed to the 'therapy' side of conversion practices. Despite this, he raised the question of how it might be implemented and monitored within the context of how he was exposed to it:

Oh I think it's good, yeah, I think it would be really important. I think, yeah I think, like I know I haven't experienced the kind of counselling side, just pure counselling side. And you know, I know I attended more of the religious kind of practice of it, like a spiritual, the more prayer-based aspect of it. Like with regulations, how do you kind of say what's, you know is it to ban it outright or other things, how do you kind of measure that. But I think I do really support it. [P3]

P4 was adamant that SOGICE needs to be banned in all shapes and forms. She spoke about the fact that therapists and other professionals are in a position of power and when they speak with authority about sexual orientation and gender identity, they are very influential to both the client and their families where the client is a minor. This becomes problematic if they lack expertise, especially about issues around gender identity. P4 argues that therapists and other professionals who suggest that individuals are going through a phase or who undermine the individuals' perspectives will cause additional harm to an already vulnerable group. While it will be hard to police what happens in people's homes, banning SOGICE will send a strong message that it doesn't work and that it is not tolerated. In addition, P4 believes that there needs to be better understanding generally, and within the helping professionals about the range of practices that constitute conversion practices and that telling someone they are confused about their gender identity is a form of conversion therapy, which she refers to as 'conversion therapy lite':

One it needs to be banned, it just needs to be banned in all its forms outright as long as it isn't it sends a message that conversion therapy lite can exist everywhere else... good parents are bringing their kids to see a therapist. And then when they do, they are meeting this [] person who's like look they've got the authority of a therapist and they are like look I teach [name of course] I know for a fact that your child is just [] confused. That's conversion therapy. [P4]

P5 was also very clear that it should be banned and that any professional should not be permitted to provide or advise SOGICE. Like P4, he believes that this would also send a message more generally that individuals with minority sexual orientation and gender identity do not need to be changed because there is nothing wrong with them. In addition, there needs to be more awareness of the harmful effects that SOGICE has on those exposed to it. Furthermore, for faith communities, he detailed that pastoral care needs to be about supporting people and working through the struggles they have with their sexuality or gender identity. He believes that there needs to be a clear line drawn between what is pastoral support and what is abusive and a legislative ban on SOGICE will support the narrative that people's sexual orientation or gender identity can't be or shouldn't be changed regardless of the context:

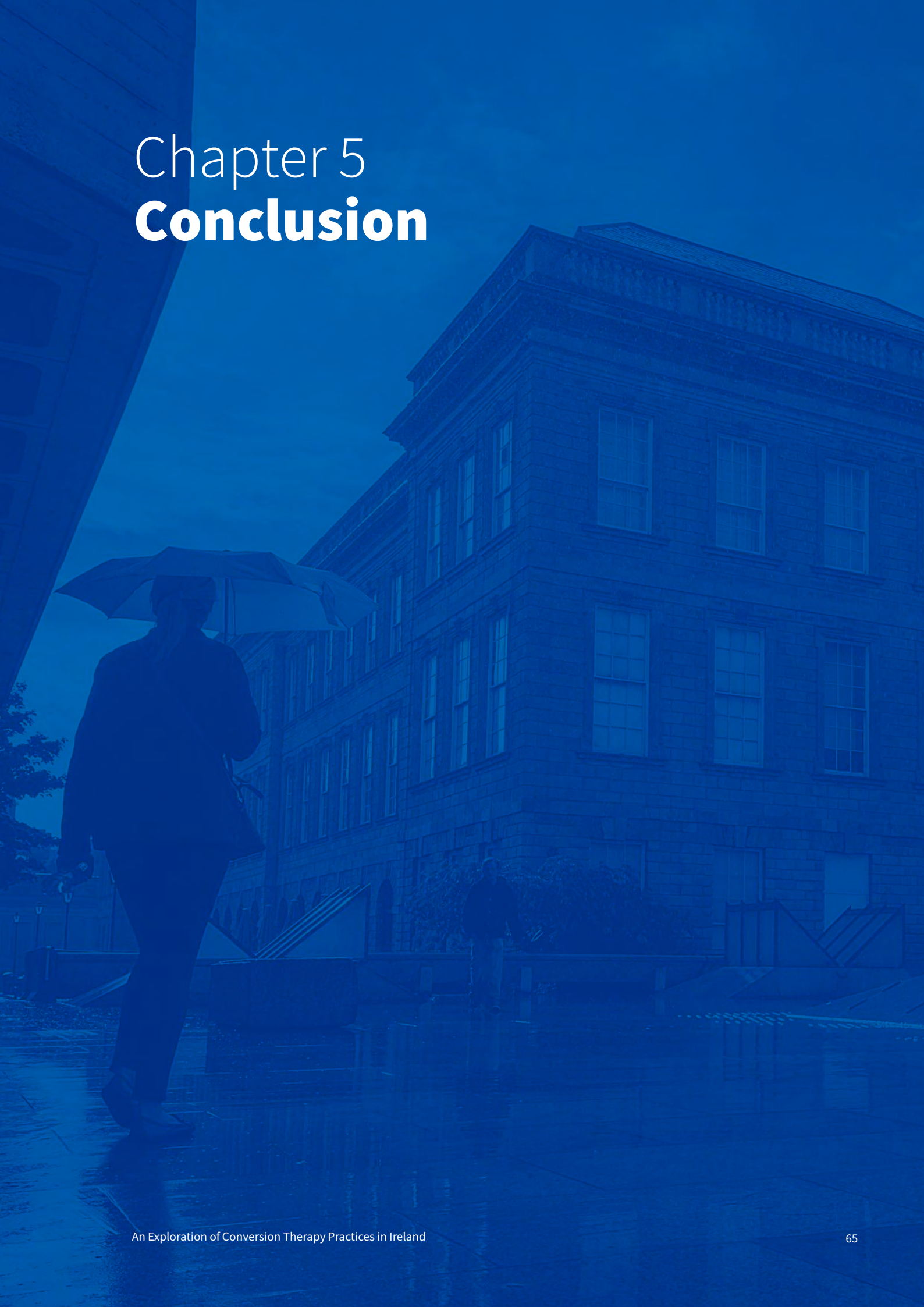
So yeah, so I think that you know I'm very keen to see conversion therapy banned because I think that you know we shouldn't convolute faith and spirituality and mentoring as an excuse for you know imposing harmful practices on people either through counselling or prayer ministry or you know whatever the experience is.

Because pastoral support shouldn't be about wanting to change somebody, pastoral support should be about listening to somebody's struggles and then providing them with you know support and space to say well these are your options. [P5]

P6 was not sure if what he experienced could be described as conversion therapy but generally supports the ban on SOGICE. When asked the same question, P7 supported the ban because he was clear that conversion practices were damaging and had damaged him. However, he acknowledged that he had some reservations which are outlined in next quotation:

I would support the ban in the sense that I can... I can see the damage that it caused to me.....and I just would be sometimes worried if this, I don't know if this is a fair thing to say but I would be worried that the ban on conversion therapy would not enable us to maybe ask questions of ourselves as a group of gay people. I'm aware I'm making sweeping generalisation here but what I'm trying to say is I'd be just afraid that I would be slightly afraid that such a, I think it has to be absolutely banned, do not get me wrong. But I would just be afraid that banning it might ban any conversation that could be had. [P7]

P7 also talked about the role of the church in terms of speaking out against conversion therapy that occurs in the context of religious beliefs. Organisations that exist under the auspices of formal church networks and who advocate and encourage conversion practices should not be permitted to operate.

A blue-tinted photograph of a person walking on a wet street, holding an umbrella. The person is in the foreground, walking away from the camera. In the background, there is a large, multi-story building with many windows. The street is wet and reflects the light. The overall mood is somber and reflective.

Chapter 5

Conclusion

5.1 Introduction

The aim of this study was to explore the practice of conversion therapy in Ireland. Specifically the study sought to establish:

- a definition of conversion therapy and conversion practices as they operate in Ireland (including what conversion practices are used, what signifiers are used and how people consent or assent);
- who is subjected to conversion practices (minority sexual orientation/minority gender identity);
- if there are longer term consequence of such practices for the individual;
- if there are any support needs for people who have been subjected to conversion therapy.

Data was collected from a systematic literature review, a cross sectional survey and individual semi-structured interviews. Twenty three research papers were included in the systematic review, 278 respondents completed the survey and seven individual in-depth interviews were completed. The survey established that 70 respondents reported that they were offered conversion therapy and 38 respondents reported that they experienced conversion therapy. Summary responses to the research objectives can be reviewed in table 5.1.

Table 5.1:
Summary findings addressing research question

Research Question	Response
Definition of conversion therapy.	Within the research literature there are moves to use the terms Sexual Orientation Change Efforts [SOCE] and Gender Identity Changes Efforts [GICE] often combined as SOGICE. The participants in this study used the term conversion therapy to describe their experiences and generally meant it as religious or professional attempts to change or modify minority sexual orientation or gender identity.
What conversion practices are used?	In the context of SOCE the findings suggest that a combination of cognitive, behavioural, psychoanalytical and religious/spiritual methods are used which focus on reducing same sexual behaviour. Corresponding increases in heterosexual behaviour were signifiers of 'success'. In terms of GICE, the findings suggest that similar strategies are used although interactions with therapists who created barriers to gender affirming care or closed down discussions about gender identity were interpreted as a form of conversion therapy. One participant who identified as trans and intersex argued that the surgery that she had to assign gender when she was born was a form of conversion therapy.

