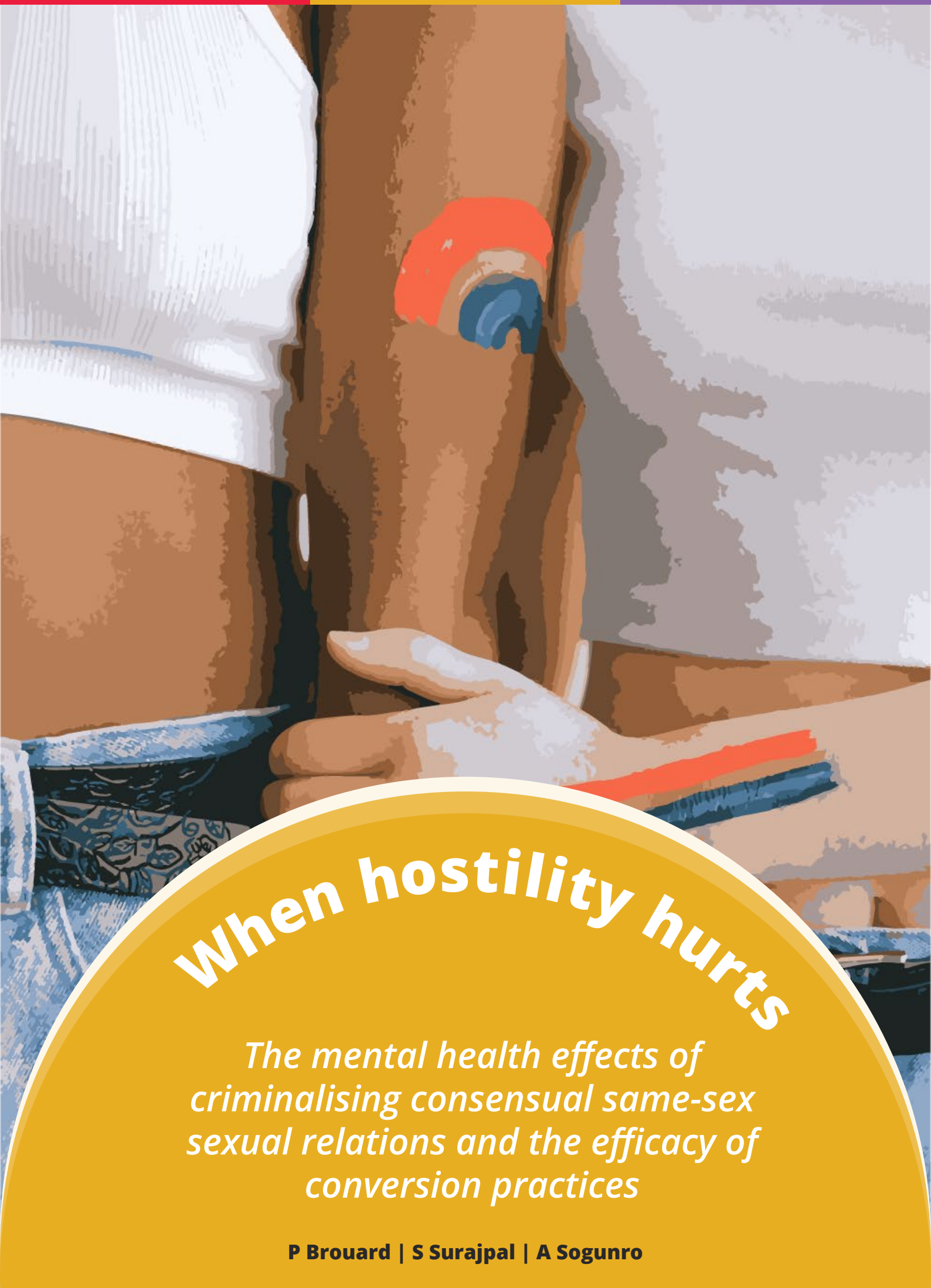

When hostility hurts

The mental health effects of criminalising consensual same-sex sexual relations and the efficacy of conversion practices

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1. Introduction

a. Purpose of briefing

This briefing is based on an expert testimony prepared by the Centre for Human Rights (CHR) and the Centre for Sexualities, AIDS and Gender (CSA&G) at the University of Pretoria, South Africa. It was prepared for a decriminalisation case and in the interests of confidentiality that country will not be named. We have received permission to produce this adapted briefing, as long as all markers related to the case have been removed.

The briefing sets out widely accepted medical and psychological knowledge on two key issues. First, the mental health effects of the criminalisation of consensual same-sex sexual relations and, second, whether homosexuality can be treated or cured through counselling or therapy. The briefing also highlights the human rights impacts of criminalisation and conversion practices on the rights of LGBTIQ+ persons.

The briefing was researched and drafted by Pierre Brouard, Clinical Psychologist and Deputy Director of the CSA&G and a member of the Executive of the Sexuality and Gender Division of the Psychological Society of South Africa, Sohela Surajpal (researcher) and Dr Ayodele Sogunro (manager) of the Sexual Orientation, Gender Identity and Expression, and Sex Characteristics (SOGIESC) Unit at the CHR.

2. Psychological impact of the criminalisation of same-sex sexual relations

a. Creation of a climate of rejection, fear and persecution

The criminalisation of consensual same-sex sexual relations has far-reaching impact, affecting not only those who are actually arrested and convicted for these crimes. Criminal sanctions create a pervasive climate of fear and persecution, encouraging stigmatisation, discrimination and violence which harm mental health outcomes of sexual minorities.

On this topic, the United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health has stated that 'criminalisation may not be the sole reason behind stigma, but it certainly perpetuates it, through the reinforcement of existing prejudices and stereotypes... Where same-sex conduct is illegal, sexual orientation may be treated as a problem that needs to be corrected, ignored or used to legitimize violence directed towards these individuals'.[1]

The United Nations High Commission has confirmed a 'link between criminalisation and homophobic hate crimes, police abuse, torture, and family and community violence, as well as constraints that criminalization places on work of human rights

1 A/HRC/14/20 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover para 22-23.

defenders working to protect the rights of LGBT persons'.[2]

This environment of fear, violence and impunity has negative implications for the mental health of sexual minorities targeted by these laws. In 2018, the Cornell University Centre for the Study of Inequality reviewed more than 300 studies reporting on primary research into the effects of discrimination on the health of gender and sexual minorities.[3] The review found that out of the 300 peer-reviewed studies, 286 studies (a total of 95%) concluded that discrimination is associated with mental and physical health harms for gender and sexual minorities.[4]

This impact can be described using the framework of minority stress theory. Minority stress theory posits that experiencing and fearing homophobic stigma causes feelings of distress that have profound negative impact for health outcomes.[5] Minority stress may affect health in two ways.

First, experiences of discrimination acts as a stressor that adversely effects emotional and physiological responses (for example, increase levels of anger and increased blood pressure).[6] When these responses are activated frequently over time, biological systems undergo strain and the individual experiences increased risk of poor physical and mental health outcomes.[7] The second and alternative way minority stress impacts health is through affecting health behaviour.[8] For example, constant experiences of discrimination may result in the development of unhealthy behaviour as coping mechanisms, such as taking up smoking or regular drinking, or failure to participate in healthy behaviour such as failing to seek medical treatment or screen for diseases.[9]

It is also well documented that lowered self-esteem arising out of systemic and structural homophobia can lead to poorer sexual decision making in gay men, leading to a higher risk of contracting HIV.[10]

Minority stress theory has enjoyed widespread empirical support as a framework for understanding mental health disparities among sexual minorities. In a seminal study on this topic, Meyer found that homosexual men who reported high levels of minority stress and experienced

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2 A/HRC/19/41 Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity: Report of the United Nations High Commissioner for Human Rights para 42.

3 Cornell University Center for the Study of Inequality 'What does the scholarly research say about the effects of discrimination on the health of LGBT people?' (2019).

4 Cornell University Centre for the Study of Inequality (n 3 above).

5 DJ Lick et al 'Minority Stress and Physical Health Among Sexual Minorities' (2013) 8 Perspectives on Psychological Science 528.

6 JH Ng et al 'Explaining the Relationship Between Minority Group Status and Health Disparities: A Review of Selected Concepts' (2019) 3(1) Health Equity 49.