Table 5.1:
Summary findings addressing research question (continued)

Research Question	Response
Consent and assent.	The five gay men who were interviewed were clear that they voluntarily accessed and sourced SOCE themselves although this needs to be taken in the context of the internal, religious and societal pressures that encouraged them to seek conversion therapy in the first place. In the survey, the majority of the participants stated that they did not provide consent and in some cases there were indications that it was provided against the participants will. Five of the seven trans participants indicated that they did not provide consent.
Who is subjected to conversion practices?	Individuals with minority sexual orientation and minority gender identity were exposed to conversion practices in this study. Individuals who identified as intersex and trans or non-binary were also exposed to conversion practices.
If there are longer term consequence of such practices.	For both the survey and interview participants there were both short and long term harmful consequences for those exposed. These harms were marked and enduring for those participants who had been exposed to formal practices over a longer timeframe to the extent that some had not resolved some of the issues at the time of interview. These harms extended to spouses and children where participants had been encouraged to marry. The combined evidence from the literature and the study is clear that conversion practices pose a significant risk to mental health. In addition, conversion practices delay acceptance of sexual orientation or gender identity. For people of faith, the lack of 'success' may worsen guilt and perpetuate internalised homophobia or transphobia.
Support needs for people who have been subjected to conversion therapy.	There was limited discussion about support needs within the literature with only one paper specifically looking at the area. In this study, those who were adversely affected by conversion practices resolved their distress by navigating informal and formal supports. Recovery was contingent on recognising that mental health had been affected and where necessary sourcing therapy that affirmed their sexual orientation or gender identity was accessed. For some, accessing an LGBTI+ affirmative church or faith based organisation was also central to recovery.

5.2 Discussion and implications

Conversion therapy has been typically referred to as any intervention that aims to change a person's minority sexual orientation to heterosexual or minority gender identity to cisgender (Jowett et al., 2021). There has been some move away from the use of the word 'therapy' in favour of the word 'practices', firstly to reflect the range of interventions associated with it and secondly to shift the narrative away from any alignment with therapeutic or helpful activities. Recent research literature tends to use the terms 'sexual orientation change efforts' [SOCE] and 'gender identity change efforts' [GICE] often combined [SOGICE] where research explores both sexual orientation and gender identity. While the focus here is still on changing individuals' sexual orientation or gender identity, there is some emphasis in the literature reviewed on practices that modify, suppress or deter adoption of lesbian, gay, bisexual or transgender identities. Similarly these terms, while less familiar, provide a more accurate description as efforts to change sexual orientation or gender identity are not therapy, are not evidence based and are often harmful to those exposed (Haldeman, 2022). SOCE is formally defined by the American Psychological Association (APA) as "A range of techniques used by a variety of mental health professionals and non-professionals with the goal of changing sexual orientation or any of its parts" (APA, 2021a, p. 1). GICE is defined as "A range of techniques used by mental health professionals and non-professionals with the goal of changing gender identity, gender expression, or associated components of these to be in alignment with gender role behaviours that are stereotypically associated with sex assigned at birth" (cited by APA, 2021b, p1). Both definitions are in line with those offered by the research literature.

In this study, the participants were familiar with the term 'conversion therapy'. Given the range of practices described, policy and legislation must be clear about the definition of conversion therapy while also explicitly describing what those practices are (Human Rights Council, 2020). For example, the city of Edmonton in Canada passed a bylaw in 2019 prohibiting conversion practices (Edmonton City Council, 2019). Within the legislation they clearly state what activities were being prohibited as well as detailing the activities that were not included:

The offering or provision of counselling or behaviour modification techniques, administration or prescription of medication, or any other purported treatment, service, or tactic used for the objective of changing a person's sexual orientation, gender identity, gender expression, or gender preference, or eliminating or reducing sexual attraction or sexual behaviour between persons of the same sex, not including

(a) services that provide acceptance, support, or understanding of a person or that facilitate a person's coping, social support, or identity exploration or development, or

(b) gender-affirming surgery or any service related to gender-affirming surgery (City of Edmonton, 2019, p4).

The findings identify different conceptualisations of conversion therapy and these correspond with the Sexual Orientation and Gender Identity and Expression Change Efforts (SOGIECE) pyramid presented by Kinitiz et al. (2021). These two different but interrelated levels of conversion therapy

reinforce each other and are not mutually exclusive. Negative societal attitudes towards LGBTI+ individuals were described in both the survey and by the interview participants and form the base of the pyramid, in a sense providing the foundation for formal and informal conversion therapies to flourish. These negative attitudes were experienced as homophobia and transphobia by the participants with religious interpretations of sexuality and gender identity often very influential, in particular for gay men who experience SOCE. These are described as cissexism and heterosexism both of which privilege cisgender and heterosexual norms and ideals above other sexual orientations and gender identities. These attitudes and beliefs can delay acceptance of LGBTI+ identities and cause individuals to modify their behaviour and in that way align with conversion practices. They also have a negative effect on individuals who experience and internalise them which was described in detail by one of the interview participants in this study. However as recognised by that participant, legislation to ban conversion therapy may not have prevented their experience in this instance. Therefore, measures to promote LGBTI+ individuals visibility and inclusion, equality, health and safety as advocated by the National LGBTI+ Inclusion Strategy (Government of Ireland, 2019) will go some way to addressing some of these issues. Legislation to ban conversion therapy will also support safety and health by ensuring that those who experience distress about their sexual orientation or gender identity because of homophobia or transphobia are unable to access formal conversion practices which have the potential to cause further harm. Raising awareness of the harms associated with conversion practices as well as highlighting the evidence that it is ineffective will also help to prevent it from being advocated as a legitimate course of action for those who experience distress about their sexual orientation or gender identity.

Conversion therapy can take many forms and occur in many different settings and strategies to eradicate the practice need to take this into consideration. Legislation to ban conversion therapy is likely to focus on professional contexts with licenced practitioners. Those working with LGBTI+ individuals need to be aware that SOCE and GICE are ineffective and harmful and that people who seek out these treatments need to be given clear and accurate information about their ineffectiveness and their potential for harm. Guidelines are available to support practitioners to work therapeutically with LGBTI+ individuals and evidence suggests that LGBTI+ individuals are responsive to affirmative approaches which acknowledge minority sexual orientation and gender identity as normal variants of human sexuality and gender expression (APA 2021a; 2021b). Interventions that perpetuate stigma, oppression and exclusion and seek to change, suppress or modify sexual orientation or gender identity expression such as the ones described by the participants in this study do not correspond with affirmative practices. As Ryan and Callaghan (2022) contend, laws which prohibit conversion practices pose no risk to evidence based and clinically appropriate practice.

People of faith may seek out SOCE and GICE because they believe that their LGBTI+ identity cannot correspond with religious beliefs/practices and scripture based interpretations of human sexuality and gender identity. This can cause significant distress as religious beliefs are intrinsic to the person and their relationships with their family and faith community (Plante, 2022). It is important that people who work with LGBTI+ individuals understand the importance of faith and why as people of faith they might seek SOGICE. While there are faith organisations that are LGBTI+ affirming, joining these may

not be an option to everybody, especially where the person is a minor. Prayer and pastoral care can provide support to LGBTI+ people of faith however, efforts to change or suppress sexual orientation or gender identity that are rooted in worship or spirituality can cause significant harm. Evidence suggests that these are interpreted as abusive and although it may seem that they are entered into voluntarily, power differentials may limit the provision of informed consent. There is concern among some religious communities that policy and legislation to ban conversion therapy may negatively impact on religious freedom. However, according to the UN Special Rapporteur on freedom of religion or belief, a person's sexual orientation or gender identity should not be 'treated' using practices that harm.²⁷ The right to believe religious scripture about the nature of sexuality and gender identity is protected by international human rights legislation.²⁸ The right to inflict potential harm based on religious teachings to change or suppress sexual orientation and gender identity or for other faith based reasons is not. The Human Rights Council (2020) is mindful of the role of self-determination and the rights of individuals to express their sexual orientation and/or gender identity in accordance with their faith. Therefore:

In processes of self-determination and addressing the existential dilemmas that may be connected to those processes, individuals may choose to avail themselves of mechanisms of support and counselling, some of which may be based on psychological, medical or religious approaches related to the exploration, free development and/or affirmation of one's identity...however, based on the overwhelming evidence available, none of those approaches can claim "conversion" as an outcome, just as none can claim that diverse sexual orientation or gender identity is an illness or disorder requiring therapy (Human Rights Council, 2020, para 70, p. 17) .

Some of the participants in this study were also concerned about the role of self-determination and the rights of individuals to seek out conversion practices even with the knowledge that they are ineffective and potentially harmful. However, Boulos & González-Cantón (2022) argue that even when consenting adults seek out conversion therapies, these practices are inherently debasing as they pathologize and stigmatise LGBTI+ individuals promoting the belief that they are somehow inferior to their heterosexual and cisgender counterparts which is tantamount to discrimination. Countries therefore, have an obligation to enact legislation that protects and upholds the full range of human rights for LGBTI+ individuals (Human Rights Council, 2020).

²⁷ <https://www.theguardian.com/commentisfree/2021/apr/23/legal-defence-lgbt-conversions-sexuality-rights-belief>

²⁸ <https://www.un.org/en/about-us/universal-declaration-of-human-rights>

5.3 Limitations

While the findings provide evidence that conversion practices exist in Ireland, the sample sizes for both the survey and interviews are small. The survey used a non-probability sample and is therefore not statistically representative of the wider LGBTI+ community. Similarly, the findings from the interviews are not generalisable although they are supported by the international literature. While there is some diversity within the survey sample, a larger more representative interview sample would have enhanced the study findings.