7 Ng et al (n 6 above) 49.

8 Ng et al (n 6 above) 49.

9 Ng et al (n 6 above) 49 and 51.

10 PN Halkitis 'Discrimination and homophobia fuel the HIV epidemic in gay and bisexual men' Psychology and AIDS Newsletter April 2012 https://www.apa.org/pi/aids/resources/exchange/2012/04/discrimination-homophobia (accessed 24 March 2022).

internalised homophobia, expectations of rejection and discrimination, and actual events of discrimination and violence, were three times more likely to report elevated psychological symptoms such as anxiety, hopelessness and poor self-esteem in comparison with peers who reported lower levels of minority stress.[11] A study in 2008 investigated the experiences of 74 gay men and concluded that minority stress in the form of internalized homophobia, discrimination experiences, and expectations of rejection were differentially associated with HIV risk behaviour, substance use, and depressive symptoms.[12] In 2011 Hatzenbuehler compared the results of 31 852 11th grade students who completed a teen health survey with the supportiveness of their social environment and found that youth who were sexual minorities were 20% more likely to attempt suicide in unsupportive environments when compared to supportive environments.[13]

Additionally, the Special Rapporteur on Health has noted that:

> In jurisdictions in which their sexual conduct is criminalised, affected individuals are much more likely to be unable to gain access to effective health services, and preventive health measures that should be tailored to these communities are suppressed. The fear of judgement and punishment can deter those engaging in consensual same-sex conduct from seeking out and gaining access to health services.[14]

The Special Rapporteur has stated that this is also a direct result of health care workers' prejudice, hostility, lack of awareness and refusal to treat patients who are sexual minorities. Additionally, criminal laws may require health professionals to divulge details of patient interaction, jeopardising the doctor-patient relationship and medical confidentiality.

In addition, criminal laws encourage harassment and repression of human rights defenders who advocate for the rights of gender and sexual minorities. These human rights defenders may receive threats when doing their work, via letters and e-mails and on social media, including death threats and threats of sexual violence.[15] Online hate speech and harassment of LGBTQI+ activists is widespread.

b. Impact on those arrested, convicted and detained for same-sex conduct

These mental health outcomes are amplified in the case of persons who are arrested, convicted and punished for engaging in consensual same-

11 IH Meyer 'Minority stress and mental health in gay men' (1995) 36 Journal of Health and Social Behaviour 51.
12 ML Hatzenbuehler, S Nolen-Hoeksema and SJ Erickson 'Minority Stress Predictors of HIV Risk Behavior, Substance Use and Depressive Symptoms: Results from a Prospective Study of Bereaved Gay Men' (2008) 27(4) Health Psychology 460.
13 ML Hatzenbuehler 'The Social Environment and Suicide Attempts in Lesbian, Gay and Bisexual Youth' (2011) 127(5) Pediatrics 896 and 900-901.
14 Report of the Special Rapporteur on the Right to Health (n 1 above) para 18.
15 Office of the Council of Europe Commissioner for Human Rights 'Human Rights of LGBTI People in Europe: Current Threats to Equal Rights, Challenges Faced by Defenders, and the Way Forward' (2021) 7.

sex sexual conduct and are likely to experience discrimination and violence.

In 2021 a group of Ghanian human rights defenders was arrested for allegedly promoting homosexuality. The activists described their arrest as brutal. One said:

> I went into the conference room, tried to organize and hide our training material. They grabbed me and four of them started beating me with their hands, fists. When one participant took a video recording the incident, they stopped hitting me and started physically attacking the other participants. Then they called the SWAT team, heavily armed with body armor, weapons, and loud sirens.[16]

Another testified that:

> Police officers humiliated her and other lesbians in detention. She said that police officers guarding them would sometimes enter their cell with their friends and say, "Come and look at the lesbians, they were the ones who were caught at the hotel doing lesbianism."
>
> She said that the detainees were unable to bathe and that the authorities did not provide blankets, mattresses, food, or drinking water.[17]

These conditions have been confirmed as common for sexual minorities arrested and detained by the state. The United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has noted that when sexual minorities are arrested under laws criminalising same-sex conduct, 'a number of reports refer to the use of degrading language, contact and treatment during arrest' and 'men suspected of homosexual conduct are subjected to non-consensual anal examinations to "prove" or "disprove" their homosexuality'.[18]

Once arrested and detained, abuse is only heightened. The Subcommittee notes that:

> 'there is abundant evidence to conclude that torture and ill-treatment of lesbian, gay, bisexual, transgender and intersex persons are endemic concerns… *and that such treatment takes place in police stations, prisons, hospitals and other health-care settings, military, juvenile and migration detention facilities and other places of detention'.*[19] (Emphasis added)

Sexual minorities in prisons and other places of detention face ill-treatment from both officials and other inmates. The Subcommittee on the Prevention of Torture and Special Rapporteur on Torture have noted that there is usually a 'strict hierarchy' in detention facilities, and that sexual minorities tend to find themselves at the 'bottom of the hierarchy':

16 Human Rights Watch 'Ghana: LGBT Activists Face Hardships After Detention' 20 September 2021 https://www.hrw.org/news/2021/09/20/ghana-lgbt-activists-face-hardships-after-detention (accessed 23 March 2022).
17 Human Rights Watch (n 16 above).
18 CAT/C/57/4 Ninth Annual Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment para 60-61.
19 Report of the Subcommittee on Prevention of Torture (n 18 above) para 49.

> Complaints of insults, beatings, confinement and targeted forms of violence are not uncommon... Some studies have recorded that non-heterosexual inmates are 10 times more likely than heterosexual inmates to be sexually assaulted by other inmates, and 3 times more likely to be sexually assaulted by prison staff... for example, one gay inmate reported to the Subcommittee that he had been raped on multiple occasions and made to walk around wearing short skirts, and lesbians have reported having been subjected to so-called "corrective rape".

> Even measures that appear to be protective can often operate to the detriment of individuals. Authorities routinely rely on prolonged periods of protective custody, isolation or solitary confinement as default forms of protection, but those measures are extremely taxing on the person and restrict access to education, work and programme opportunities that affect time off for good behaviour and parole. As a result, lesbian, gay, bisexual and transgender persons are not only likely to serve their sentences in isolation, but also more likely to serve longer time.[20]

Upon release, sexual minorities convicted of same-sex conduct are likely to face ostracization and stigma which may cause them to lose their support structures, be alienated by family and friends, experience job loss and even homelessness. One Ghanian activist arrested and revealed to be lesbian said that upon her release from prison, her family came to know of her sexual orientation. She had been living with her aunt prior to arrest, but upon release her aunt forbade her from returning to the house. She was also prevented by family from seeing her two children. At the time of the interview, she was living with a friend and had no income or livelihood.[21]

The verbal, physical and sexual abuse endured during arrest and detention and the effect of stigma after release outlined above are naturally likely to negatively impact the mental health of affected persons.

A systematic review of literature on the experiences of sexual minorities in prison undertaken in 2021 confirmed the Subcommittee's findings on the abuse endured by sexual minorities in prisons and revealed that persons who endured these conditions experienced 'hypervigilance and increased stress and anxiety'[22] and 'significantly higher incidences of depression, anxiety and suicidality compared with the non-LGBTQ+ [prison] population'.[23]

Further research has shown that the constant threat of violence and strict regulation of sexuality sexual minorities experience in prison causes increased levels of anxiety and stress, which may lead to clinical depression, high levels of distrust, isolation and hypervigilance.

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20 Report of the Subcommittee on Prevention of Torture (n 18 above) para 61-64. Some excerpts have been omitted for brevity.

21 Human Rights Watch (n 16 above).

22 G Donohue, E McCann and M Brown 'Views and Experiences of LGBTQ+ People in Prisons Regarding Their Psychosocial Needs: A Systematic Review of the Qualitative Research Evidence' (2021) 18 International Journal of Environmental Research and Public Health 10.

23 Donohue, McCann and Brown (n 22 above) 10.

[24]Additionally, increased risk of rape, which for sexual minorities in prison is often violent and repeated, increases the risk of post-traumatic stress disorder as well as depression, anger, guilt, disruption of belief systems, and sexual dysfunction.[25]

Finally, 'protectionist' measures such as putting sexual minorities in solitary confinement for long periods of time for their protection is dangerous. The 'extreme level of sensory deprivation, over a prolonged period of time can cause people to lose the ability to concentrate, to hallucinate, and in some cases to lose their aptitude for social interaction'.[26]

The criminalisation and thus arrest and detention of sexual minorities under laws criminalising same-sex conduct has overwhelming negative effect on their mental health. It can be further argued that such arrests and inhumane treatment have a negative effect on sexual minority communities, causing fear and alarm, fracturing support systems and weakening social capital. A community divided is a less well community.

Often, police do not charge sexual minorities but use criminal laws to blackmail, harass and extort sexual minorities, contributing to the climate of fear.[27]

In sum, the criminalisation of consensual same-sex conduct creates an unsupportive and dangerous environment, increasing minority stress which harms the mental health of sexual minorities and preventing sexual minorities from seeking out and receiving adequate mental and physical health care. When sexual minorities are arrested and detained under these laws, they suffer further victimisation and abuse, leading to acute psychological harm.

These findings are uncontroversial and uncontested in the medical and psychological field.

3. Can homosexuality be cured?

a. Are conversion practices effective?

Conversion practices describes a range of practices which attempt to change the sexual orientation or gender identity of a person, generally in an attempt to 'cure' or 'treat' a homosexual or transgender identity.[28] Some of these may be religious, cultural or even surgical in nature, however, the main focus of this briefing are those practices rooted in psychotherapy, the so-called conversion 'therapy', with a brief reflection on other conversion practices, including studies from the African context.

24 E McCauley and L Brinkley-Rubinstein 'Institutionalisation and Incarceration of LGBT Individuals' in KL Eckstrand and J Potter (eds) Trauma, Resilience, and Health Promotion in LGBT Patients (2017) 158.
25 McCauley and Brinkley-Rubinstein (n 24 above) 158.
26 McCauley and Brinkley-Rubinstein (n 24 above) 158-159.
27 Amnesty International 'Speaking Out: Advocacy Experiences and Tools of LGBTI Activists in Sub-Saharan Africa' (2014) 46.
28 Academy of Sciences South Africa and Uganda Academy of Sciences 'Diversity in Human Sexuality' (2015) 49 and UK Council for Psychotherapy 'Conversion therapy – Consensus statement'

Psychotherapist approaches to conversion practices include cognitivebehavioural therapy or 'talk' therapy, where patients are encouraged to understand homosexual thoughts and behaviour and develop strategies to modify them,[29] as well as aversive methods to condition clients away from their homosexual desires, often by forcing patients to associate homosexual desire with physical or painful stimuli like electric shock, nausea-inducing chemicals, paralysis-inducing chemicals, and disturbing imagery.[30] Other behavioural methods mentioned in the literature included directed masturbation, orgasmic reconditioning, and hypnosis,[31] while medical interventions include lobotomies, removal of sex organs, administration of pharmaceutical drugs, hormone or steroid therapy.[32]

Underlying all the practices discussed above is the idea that same-sex attraction is a pathology (i.e., an illness or disorder of some kind) and, thus, can be cured through medical or psychological intervention. However, all contemporary, authoritative psychiatric and psychological sources consider same-sex attraction to be a natural part of human diversity and not a disorder.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychology Association and often considered the most authoritative source on mental and psychological disorders. The first edition of the DSM, published in 1952, classified homosexuality as a personality disturbance – a form of mental disorder. At the time, this was the prevalent view amongst psychologists, who viewed homosexuality as a disorder caused by, among other things, 'intrauterine hormonal exposure, excessive mothering, inadequate or hostile fathering, sexual abuse, etc'.[33] Although, notably, this view – even then – was challenged by some.

Sigmund Freud, often dubbed the father of psychology, wrote towards the end of his life that 'homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development'.[34] He went on to say that 'in general, to undertake to convert a fully developed homosexual into a heterosexual does not offer much more prospect of success than the reverse'.[35] (Emphasis added)

This view gained prominence and homosexuality was finally removed from the second edition of the DSM in

29 LA Gans 'Inverts, Perverts, and Converts: Sexual Orientation Conversion Therapy and Liability' (1999) 8(2) Boston University Public Interest Law Journal 8(2) 221, 223-224 and A/HRC/44/53 Practices of so-called "conversion therapy" Report of the Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity para 42.

30 Gans (n 29 above) 223 and Report of the Independent Expert (n 29 above) para 43.

31 Report of the Independent Expert (n 29 above) para 44.

32 Gans (n 29 above) 223 and Report of the Independent Expert (n 29 above) para 46.

33 J Drescher 'Out of DSM: Depathologizing Homosexuality' (2015) 5(4) Behavioural Sciences 56.

34 S Freud 'Anonymous (Letter to an American mother)' in E Freud (ed) The Letters of Sigmund Freud (1935) 423-4.

35 S Freud The Psychogenesis of a Case of Homosexuality in a Woman (1920) 145-172.

1973.[36] This change can be attributed to extensive research into same-sex attraction which had the effect of shifting scientific understanding.