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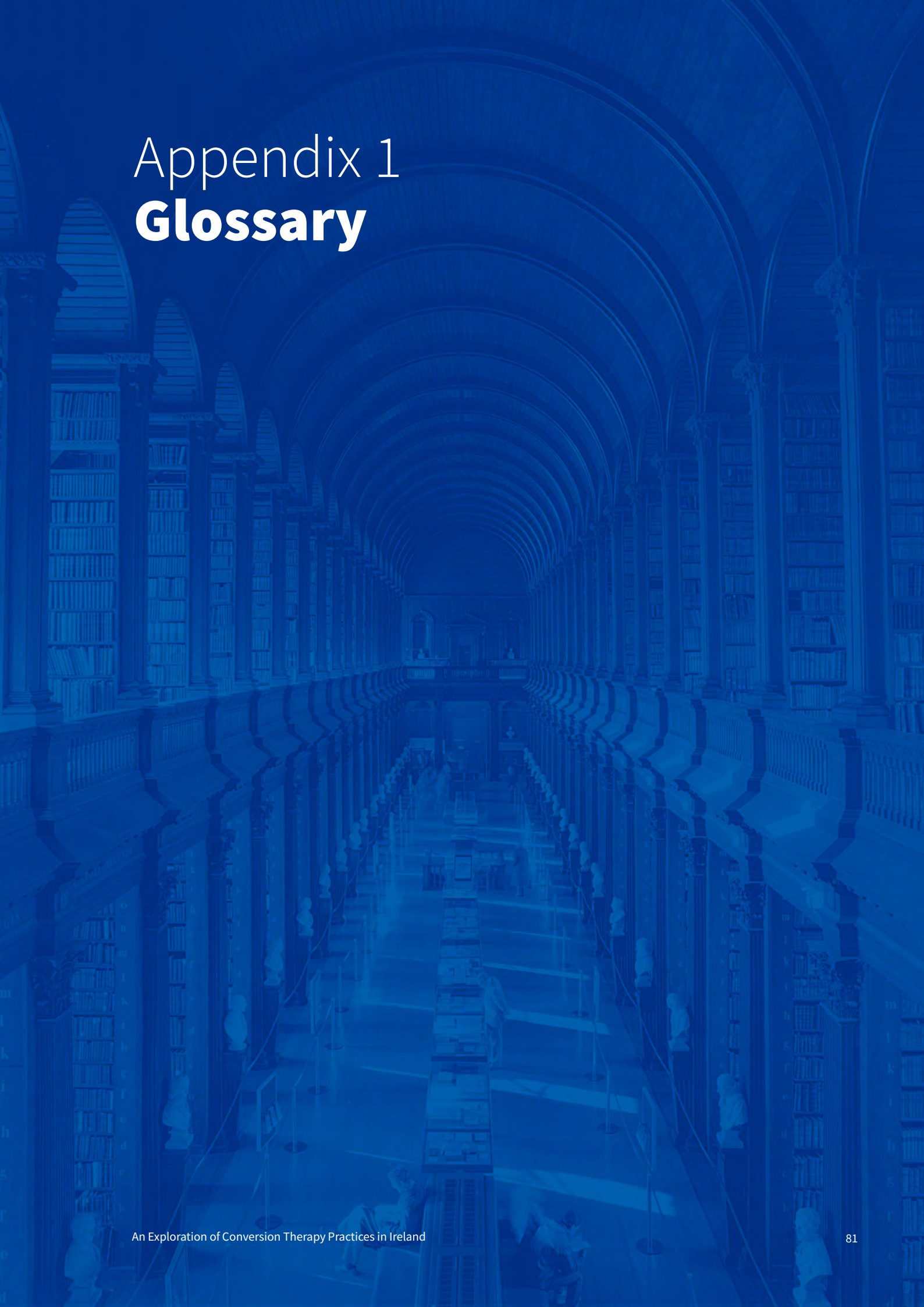
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Appendix 1

Glossary

Appendix one – Glossary²⁹

Asexual	Asexual, often called “ace” for short, refers to a complete or partial lack of sexual attraction or lack of interest in sexual activity with others. Asexuality exists on a spectrum, and asexual people may experience no, little or conditional sexual attraction (Human Rights Council https://www.hrc.org/resources/understanding-the-asexual-community)
Bisexual	Attraction towards more than one gender or sex. Distinct from pansexual, which includes attraction towards people regardless of gender or sex
Cisgender	Used in this report to refer to people whose gender identity matches their sex assigned at birth, i.e. who are not transgender.
Cissexism	The assumption that a cisgender identity is more authentic or natural than a trans identity. The belief that a person’s sex assigned at birth always remains their real gender (Transgender Equality Network Ireland https://teni.ie/resources/trans-terms/).
Conversion Therapy	Interventions aimed at changing someone’s sexual orientation or therapy gender identity (typically from minority sexual orientations or gender identities to heterosexual and cisgender). Also referred to as reparative therapy, Sexual Orientation Change Efforts (SOCE) or Gender Identity Change Efforts (GICE).
Ex-gay	A person who has undergone ‘conversion therapy’ and has ceased to identify as lesbian, gay or bisexual but may still experience same-sex attraction and engage in same-sex behaviour.
Gay	A term used to describe someone who has an emotional, romantic or sexual orientation towards someone of the same sex or gender.
Gender dysphoria	A medical diagnosis that someone is experiencing discomfort or distress because there is a mismatch between their sex and their gender identity.
Gender expression	A person’s outward expression of their gender. This may differ from their gender identity or it may reflect it.

29 Adapted from Jowett et al (2021) except where indicated. We are aware that the terminology associated with sexual orientation and gender identity is rapidly evolving, contextual and has different interpretations. No omission or offence is intended.

Gender fluidity	Is a nonbinary gender identity. Gender fluid individuals experience different gender identities at different times. A gender fluid person's gender identity can be multiple genders at once, then switch to none at all, or move between single gender identities (Transgender Equality Network Ireland https://teni.ie/resources/trans-terms/).
Gender identity	A person's internal sense of their own gender. This does not have to be man or woman. It could be, for example, nonbinary .
Gender identity Change Efforts [GICE]	A range of techniques used by mental health professionals and non-professionals with the goal of changing gender identity, gender expression, or associated components of these to be in alignment with gender role behaviours that are stereotypically associated with sex assigned at birth" (cited by APA, 2021b, p1)
Gender incongruence	A mismatch between an individual's sex and their gender identity. This may or may not be accompanied by discomfort or distress. This is identified as a sexual health issue by the World Health Organisation and not a mental or behavioural disorder.
Heteronormative	The assumption that heterosexuality is the standard for defining normal sexual behaviour and that male–female differences and gender roles are the natural and immutable essentials in normal human relations (APA, https://dictionary.apa.org/heteronormativity).
Heterosexism	Prejudice against any non-heterosexual form of behaviour, relationship, or community, particularly the denigration of lesbians, gay men, and those who are bisexual or transgender (APA, https://dictionary.apa.org/heterosexism).
Heterosexual	A term used to describe someone who has an emotional, romantic or sexual attraction towards someone of the opposite sex or gender. Also referred to as straight.
Homosexual	A term used to describe someone who has an emotional, romantic or sexual attraction towards someone of the same sex or gender.
Intersex	An umbrella term for people with sex characteristics (hormones, chromosomes and external/internal reproductive organs) that differ to those typically expected of a male or female. Intersex people may identify as male, female, nonbinary or intersex.

Lesbian	A term used to describe a woman who has an emotional, romantic or sexual orientation towards someone of the same sex or gender. Some women who fit this definition may prefer to identify as gay.
LGBTI+	An abbreviation used to refer to lesbian, gay, bisexual, transgender and intersex people. In this report it is used as an umbrella term for any minority sexual orientation or gender identities (including asexual, nonbinary).
Minority gender identity	Used in this report to refer to anyone not identifying exclusively as a man or woman (e.g. nonbinary) or identifying as transgender or anyone with a transgender history.
Minority sexual orientation	Used in this report to refer to anyone not identifying as heterosexual. This includes gay, lesbian, bisexual, pansexual, asexual, same-sex attracted etc.
Nonbinary	An umbrella term used to describe gender identities where the individual does not identify exclusively as a man or a woman. They may regard themselves as neither exclusively a man nor a woman, or as both, or take another approach to gender entirely. There are many included within this, such as agender, genderqueer and gender fluid.
Pansexual	Attraction towards people regardless of gender or sex.
Queer	A term used mainly by people who identify with a minority sexual orientation or gender identity. In the past, it was used as a derogatory term for LGBTI+ individuals.
Reparative therapy	A specific form of conversion therapy associated with British theologian Elizabeth Moberly and American psychologist Joseph Nicolosi. The term is often used interchangeably with conversion therapy.
Sex	Registered by medical practitioners at birth based on physical characteristics. Sex can be either male or female. Assignment is based on hormones, chromosomes and genitalia.
Sexual fluidity	A term for natural changes in sexual attractions or identity. Sexual orientation is stable and unchanging for most people, but some people may experience change. This is distinct from deliberate attempts to change a person's sexual orientation.