Beginning in the 1950s Dr Evelyn Hooker, funded by the National Institute of Mental Health in the United States of America, tested the assumption that same-sex attraction was linked to psychopathology (psychological disorder).[37] Dr Hooker studied 30 homosexual males and 30 heterosexual males, controlled for age, IQ, and education. Dr Hooker administered three projective tests to each man, each test designed to measure a person's pattern of thought, attitudes, and emotions. Independent experts classified two-thirds of the heterosexuals and two-thirds of the homosexuals in the three highest categories of adjustment and could not distinguish respondents' sexual orientation at a level better than chance. The results of the study were clear: there was no evidence that gay men were mentally unhealthy or maladjusted. Hooker suggested in conclusion that '1. Homosexuality as a clinical entity does not exist. Its forms are as varied as are those of heterosexuality. 2. Homosexuality may be a deviation in sexual pattern *which is within the normal range, psychologically*'.[38] (Emphasis added)

Hooker's research challenged contemporary understanding and spurred a wealth of empirical research testing her conclusions.

For instance, in one of the most extensive studies on homosexuality, Curran and Parr studied 100 homosexual men in 1957, subjecting them to psychiatric testing and treatment.[39] Their sample was drawn from cases of active homosexuals referred for a psychiatric opinion after facing criminal charges, due to their own concern about homosexuality, or for various other psychiatric problems (for example, depression or excessive drinking) rather than direct worry over homosexuality.[40] Thus, the sample size was likely to contain a high proportion of the 'psychiatrically disturbed and criminally charged',[41] however, only 49% demonstrated any psychiatric abnormalities (other than homosexuality) and those abnormalities were 'often slight' and generally 'a reaction to the difficulties of being homosexual'.[42] Curran and Parr concluded that:

> If homosexuality is a disease (as has often been suggested), it is in a vast number of cases monosymptomatic, non-progressive, and compatible with subjective well-being and objective efficiency. In our series, both practising and non-

36 'Psychiatrist, in a shift, declare homosexuality no mental illness' The New York Times 16 December 1973 https://www.nytimes.com/1973/12/16/archives/psychiatrists-in-a-shift-declare-homosexuality-no-mental-illness.html (accessed 16 March 2022).
37 E Hooker 'The adjustment of the male overt homosexual' (1957) 21 Journal of Projective Techniques 18-31.
38 Hooker (n 37 above) 30.
39 D Curran and D Parr 'Homosexuality: An Analysis of 100 Male Cases Seen in Private Practice' (1957) British Medical Journal 797.
40 Curran and Parr (n 39 above) 797.
41 Curran and Parr (n 39 above) 800.
42 Curran and Parr (n 39 above) 801.

> practising homosexuals were on the whole successful and valuable members of society, quite unlike the popular conception of such persons as vicious, criminal, effete, or depraved.[43]

In the four decades since the publication of the DSM II, this position has remained sound, confirmed by extensive research.[44] The DSM III, DSM IV and DSM V reflect prevailing wisdom, definitively establishing that same-sex attraction is not a disorder. The American Psychology Association has affirmed this position when giving expert opinion in a number of court cases.[45] In 1990, the World Health Organisation also official removed homosexuality from its list of mental illnesses, no longer classifying homosexuality as a disease.[46]

Numerous national professional psychological bodies have released or endorsed statements agreeing with this position, such as bodies in Argentina, Uruguay, Germany, Russia, South Africa, Vietnam, Hong Kong, the Philippines, Denmark, Brazil, France, New Zealand, the United Kingdom and United States of America.[47] The Pan American Health Organization, which is the specialized health agency of the Inter-American system and the Regional Office for the Americas of the World Health Organization, released a position statement in 2012 stating that:

> There is professional consensus that homosexuality represents a natural variation of human sexuality without any intrinsically harmful effect on the health of those concerned or those close to them. In none of its individual manifestations does homosexuality constitute a disorder or an illness, *and therefore it requires no cure.*[48] (Emphasis added)

In 2018, the International Psychology Network for Lesbian, Gay Bisexual, Transgender and Intersex Issues (IPsy-Net) released a statement affirming that 'psychology as a science and a profession has expertise based on decades of research demonstrating that LGBTIQ+ identities and expressions are normal and healthy variations of human functioning and relationships… homosexuality is not a diagnosable mental disorder'.[49]

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43 Curran and Parr (n 39 above) 801.

44 The Academy of Sciences South Africa and Uganda Academy of Sciences (n 28 above) note that more than 100 empirical studies have confirmed Dr Hooker's conclusion that homosexuality is not inherently linked to psychopathology (although, stigma and discrimination may cause increased levels of psychological harm to persons who experience same-sex attraction).

45 See for example Jegley and Another v Picado (2001) 16 (Supreme Court of Arkansas) and Shields and Others v Madigan (2005) 3 (Supreme Court of the State of New York).

46 Organisation Panamericaine de la Sante 'Therapies to change sexual orientation lack medical justification and threaten health' https://www3.paho.org/hq/index.php?option=com_content&view=article&id=6803:2012-therapies-change-sexual-orientation-lack-medical-justification-threaten-health&Itemid=1926&lang=fr (accessed 16 March 2022).

47 Academy of Sciences South Africa and Uganda Academy of Sciences (n 28 above) 49.

48 Pan American Health Organization '"Cures" for an illness that does not exist: Purported therapies aimed at changing sexual orientation lack medical justification and are ethically unacceptable' (2012) 1.

49 IPsy-Net 'Statement on LGBTQI+ Concerns' (2018) 5.

Additionally, the body 'actively challenge[d] claims made by political, scientific, religious, or other groups that claim or profess that LGBTIQ+ identities, expressions, and sex characteristics are abnormal or unhealthy'.[50] This statement was endorsed by professional psychological associations based in: Australia, Brazil, Cameroon, Canada, Colombia, Germany, Guatemala, Hong Kong, Hungary, Lebanon, New Zealand, Norway, the Philippines, Russia, South Africa, Spain, the United Kingdom and the United States.[51]

In sum, the pre-eminent position adopted by experts based on scientific evidence and years of research is that same-sex attraction is not a pathology or disorder, but instead, a natural part of human diversity.

Naturally, science does not support attempting to 'cure' natural parts of human diversity. As such, prevailing medical opinion does not support conversion practices, including therapy and counselling aimed at treating same-sex attraction. Some therapists continue to engage in so-called conversion therapy of the kind endorsed by section 16 of the Dominica Criminal Code, however, these practitioners are in the minority and their practices are not supported by broad professional consensus.

Several studies of therapists who subscribed to conversion 'therapy' and attempted to prove its efficacy are detailed below. As is apparent, they did not succeed in proving efficacy.

In the 1960s and 70s, conversion 'therapy' remained popular and a number of studies attempted to investigate and prove the efficacy of various techniques. Curran and Parr(mentioned above) reviewed 100 homosexual men undergoing psychiatrictreatmentforhomosexuality and were able to follow up with 59 of those men four years after treatment. 25 of those men had continued to undergo psychotherapy during the follow up period of four and a half years.[52] Of those 59, only nine reported increased capacity for heterosexual attraction.[53] Six of those men had previously identified as bisexual, and so were always in any event attracted to both men and women.[54] Of the men who were exclusively attracted to men, only one reported an increase in heterosexual attraction.[55] Additionally, Curran and Parr noted that 'when a change was found it often amounted only to a slight alteration in the balance of masturbatory fantasies'.[56] The 25 men who underwent psychotherapy during the follow up period were found to have no statistically significant difference in outcome to men who had not undergone said treatment.[57]

50 IPsy-Net (n 49 above) 5.
51 For a full list see IPsy-Net (n 49 above) 6.
52 Curran and Parr (n 39 above) 800.
53 Curran and Parr (n 39 above) 799. 47 of the men found their attraction unchanged and the remaining 3 (bisexual men) found that they experienced more homosexual attraction and desire.
54 Curran and Parr (n 39 above) 799.
55 Curran and Parr (n 39 above) 799 and 801.
56 Curran and Parr (n 39 above) 799.
57 Curran and Parr (n 39 above) 800.