Sexual identity	A term used to refer to the label people use to describe their sexual orientation. This may or may not be a true reflection of their actual sexual attractions. Common sexual identities include straight, lesbian, gay, bisexual, pansexual and asexual.
Sexual orientation	Describes who a person is emotionally, romantically or sexually attracted to.
Sexual orientation change efforts [SOCE]	A range of techniques used by a variety of mental health professionals and non-professionals with the goal of changing sexual orientation or any of its parts” (APA, 2021a, p. 1).
Straight	Someone who is attracted to members of the opposite sex. Also referred to as heterosexual.
Transgender/ Trans	An umbrella term used to describe individuals who have a gender identity that is different to the sex recorded at birth. This might lead to gender dysphoria or incongruence. Nonbinary people may or may not consider themselves to be transgender.
Transsexualism	A term historically used as a medical diagnosis for transgender people. This was later replaced with the diagnosis of gender identity disorder and most recently with the diagnosis of gender dysphoria or gender incongruence.
Unwanted same-sex attraction	A term used by those seeking to change their sexual orientation who do not wish to identify as lesbian, gay or bisexual.
Variations in sex characteristic	An umbrella term used to describe physical sex development which characteristics differs from what is generally expected of ‘males’ or ‘females’. These variations are congenital and may be chromosomal, gonadal, anatomical or hormonal. This is more commonly known as intersex.

Appendix 2

Summary table of research papers included in the systematic review



• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Blais et al. (2022) • Canada • Sexual Orientation and Gender Identity and Expression Conversion Exposure and their Correlates among LGBTQI2+ Persons in Quebec, Canada	Methodology: Quantitative/cross sectional survey Aim: The current study describes the prevalence of SOGIE conversion attempts and involvement in conversion services, as well as their sociodemographic correlates, among LGBTQI2+ persons in Quebec (p4) Focus: SOCE, GICE	Sample size: n=3261 Experienced Conversion Practices [CP]: n=799 Sample Characteristics: Gender identity: Cisgender Man n=1304; cisgender woman n=1400; Trans men and non-binary AFAB n=379; Trans women and non-binary AMAB n=177. Sexual orientation: Gay or lesbian n=1932; bisexual n=537; queer n=243; pansexual n= 340; asexual n=104; other n=105. Intersex variation: n= 14 Ethnicity: White n=2899; indigenous n=108; people of colour n=254. Age: range NR Mean: NR Religion: NR	Definition: The concept of SOGIE change efforts has been coined to describe any direction or advice that intentionally delays or impedes self-acceptance of one's sexual orientation, gender identity, or gender expression. Conversion therapy refers to more sustained, structured, specific interventions aiming at changing, discouraging, or repressing SOGIE. It relies on various techniques, inspired by psychotherapeutic, medical, or faith-based principles (e.g., talk therapy, aversion therapy, hormone therapy, spiritual guidance) and takes place in various contexts ranging from private or public settings to "gay conversion camps" or religious institutions (p2). Practices described: Specific practices were not described but the context of the participants most recent involvement categorised as healthcare professional, member of the clergy or religious group, or other (counsellors, therapists, teachers etc.). Assent/consent: Around 52% consented themselves to attend SOCE with over half aware of what the purpose of SOCE was. The remainder reported that a parent or other family member consented for them. Often other people were involved in the decision-making process with participants often reporting that it was easier to attend and try to change their SO or they felt that they couldn't say no when it was suggested they attend. Fifty six percent (56%) of those exposed to GICE consented themselves but only 30% were aware of the purpose. Other people were involved in the decision-making process. Many attended to make their lives easier, to please others and to avoid negative consequences.	Participants' views of outcomes: Not reported [NR] Harms: NR Benefits: NR Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Chan et al. (2022) • Hong Kong • Experiences, Motivations, and Impacts of Sexual Orientation Change Efforts: Effects on Sexual Identity Distress and Mental Health Among Sexual Minorities	Methodology: Quantitative/cross sectional survey Aim: Sexual minority individuals who had undergone SOCE would show higher levels of internalized homonegativity, identity uncertainty, and difficult processes than those who had not undergone SOCE. Individuals who had experienced SOCE would also show higher levels of depressive symptoms, anxiety symptoms, and suicidal ideation than their counterparts. The associations between SOCE and mental health would be mediated by sexual identity distress (i.e., internalized homonegativity, identity uncertainty, and difficult processes). Focus: SOCE	Sample size: n=219 Experienced CP: n=48 Sample Characteristics: Gender identity: Male n=34; Female n=14 Sexual orientation: Lesbian and gay n=38; Bisexual and pansexual n=7; other n=3. Ethnicity: NR Age range: 17-63 Mean: 29.74 Religion: Religious beliefs n=35; No religious beliefs n=13	Definition: Sexual orientation change efforts (SOCE) are practices that aim to manage, suppress, or eliminate same-sex attraction, as well as foster other-sex attraction. While common forms of SOCE include psychotherapeutic techniques, medical interventions, and religious approaches, specific variants of SOCE are wide-ranging, such as conversion therapy, reparative therapy, aversion therapy, medication, pastoral counselling, and personal righteousness (p1). Practices described: Most practices were described as religious with psychological approaches and other approaches also described. Assent/consent: Most of the participants had attended SOCE on their own volition. Some were advised to attend by their family or religious leaders/religious community members. Over half never expected it to work but attended to fulfil other people's expectations.	Participants' views of outcomes: Over 91% believed that SOCE was not effective or somewhat ineffective. No-one said that it was somewhat or very effective. Most participants stated that their attempts at SOCE were not achieved because sexual orientation is inborn or shaped at an early age and can't be changed. One participant reported a change from non-heterosexual to heterosexual with six participants stating that they had some short-term changes to heterosexual but are non-heterosexual now. Harms: Harms reported included being given false hope, developed shame, guilt, and self-hatred, feel disappointed in oneself, distrust others, harm family relationships (e.g., hate/blame family members), disrupt interpersonal relationships (e.g., stay away from friends), impair mental health, trigger suicidal thoughts, lose faith, fear of religious consequences (e.g., go to hell), create financial burden, waste of time. Participants who had experienced SOCE showed significantly higher levels of internalized homonegativity, identity uncertainty, and difficult processes than their counterparts who had not experienced SOCE. They were also at a greater risk of developing depressive symptoms and suicidal ideation. Benefits: Finding a safe place to share about themselves (27.1%) and bringing hope to life (22.9%) were the most common benefits during the process of SOCE. For short-term benefits, the participants mainly felt accepted by others (20.8%), felt socially connected (14.6%), and showed improved interpersonal relationships (14.6%). For long-term benefits, they indicated that SOCE solidified their sexual identity (47.9%) and facilitated the coming-out process (12.5%). Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• del Río-González et al. (2021) • Columbia • Sexual Orientation and Gender Identity Change Efforts and Suicide Morbidity Among Sexual and Gender Minority Adults in Colombia	Methodology: Quantitative/cross sectional survey Aim: Describes the prevalence of life time suicidal ideation, suicide planning, and suicide attempts, and the association between SOGICE experiences and suicide morbidity among SGM people in Colombia. Assesses differences among SGM groups defined at the intersection of gender/sex assigned at birth and sexual orientation/ gender identity (p464). Focus: SOCE, GICE	Sample size: n=4160 Experienced CP: n=931 <u>Sample Characteristics:</u> Gender identity/sexual orientation: Lesbian women n=269; Gay men n=348; Bisexual women n=120; Bisexual men n=51; Trans women n=46; Trans men n=31, Gender nonbinary n= 66. Ethnicity: NR Age range: 18-85 Mean: 26.8 Religion: NR	Definition: Treatment from someone which tried to change sexual orientation to straight. Treatment that tried to make their gender identity align with the sex assigned at birth (p 463). Practices described: Participants were asked about being exposed to SOGICE from either health professionals or religious leaders or from both. Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: Exposure to SOGICE was associated with increased odds of lifetime suicide ideation (69%), suicide planning (55%) and suicide attempts (76%) among sexual and gender minority groups. There were differences between sexual and gender minority groups with cisgender sexual minority men being most affected. SOGICE experiences were associated with suicide morbidity when demographic variables were controlled Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• DeWee (2017) • South Africa • The Meaning of Corrective Rape as Experienced by Black South African Lesbians	Methodology: Qualitative, specifically IPA Aim: To explore the lived experiences of a group of Black lesbian women who endured corrective rape through speaking back at institutionalized patriarchy and heteronormativity. Focus: SOCE (Specifically corrective rape)	Sample size: N=4 Experienced CP: 4 <u>Sample Characteristics:</u> Gender identity: Female: n=4 Sexual orientation: Lesbian: n=4 Ethnicity: Black: n=4 Age range: 25-32 Mean: 27.75 Religion: No religion reported for 2 participants.	Definition: Corrective rape or curative rape is a form of sexual violation that is perpetrated with the explicit intention of ‘curing’ the lesbian woman of her emotional and sexual attraction to another woman. Corrective rape survivors, however, explicitly discern that their assailants intended to humiliate and punish them for their sexual identity expression and lifestyle, while executing an attack on their identity. Their rape is thus intended to ‘cure’ and transform them, albeit by coercion, into heterosexual women. For the purpose of this study, corrective rape is defined as the sexual violation of a lesbian woman with the intention of the perpetrator to turn her into a normatively heterofeminine woman (p9). Practices described: Corrective rape. Assent/consent: Non consensual	Participants’ views of outcomes: NR Benefits: NR Harms: Trauma associated with the sexual assault. Two of the women were raped at gunpoint. Symptoms of PTSD, physical sequelae of the rape: Physical injuries, intimacy issues, pain, and sleep disturbance. Impact worsened by discrimination and the lacklustre response to their experiences (e.g., not being believed) and not being able to talk about the incident or their identities. Sense of betrayal as they often knew the rapist(s). All participants experienced symptoms associated with clinical depression. Isolation and withdrawal, hopelessness, shame, anxiety guilt, fear of being raped again. Low self-worth, poor self-esteem, self-blame. Pregnancy and HIV infection. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/ harms/support needs)
• Earley et al. (2020) • United States/United Kingdom/ Canada/Ireland • Counselling formerly Heterosexually Partnered Gay Fathers Raised with Religion	Methodology: Qualitative, specifically IPA Aim: This research aims to: (1) explore the counselling experiences of formerly heterosexually partnered gay fathers raised with religion; and (2) offer suggestions for counselling and mental health professionals in their work with this population. Focus: SOCE	Sample size: N=12 Experienced CP: n=7 <u>Sample Characteristics:</u> Gender identity: Male: n=12 Sexual orientation: Gay N=11; Gay/Bisexual n=1 Ethnicity: White: n=11; Hispanic n=1 Age range: 25-68 Mean: 42 Religion: No religion n=8; Catholic n=1; Methodist n=1; Christian Orthodox n=1; Masorti Judaism n=1	Definition: Men with religious beliefs are said to be most at risk of seeking Gay Conversion Therapy; described by its proponents as a “therapeutic approach” (a notion that is obviously disputed) that aims to provide “gay-to-straight” outcomes for clients. (p772). Practices described: Seven of the 12 participants experienced CP. Five in the context of Christian churches and two in the field of psychiatry. Group and individual therapies described. Different approaches described, ‘restoring heterosexuality’ through activities that were perceived as masculine. Assent/consent: NR	Participants’ views of outcomes: All men who were exposed to SOCE identified as non-heterosexual at time of publication. Benefits: Some of the participants reported that the group meetings helped them to feel less alone with their conflicted feelings about their sexual orientation. Harms: Participants who were exposed to GCT were made to feel guilty about being gay, it triggered anxiety attacks for one person, another felt that it had contributed to his diagnosis of generalised anxiety disorder, and he remains on anti-anxiety medication at the time of interview. One participant was encouraged to join an ex gay group called ‘Exodus International’ where he reported learning how to hide his sexuality. Approaches were based on shame but never took away the feelings according to one participant. One person felt that it offered a temporary resolve but was tormented about the lack of success. ‘Taken together, participants experience of GCT and other types of gay pathologizing therapies were unanimously reported as harmful and ethically problematic as they ignored their needs in favour of suppressing or curing their same-sex desires (p773). Support Needs: Discussed in the context of gay fatherhood. Supports a gay affirmative approach but cautions against a one size fits all approach.

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• Goodyear et al. (2021) • Canada • “They Want You to Kill Your Inner Queer but Somehow Leave the Human Alive”: Delineating the Impacts of Sexual Orientation and Gender Identity and Expression Change Efforts	Methodology: Qualitative interpretive description. Aim: The aim of this study was to delineate the emotional, social, and mental health impacts associated with SOGIECE, as well as the significance and meaning ascribed to these impacts, as described by people with lived experience (p 600). Focus: SOCE, GICE	Sample size: n=22 Experienced CP: n=22 Sample Characteristics: Gender identity: Woman n=4; Man n=17; Nonbinary n=3; Genderfae¹ n=1; Trans n=4; Cisgender n=17; not sure n=1; Two spirit n=1. Sexual orientation: Bisexual n=3; Gay=15; Pansexual n=1; Queer n=5; Straight n=1; other n=1. Ethnicity: White n=17 Arab n=1 Black n=1 First nations n=1 Multi racial n=1 Southeast Asian n=1 Age range: 20-64 Mean: 38.7 Religion: NR 1 Genderfae is a form of genderfluidity that never encompasses male or masculine genders https://www.lgbtqia.wiki/wiki/Genderfae	Definition: SOGIECE constitute a variety of practices that aim to deny or suppress feelings and desires related to non-heterosexual identities, as well as expressions of gender and gender identities that differ from one's sex assigned at birth (p599). Practices described: Participants in this study described having experienced various “types” of SOGIECE, including formalized individual and group counselling sessions (e.g., with faith leaders and/or healthcare providers; at conversion therapy camps and/or retreats), other faith-based practices (e.g., guided prayer sessions, exorcisms), and more general experiences of queerphobia in which participants were pressured to repress their sexual and gender identities (p603). Assent/consent: While participants acknowledged that they had attended voluntarily, they also noted that there was a level of coercion from eternal sources to seek out and attend SOGICE.	Participants’ views of outcomes: All men who were exposed to SOCE identified as non-heterosexual at time of publication. Benefits: One participant described their experience favourably because of the support and religious affirmation he received. However, he acknowledged that the ‘therapy’ was ineffective in terms of addressing his ‘same sex attraction’. Harms: Participants described the way SOGICE impacted on their mental health and social wellbeing. SOGICE made them feel ashamed and worsened internal feelings of turmoil and ‘brokenness’ negatively impacting their self-image and self-esteem. The participants stated that they had been given a false sense of hope and rather than being helpful, SOGICE had been damaging to their overall health and sense of wellbeing. Where SOGICE had led to denial of gender affirming care this had enduring consequences. Participants sexual orientations and gender identities were discredited, and this contributed to feelings of isolation and a lack of belonging. Claims made about the effectiveness of SOGICE led to feelings of inadequacy when it didn’t work for them. It also made them feel anxious with feelings of uncertainty and dread about their future. For some of the participants a line was drawn between their experience of SOGICE and subsequent diagnoses of mental health difficulties such as depression which were sometimes long lasting. Support Needs: Addressed in the recommendations, screening for SOGICE, encourage people who have experienced SOGICE to talk to their health care providers about their experiences. Trauma informed and person-centred way.

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• Green et al. (2020) • United States • Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018	Methodology: Quantitative/cross sectional survey Aim: To observe the relative odds of suicidality among LGBTQ individuals who experienced SOGICE Focus: SOCE, GICE	Sample size: N=34,808 Experienced CP: N=1088 <u>Sample Characteristics:</u> Gender identity: Transgender/nonbinary 41.5%; Cisgender 58.5% Sexual orientation: Gay/ Lesbian 48.9%; Bisexual 27.8%; Straight or something else 23.3% Ethnicity: White 66.7%; Hispanic 20%; Black 3.1% Asian American/Pacific Islander 2.1%; American Indian/Alaska Native 1%; Multiple 7% Age range: 13-24 Mean: NR Religion: NR	Definition: SOGICE involves attempts by licensed professionals (e.g., psychologists or counsellors) or practices by religious leaders to alter sexual attractions and behaviours (to make one straight or heterosexual), gender expression (to align with gender expectations for the sex assigned at birth), or gender identity (to make one cisgender). SOGICE can include the use of aversive stimuli, individual talk therapy, group therapy, and residential programs. (p1221). Practices described: NR Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: Elevated odds of suicidality were observed among young LGBTQ individuals exposed to SOGICE. When compared to LGBTQ people who did not have SOGICE, those who did were more than twice as likely to report having attempted suicide and having multiple suicide attempts. Support Needs: NR

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• Heiden-Rootes et al. (2022) • United States • The Effects of Gender Identity Change Efforts on Black, Latinx, and White Transgender and Gender Nonbinary Adults: Implications for Ethical Clinical Practice	Methodology: Quantitative Aim: To observe whether there are differences in mental health and substance use outcomes based on exposure to religious and nonreligious GICE for a racially diverse sample of transgender and nonbinary adults. Are differences in mental health and substance use outcomes based on religious and nonreligious GICE exposure different based on race (p929). Focus: GICE	Sample size: N=27,715 Experienced CP: N=3,438 <u>Sample Characteristics:</u> Gender identity: Cross-dresser n=97; Trans woman n=2195; Trans man n=706; Nonbinary/Genderqueer (birth-assigned female) n=277; Nonbinary/genderqueer (birth-assigned male) n=163 Sexual orientation: Asexual n=308; Bisexual n=619; Gay/ Lesbian n=744; Heterosexual n=744; Pansexual n=490; Queer n=311; Other n=222 Ethnicity: Black/African American n= 441; Latinx/Hispanic n=528; White n=2469 Age range: 18-65 Mean: NR Religion: NR	Definition: SOCE, also known as conversion or reparative therapy, falsely claim that such efforts will alter a person with a marginalized sexual orientation (e.g., bisexual, lesbian, gay, pansexual, etc.) to identify as heterosexual. Similarly, those who use GICE are seeking to change individuals with a marginalized gender identity (e.g., transgender, nonbinary, genderqueer, etc.) into having a cisgender identity (p928). Practices described: Not explicitly described. Religious and nonreligious GICE. Non-religious GICE was reported more frequently among participants exposed. Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: GICE that was provided by both religious and non-religious organisations or mental health professionals were associated with increased odds of suicidal ideation and attempts. A lack of family support was associated with GICE. Exposure to GICE in the non-religious context was associated with severe psychological distress. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Higbee et al. (2022) • United States • Conversion Therapy in the Southern United States: Prevalence and Experiences of the Survivors	Methodology: Quantitative Aim: What is the prevalence of conversion therapy in the Southern United States? What demographic factors are correlated with the probability that someone under 18 undergoes conversion therapy? How does conversion therapy impact the mental health of those who experienced it before turning 18? (p617) Focus: SOCE	Sample size: N= 4096 Experienced CP: N=475 <u>Sample Characteristics:</u> Gender identity: Man n=192; Woman n=140, Trans Man/Woman n=109; , Non-Binary n=34 Sexual orientation: Heterosexual n=21; Lesbian n=122; Gay n=201; Bisexual n=58; Other n=73 Ethnicity: Non-Hispanic White n=357; Black/African American n=31; Hispanic n=48; Other n=39 Age range: 18- ≥ 50 Mean: NR Religion: NR; religion very or somewhat important for almost 48% of participants.	Definition: Conversion therapy (also referred to as reparative therapy, sexual reorientation therapy [SRT], sexual orientation change efforts [SOCE], ex-gay therapy, or gender identity change efforts [GICE] when directed toward gender minority individuals) occurs when a formal group of people, usually religious or mental health professionals, attempts to change someone's sexual orientation to "heterosexual" or their gender identity to "cisgender" p612. Practices described: Not explicitly described, categorised as 'types' – mental health practitioner, religious leader/clergy or other. Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: Participants who were exposed to conversion therapy as an adolescent were found to have a higher probability of experiencing a serious mental illness. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Jones et al. (2021) • Australia • Religious Conversion Practices and LGBTQA+ Youth	Methodology: Quantitative Aim: Four research questions: Do Australian LGBTQA + youths' conversion practice attendances differ by demographic factors? What is the relationship between conversion practice attendance and social experiences? What is the relationship between conversion practice attendance and socio-behavioural outcomes? What is the relationship between conversion practice attendance and individual health and well-being? Focus: SOCE, GICE	Sample size: N=6412 Experienced CP: N=256 Sample Characteristics: Gender identity: Cisgender n=190; Trans or gender diverse n=46; male n=115; female n=74 Sexual orientation: Single (same) gender attracted n=101; multi gender attracted n=101 Ethnicity: 3.9% were Aboriginal or Torres Strait Islanders Age range: 14-21 Mean: 17.3 Religion: NR; Household religious affiliation: religion n=108; no religion n=148.	Definition: Practices that are rooted in conversion ideology that believes that LGBTQA+ identities are 'broken' or 'sinful' and in need of fixing or suppression and that heteronormative and cisgender identities are the ideal. 'Conversion practices' comprises of processes engaged in towards desired changes in gender and/or sexuality based in conversion ideology. Conversion practices may include (but are not limited to) counselling, group work, programmes or interventions (perhaps therapeutic/corrective prayer, performing celibacy or endorsed sexual relationships, personal or group behavioural suppression, etc.). These practices can be formal or informal, and regionally variable—such as witchdoctor exorcisms in Mozambique (p2). Practices described: Focuses on religious conversion practices but no detail provided. Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: Participants who had attended conversion practices reported increased symptoms of anxiety and psychological distress and reported less health and wellbeing. They were also two and a half times more likely to think about suicide, plan suicide and almost four times more likely to attempt suicide than those who did not attend. Those who attended were also more likely to have a diagnosis of mental illness in particular, post-traumatic stress disorder and schizophrenia. Support Needs: Most LGBTQA+ participants preferred in person inclusive/only counselling services above text/web chat or telephone general counselling.

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Jones et al.(2022a) • Australia • Religious Trauma and Moral Injury from LGBTQA+ Conversion Practices	Methodology: Qualitative Aim: To enhance understanding of the spiritual harms experienced by survivors of LGBTQA + change and suppression practices, improve understandings of survivors’ support needs around the nature and extent of religious trauma and moral injury, and to inform services working towards supporting their recovery from such experiences. Focus: SOCE, GICE	Sample size: n=42 Experienced CP: n=42 Sample Characteristics: Gender identity: Cisgender male n=23; cisgender female n=11; non-binary/gender queer n=5; transgender female n=4; transgender male n=2; non-binary n=1 Sexual orientation: Gay n=19; lesbian n=10; bisexual n=9; queer n=4; asexual n=2; pansexual n=2; other n=1. Ethnicity: Anglo-Australian n=28; South-East Asian n=3; East Asian n=1; Mediterranean n=1; Middle Eastern Australian n=3; European n= 3; African n= 2; Anglo/ European n=2; Anglo/ Maori n=1 Age range: 20s-50s Mean: NR Religion: Protestant Christian n=33; Orthodox Christian n=2; Jewish n=3; Muslim n=2; Roman Catholic n=1; Maronite Christian n=1; Druze n=1; Mormon/LDS n=1; Buddhist n=1.	Definition: The ideology that informs LGBTQA + conversion practices thus posits that LGBTQA + subjectivity and spiritual belonging are incommensurable. This has led to the development of cultures that promote and engage in various practices directed at changing or supressing LGBTQA + sexual orientations and gender identities. Providers of conversion practices have often been internationally networked and informed by remarkably similar ideological assumptions. Consequently, the types of conversion practices offered in different religious and geographical settings are quite similar (p1). Practices described: Prayer, scripture reading, pastoral counselling, pilgrimage and spiritual deliverance or exorcism. Other conversion practices reported included formal psychological counselling, peer support groups, ‘ex-gay’ programs, coerced heterosexual marriage and rape. While some had attended formal therapies, all had experiences spiritual/religious practices as well. Assent/consent: Most participants sought out or engaged in conversion practices voluntarily. However, this was in the context of internalised homo/ transphobia that emerged due to their religious beliefs. Some participants were tricked or coerced into conversion practices which were often perceived as more traumatic	Participants’ views of outcomes: Not explicitly discussed but participants did talk about the time wasted engaging in SOGICE when they could have been living authentic lives Benefits: One participant suggested that finding an online group who had the same issues as him was edifying and exciting. Harms: Multiple psychological harms reported including anxiety, depression, and suicidal behaviour. Paper focuses on religious trauma, and this was evident in the negative experiences of the conversion practices that the participants were exposed to. Their sexual orientation and/ or gender identify were discredited and this exacerbated the homonegativity that they were already internalising. Their relationship with their religious communities was deeply affected and this rejection and loss of community was experienced as traumatic. Furthermore, it created an internal conflict between their religious beliefs and their sexual orientation or gender identity which was long lasting and disrupted their opportunities for meaningful relationships and often drove them to seek out conversion practices. Some felt a sense of shame for being tricked or coerced into conversion practices and those who entered it voluntarily regretted their complicity in engaging with something that was so damaging. Support Needs: NR

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• Jones et al.(2022b) • Australia • Supporting LGBTQA+ Peoples' Recovery from Sexual Orientation and Gender Identity and Expression Change Efforts	Methodology: Qualitative Aim: The present study aimed to understand common themes across Australian SOGIECE survivors' experiences of recovery from SOGIECE? And views on what support approaches or resources assist recovery? Focus: SOCE, GICE	Sample size: n=35 Experienced CP: n=35 <u>Sample Characteristics:</u> Gender identity: Cisgender male n=20; cisgender female n=5; non-binary/ gender queer n=5; transgender female n=4; transgender male n=1 Sexual orientation: Gay n=17; lesbian n=8; bisexual n=8; queer n=2; asexual n=2; pansexual n=2; other n=1. Ethnicity: Anglo-Australian n=25; South-East Asian n=2; Mediterranean n=1; Middle Eastern Australian n=3; European n= 1; African n= 1; Anglo/ European n=2; Anglo/ Maori n=1. Age range: 20s-50s Mean: NR Religion: Protestant Christian n=30; Orthodox Christian n=2; Jewish n=2; Muslim n=1; Roman Catholic n=1; Maronite Christian n=1; Druze n=1; Mormon/LDS n=1; Buddhist n=1.	Definition: Multiple psychological and rights bodies denounce religious Sexual Orientation and Gender Identity and Expression Change Efforts (SOGIECE) aimed at converting lesbian, gay, bisexual, transgender, intersex, queer and asexual (LGBTQA+) people to fit cisgender heteronormative ideals as ineffective and harmful. Practices described: NR Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: Harms were discussed in the context of the participants recovery from SOGICE exposure (see Jones et al., 2002a). Support Needs: The importance of having time to recover and the availability of support was underscored by the participants. For some participants recovery from SOGICE took a long time and was sometimes complicated by the mental health difficulties that emerged from their engagement with it. In addition, recovery involved the dual processes of reconciling their faith with their sexual orientation or gender identity which had been discredited. Recovery involved seeking support from affirming professionals, individual and groups. This included finding or becoming allies and finding a church or faith group that were affirming and inclusive to LGBTQA+ people. This sometimes involved ceasing contact with family and other networks that were unsupportive or non-affirming. Recovery sometimes meant leaving church or faith in a non-formal context. Mental health professionals need to be attuned to the participants needs and the tensions that were created between their religious convictions and sexual orientation or gender identity. Professionals who were LGBTQA+ affirmative and who had specialist training were seen as helpful. Non-judgemental approaches and providing additional resources which were affirming, informative and wide ranging to support their recovery were also valued.

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Kinitz et al. (2021) • Canada • “Conversion Therapy” Experiences in Their Social Contexts: A Qualitative Study of Sexual Orientation and Gender Identity and Expression Change Efforts in Canada	Methodology: Qualitative Aim: To describe in what forms, with whom, where, when, and why Canadians experience sexual orientation and gender identity and expression change efforts (p443) Focus: SOCE, GICE	Sample size: n=22 Experienced CP: n=22 Sample Characteristics: Gender identity: Male n= 17; Female n=4; Nonbinary n=3; Other (gender queer) n= 1 Sexual orientation: Bisexual n= 3; Gay n= 15; Pansexual n= 1; Queer n= 5; Straight n= 1, Other n= 1 Ethnicity: White n=17 Arab n=1 Black n=1 First nations n=1 Multi racial n=1 Southeast Asian n=1 Age range: 18 ≥ 50 Mean: NR Religion: Agnostic N= 4; Atheist N= 5; Buddhist N= 2; Christian/Catholic N= 6; Muslim N= 2; Other (Universalist, Pagan, unsure) N= 5	Definition: SOGIECE as an umbrella term to encompass the wide range of practices that attempt to alter or suppress one’s sexual orientation and/or gender identity and/or expression (p443). Practices described: SOGIECE occurred in faith based and secular settings and were structured and formal such as attending one to one counselling, retreats, and conferences. Therapies underpinned by the ideology that same sex attraction is caused by trauma, parenting, a void in one life and sometimes demonic possession. Strategies included fasting, prayer, reading scripture, engaging in masculine activities, avoiding or suppressing homosexual outcomes (e.g. not watching gay porn). Some completed courses online or were given literature to read. Participants also described medical treatments provided by psychiatrists or being denied gender affirming care. Some sought SOGIECE online or were taken out of the country. Assent/consent: Participants entered SOGIECE voluntary but often in the context of coercion from parents, societal attitudes to homosexuality and fear of rejection. Some participants sought out gender affirming care but had SOGIECE forced onto them.	Participants’ views of outcomes: NR see Goodyear et al., (2021). Benefits: NR Harms: NR Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Lee et al. (2022) • South Korea • Gender Identity Change Efforts Are Associated with Depression, Panic Disorder, and Suicide Attempts in South Korean Transgender Adults	Methodology: Quantitative Aim: To assess lifetime exposure to GICEs and its associations with mental health indicators including medically diagnosed or treated depression and self-reported suicidality among transgender adults in South Korea (p2) Focus: GICE	Sample size: n=566 Experienced CP: n=65 Sample Characteristics: Gender identity: Trans woman n=33; trans man n=17; Nonbinary AFAB n=12; Nonbinary AMAB n=3 Sexual orientation: Heterosexual n=18; Lesbian/gay n=7; Bisexual n=25; Asexual n=12; Other n=3 Ethnicity: NR Age range: 19-60 Mean: 25.5 Religion: NR	Definition: Practices that attempt to change a person's gender identity to conform with their assigned sex at birth and thus force transgender people to live as cisgender people (p1) Practices described: Limited detail provided, GICE provided by a psychologist/counsellor, health care provider, religious leader or other not listed. Assent/consent: NR	Participants' views of outcomes: NR see Goodyear et al., (2021). Benefits: NR Harms: Participants who had undergone GICEs' showed significantly higher prevalence of depression, panic disorder and suicide attempts. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Lee et al.(2021) • South Korea • Sexual Orientation Change Efforts, Depressive Symptoms, and Suicidality Among Lesbian, Gay, and Bisexual Adults: A Cross-Sectional Study in South Korea	Methodology: Quantitative Aim: This study aimed to assess Korean LGB adults SOCE experiences and to examine their association with depressive symptoms, suicidal ideation, and suicide attempts. The hypothesis of this study is that SOCE negatively impact the mental health of Korean LGB individuals (p428) Focus: SOCE	Sample size: n=2168 Experienced CP: n=55 <u>Sample Characteristics:</u> Gender identity: Man n=30; Woman n=25 Sexual orientation: Gay/Lesbian n=41; Bisexual n=14 Ethnicity: NR Age range: 19-69 Mean: NR Religion: NR	Definition: Sexual orientation change efforts (SOCE), commonly known as “conversion therapy,” refer to pseudo-scientific practices attempting to convert lesbian, gay, and bisexual (LGB) individuals’ sexual orientation to heterosexuality. SOCE are usually conducted by religious leaders, counsellors, psychologists, or other health care providers. In the same manner, transgender and gender-diverse individuals can be subjected to gender identity change efforts that prevent them from living as their gender identity and attempt to make them live as cisgender (p 427). Practices described: NR Assent/consent: NR	Participants’ views of outcomes: NR Benefits: NR Harms: Undergoing and being advised to receive SOCE was significantly associated with suicidality among LGB adults in Korea. Being advised to receive SOCE alone was associated with higher levels of depressive symptoms. Participants exposed to SOCE reported a greater prevalence of suicide ideation and attempts than those who had not received it. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Meanley et al. (2020) • United States • Characterizing Experiences of Conversion Therapy Among Middle-Aged and Older Men Who Have Sex with Men from the Multicentre AIDS Cohort Study (MACS)	Methodology: Quantitative Aim: Describe the lifetime prevalence of conversion therapy, including the type experienced, age at start of therapy, duration, frequency, and the extent to which conversion therapy was individuals' decisions Assess differences in the prevalence of conversion therapy by HIV serostatus (p335) Focus: SOCE	Sample size: n=1237 Experienced CP: n=219 <u>Sample Characteristics:</u> Gender identity: Man n=219 Sexual orientation: MSN N=219 Ethnicity: White/non-Hispanic n=114; White Hispanic n=12; Black Non-Hispanic n=70; Black Hispanic n=5; Other n=17 Age range: NR Mean: 59.94 Religion: NR	Definition: The central tenet of conversion therapies is that same-sex attractions are pathological and demand reorientation back to heteronormative expectations of sexuality. Though not all practices have been implemented via religious platforms, many socially conservative religious groups have supported conversion therapy practices as it aligns with their rigid ideologies on heteronormative sexuality and views that same-sex attractions as immoral and sinful (p334) Practices described: Psychotherapy; group-based therapies and religion-based approaches were the most commonly reported. Gender role reinforcement, aversion therapies and pharmacological approaches were less commonly reported. Assent/consent: Over a third of those who reported lifetime conversion therapy indicated that the decision to seek out these therapies was only a little or not at all their decision (34%: n=73). Just under 43% (n=88) said that it was mostly or completely their decision to seek out SOCE.	Participants' views of outcomes: NR Benefits: NR Harms: NR Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Ogunbajo et al. (2021) • Nigeria • Religiosity and Conversion Therapy is Associated with Psychosocial Health Problems among Sexual Minority Men (SMM) in Nigeria	Methodology: Quantitative Aim: We hypothesized that higher levels of religious service attendance, a history of religious conversion therapy (defined as practices aimed at changing an individual's sexual orientation or gender identity), and endorsement of negative religious beliefs related to same-sex sexual attraction will be associated with poorer psychosocial health outcomes among SMM in Nigeria (p4) Focus: SOCE	Sample size: n=406 Experienced CP: n=69 <u>Sample Characteristics:</u> Gender identity: Man n=69 Sexual orientation: Gay/homosexual n=36; Bisexual n=34 Ethnicity: NR Age range: 18-60 Mean: 29.2 Religion: Christian n=42; Muslim n=24; Other n=4	Definition: Sexual orientation conversion therapy—any of several dangerous and discredited practices aimed at changing an individual's sexual orientation or gender identity (p4). Practices described: This looks at conversion therapy in a religious context, question posed “I have been forced to participate in a prayer service or traditional ceremony to turn me straight?” Assent/consent: Consent not obtained, describes forced participation in conversion therapy at a religious institution.	Participants' views of outcomes: NR Benefits: NR Harms: Respondents who reported a history of forced participation in religious conversion therapy increased their odds of experiencing depressive symptoms and suicidal thoughts. In addition, they had higher levels of internalised homophobia. Respondents who were HIV+, had depressive symptoms and suicidal thoughts were more likely to report a history of conversion therapy as well. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Rosik et al. (2022a) • United States • Sexual Minorities Responding to Sexual Orientation Distress: Examining 33 Methods and the Effects of Sexual Identity Labelling and Theological Viewpoint	Methodology: Quantitative Aim: The present study seeks to bridge this limitation in the literature by addressing two questions concerning methods sexual minorities use to address sexual orientation distress: (a) Which methods used to address sexual minority distress are associated with perceptions of helpfulness or harmfulness across sexual identity labels and theological perspectives and (b) which if any methods differ in the perception of helpfulness or harmfulness based on the use or rejection of an LGB+ identity label or a particular theological perspective? (p4) Focus: SOCE	Sample size: n=281 Experienced CP: n=281 Sample Characteristics: Gender identity: Man n=205; women n=61; Transgender and nonbinary n=15. Sexual orientation: Participants divide into two groups: non LGB+ identified n=102; LGB+ identified n=179. Overall, on the Kinsey scale the participants were predominantly homosexual (mean 5.48). Ethnicity: White n=257; other NR. Age range: NR Mean: 39.2 Religion: Mormon n=155; Evangelical Protestant n=10; Catholic n=9; Jewish n=5; other n=46; unaffiliated n=58.	Definition: Paper refers to sexual orientation distress and the interventions that are used to address it; interventions that affirm sexual orientation, interventions that discourage homosexuality/bisexuality and those that are neutral. Practices described: Thirty-three different approaches listed which either affirm, discourage or are neutral to minority sexual orientations. Assent/consent: NR	Participants' views of outcomes: NR Benefits: Interventions that were affirmative were seen as more helpful. For example, acknowledging sexuality to self and other had higher mean scores for helpfulness for those who used that approach. Neutral approaches such as managing anxiety or self/personal development were also seen as helpful in this context. Harms: Those approaches that sought to suppress sexual desires were seen as unhelpful. Strategies that encouraged or were more supportive of traditional religious values were seen as helpful to people who were religious and harmful to those who were not. Similarly those participants who rejected an LGB+ identity found strategies that were discouraging more helpful. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Rosik et al. (2022b) • United States • The Pursuit of Change and Acceptance of Minority Sexual Orientation in Psychotherapy: Retrospective Perceptions of Helpfulness and Harmfulness	Methodology: Quantitative Aim: To identify what characteristics might be related to perceiving five psychotherapy goals, four of which are associated with sexual orientation change efforts (SOCE), as being helpful or harmful. We also sought to determine whether these perceptions are associated with the health measures of depression, anxiety, life satisfaction, and physical health. (p185) Focus: SOCE	Sample size: n=193 Experienced CP: n=192 Sample Characteristics: Gender identity: Man n=146; women n=37; Other e.g. gender fluid, gender queer n=10. Sexual orientation: Lesbian or gay n=66; SSA or same gender attracted n=37; heterosexual with SSA n=13; heterosexual/straight n=10. Ethnicity: White n=180; other n=13. Age range: 20-73 Mean: 39.73 Religion: Mormon n=105; Evangelical Protestant n=8; Catholic n=6; Jewish n=5; other n=32; unaffiliated n=37.	Definition: According to an American Psychological Association (APA) task force report, sexual orientation change efforts (SOCE) are defined as “all means to change sexual orientation (e.g., behavioural techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches)” and encompass a variety of mental health and religious providers. (p.185) Practices described: Psychotherapy with different SOCE goals – 1) not act on SSA 2) reduce SSA 3) eliminate SSA 4) feel heterosexual attractions 5) affirm sexual orientation. Assent/consent: NR	Participants’ views of outcomes: NR Benefits: Participants with traditional religious views were more likely to find psychotherapy aimed at SOCE helpful. Those who rejected an LGBTQ+ identity was the most powerful predictor of perceived helpfulness of SOCE. Those who experienced their sexuality as authentic found affirming practices more helpful. Participants reporting more internalised homonegativity reported more benefit from SOCE. Harms: In this study while psychotherapy aimed at SOCE was perceived as harmful for some participants indices of psychological distress were not positively associated with this. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Salway et al. (2021) • Canada • Experiences with Sexual Orientation and Gender Identity Conversion Therapy Practices Among Sexual Minority Men in Canada, 2019–2020	Methodology: Quantitative Aim: Primary objective was to estimate the lifetime prevalence of CTP experiences among sexual minority men in Canada sampled in 2019–2020. Secondary objectives were to: a) estimate the prevalence of CTP and SOGIECE experience across socio demographic subgroups of sexual minority men; b) describe settings, age at initiation, and duration of CTP c) identify health disparities among individuals who experienced CTP (p3). Focus: SOCE, GICE	Sample size: n=9214 Experienced CP: n=910 Sample Characteristics: Gender identity: Non Binary n=58; Other n=12; Male n=839; Transgender n=151 cisgender n=739; Two spirit n=29 Sexual orientation: Gay n=723; Bisexual n=166 Asexual n=20; Pansexual n=96; Heteroflexible n=17; Queer n=218; Other n=16 Ethnicity: African n=15; Arab n=36; Asian n=32; Black n=31; Caribbean. N=37; Indigenous n=67; Latin American n=70; South Asian n=28; Southeast Asian n=23; White n= 671 Age range: Mean: Religion: NR.	Definition: Conversion therapy” practices (CTP) are organized and sustained efforts to avoid the adoption or expression of lesbian, gay, bisexual, or queer (LGBQ) sexual orientations, gender identities not assigned at birth, and/or non-conforming gender expressions. In the case of CTP targeting sexual orientation, these practices often borrow pseudo-scientific behavioural interventions to suppress or deter same-sex/gender attraction (including sex with members of the same sex/ gender). CTP targeting gender identity and expression likewise include so-called psychotherapeutic attempts to “discourage or delay the adoption of gender identities not assigned at birth, as well as non-conforming gender expressions (p2). Practices described: Most of the participants received SOGIECE from a religious organisation, a religious leader of a religious person. Just over 30% received it from a licenced or unlicensed health care professional. Assent/consent: NR	Participants’ views of outcomes: NR Benefits: NR Harms: Relative to people who were not exposed to SOGIECE, participants who were exposed reported more isolation and feeling left out. Mental health service access was also more common. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Sullins (2022) • United States • Absence of Behavioural Harm Following Non-Efficacious Sexual Orientation Change Efforts: A Retrospective Study of United States Sexual Minority Adults, 2016–2018	Methodology: Quantitative Aim: Do sexual minority persons who have undergone unsuccessful sexual orientation change efforts (SOCE) suffer subsequent psychological or social harm from the attempt. This study attempts, for the first time, to isolate and examine the question of current psychosocial harm for former SOCE participants among sexual minorities in representative population data. Focus: SOCE	Sample size: n=1,518 Experienced CP: n=108 Sample Characteristics: Gender identity: Female n=47; Male n=61 Sexual orientation: Lesbian/gay n=76; bisexual n=17; other n=15 Ethnicity: White n=60; black n=18; Latino n=13; other n=17. Age range: Mean: 32.7 Religion: NR	Definition: Sexual orientation change efforts (SOCE) is a summary term for therapies or programs that support change from same-sex to opposite-sex orientation in sexual attraction, identity, and/or behaviour (p2). Practices described: NR Assent/consent: NR	Participants' views of outcomes: Not described, participants described as 'unsuccessful SOCE' Benefits: Suggests that SOCE may have protective elements as it reduced the effect of minority stress and childhood adversity for suicide attempts although this effect did not fully account for the equivalence between the SOCE and non-SOCE groups Harms: Refutes earlier research which suggests that SOCE causes harm in particular suicidal morbidity as it argues that it was present before exposure to SOCE. Suggests that the prevalence of behavioural harm among those exposed to SOCE is statistically identical to those who have not experienced SOCE. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Sullins et al. (2021) • United States • Efficacy and Risk of Sexual Orientation Change Efforts: a Retrospective Analysis of 125 Exposed Men.	Methodology: Quantitative Aim: Was participation in SOCE perceived by these consumers to be helpful in alleviating unwanted same-sex attraction, identification and behaviour? To what degree was SOCE exposure perceived to be psychologically harmful or beneficial? (p.3) Focus: SOCE	Sample size: n=125 Experienced CP: n=125 <u>Sample Characteristics:</u> Gender identity: Male: n=125 Sexual orientation: Gay/same sex attraction: n=125 Ethnicity: Black n=1.6% Asian/Pacific islander n =0.8% White n= 91.1% Hispanic n=4.9% Multi racial n=1.6% Age range: 18-25 n= 14.4% 26-35 n=28% 36-45 n= 18.4% 46-55 n=23.2% 56-65n=15.2% 66+ n=0.8% Religion: Unspecified Christian 35%; Mormon 28.5%; Non-Denominational Christian 13.8%; Jewish 9.8%; Roman Catholic 6.5%; Baptist 4.1%; Episcopalian 0.8%; Methodist 1.6%	Definition: Voluntary therapeutic interventions to reduce unwanted same-sex sexuality are collectively known as sexual orientation change efforts (SOCE) (p1). Practices described: No details about interventions but were religious talk therapy, retreats, and support groups. Assent/consent: Described as voluntary in definition.	Participants' views of outcomes: 45% to 69% achieved partial reduction in unwanted same sex sexuality, 14% achieved a total reduction in sexual attraction and identification. While the overall change in each dimension of sexuality was small to modest, together they resulted in a three-fold increase incongruence among all three components of sexual orientation. Benefits: Pursuit of SOCE to be associated with enhanced psychological well-being for a large majority of participants, with negative effects being reported by less than 1 in 20 consumers. 12.1% to 61.3% reported marked or severe positive psychosocial change. Harms: A minority of participants reported marked or severe negative psychosocial change following SOCE. Support Needs: NR

• Author (Date), • Country of origin of data, • Paper Title	Methodology/Aim/Focus	Sample (Size and characteristics)	Definition/Conversion practices described Assent/Consent	Consequences of Conversion Practices (impact/benefits/harms/support needs)
• Veale et al. (2021) • New Zealand • Gender Identity Change Efforts Faced by Trans and Non-Binary People in New Zealand: Associations with Demographics, Family Rejection, Internalised Transphobia, and Mental Health	Methodology: Quantitative Aim: This study examined the prevalence of GICE in Aotearoa New Zealand. They also aimed to replicate the findings of Turban et al.'s (2020) research that found a link between GICEs, unsupportive families, and adverse mental health and extend the analyses to further understand the underlying causation behind these correlations by examining (a) whether GICE mediates the relationship between family rejection and mental health and (b) whether internalized transphobia mediates the relationship between GICE and mental health (p 3). Focus: GICE	Sample size: n=610 Experienced CP: n=120 <u>Sample Characteristics:</u> Gender identity: Trans men 23.1%; Trans women 14.2%; Nonbinary AFAB 20.8%; Nonbinary; AMAB 30% Sexual orientation: NR Ethnicity: White 18%; Māori/Indigenous 28.9%; Pacific Islander 16.7%; Asian 10.5%; other 35.3% Age range: 14 -83 Mean: 32.1 Religion: Christian 14.1%; other religion 25.2%; No religion 17.1%	Definition: Gender identity change efforts (GICE) are an example of this stigma, due to their transphobic assumption that being TNB is pathological and/or undesirable and gender identities and behaviours that are not presumed or expected based on a person's sex assigned at birth should be suppressed or changed through efforts labelled as "therapy" (p1). Practices described: Focuses on GICE that are delivered by MH professionals but non-specific other than that. Assent/consent: NR	Participants' views of outcomes: NR Benefits: NR Harms: Participants with GICE exposure were more likely than those without such exposure to report psychological distress, non-suicidal self-injury, suicidal ideation, and suicide attempts. Support Needs: Not discussed, but calls for prohibiting GICE by MH professional and others

SOCE: Sexual Orientation Change Efforts

GICE: Gender Identity Change Efforts

SOGICE: Sexual Orientation and Gender Identity Change Efforts

SOGIECE: Sexual Orientation and Gender Identity Expression Change Efforts

AFAB/AMAB: Assigned Female/Male at Birth

MSN: Men who have sex with men

SMM: Sexual minority men

NR: Not reported



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