Similarly, Bieber *et al* conducted research on a group of 106 male homosexuals who underwent between 150 and 350 hours of psychotherapy, well beyond the normal amount.[58] 29 of the 106 (27%) showed a significant shift to exclusive heterosexuality at the time of their last reported therapy session.[59] Only 18% of the exclusive homosexuals, in contrast to 50% of the bisexuals, showed a significant change.

Bieber's study is famously considered a success story for advocates of conversion 'therapy'; however, the study was criticised for failing to follow up with patients after treatment.[60] In response to this criticism, Bieber reported that only 15 of the 29 'cured' patients could be accessed for a follow up five years after treatment. Of this 15, only 12 patients had remained exclusively heterosexual, a total of 11% of the initial sample.[61]

Freund studied a large group of male homosexual patients who were shown images of nude and semi-nude men while being administered medication that made them feel highly nauseous, and were also shown films of nude or semi-nude women after receiving injections of testosterone, designed to increase arousal.[62] Immediately after treatment, 25% of the patients showed increased heterosexual adaptation, however, a follow up with patients after five years revealed that all of the allegedly 'recovered' patients once more had homosexual desires and most engaged in homosexual behaviour.[63]

More recently, in 2015 in the largest survey of its kind, Dehlin et al reviewed 1,019 persons who had undergone conversion practices in both medical and religious contexts for an average period of 10-15 years each.[64] The study found that only one respondent out of 1,019 (0.1%) subsequently identified as heterosexual.[65] None of the survey respondents reported that their same-sex attraction had been entirely eliminated and only a total of 3.1% reported a change in their sexuality.[66] Of the 3.1% who reported a change, many did not report a change in attraction but rather a change in sexual behaviour or how they thought about their sexual orientation.[67] For example, they were still attracted to persons of the same sex but did not act on their desire or they thought that their sexual orientation did not define who they were.

With the clear failures of these and numerous other attempts to alter sexual attraction, the profession began to acknowledge that conversion

58 I Bieber et al Homosexuality: A Psychoanalytic Study (1962) cited in FX Acosta 'Etiology and Treatment of Homosexuality: A Review' (1975) 4(1) Archives of Sexual Behaviour 19.
59 Acosta (n 58 above) 19.
60 Acosta (n 58 above) 19.
61 Acosta (n 58 above) 19.
62 K Freund 'Some problems in the treatment of homosexuality' in HJ Eysenck (ed) Behaviour Therapy and the Neuroses (1960) 312-326.
63 Freund (n 62 above) 326.
64 JP Dehlin et al 'Sexual Orientation Change Efforts Among Current and Former LDS Church Members' (2015) 62(2) Journal of Counselling Psychology 95-105.
65 Dehlin (n 64 above) 100.
66 Dehlin (n 64 above) 101.
67 Dehlin (n 64 above) 101.

'therapy' lacked empirical support as a sound medical or psychological practice.

In 1997, the American Psychological Association adopted a resolution expressing its concern about the 'ethics, efficacy, benefits, and potential for harm of therapies that seek to reduce or eliminate same-gender sexual orientation', noting that the topic was subject to extensive debate.[68] In 2009, the American Psychological Association adopted a resolution expressing its concern about 'the resurgence of sexual orientation change efforts' (SOCE).[69] The 2009 resolution noted that, while some individuals appeared to learn how to ignore their same-sex attraction as a result of so-called conversion 'therapy' or SOCE:

> There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area found that sexual orientation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose.[70]

The resolution concluded that there is insufficient evidence to support the use of psychological interventions to change sexual orientation and resolved to encourage mental health professionals to avoid promoting or promising change in sexual orientation.[71]

The IPsy-Net statement mentioned above (endorsed by professional psychological associations based in: Australia, Brazil, Cameroon, Canada, Colombia, Germany, Guatemala, Hong Kong, Hungary, Lebanon, New Zealand, Norway, the Philippines, Russia, South Africa, Spain, the United Kingdom and the United States) is clear that:

> As LGBTIQ+ identities and orientations are normative variations of human experience and are not diagnosable mental disorders per se, they do not require therapeutic interventions to change them. Given that conversion therapies actively stigmatize same-sex orientations and transgender identities, as well as have the potential for harm, we support affirmative approaches to therapy for LGBTIQ+ people and reject therapies that aim to cause harm to LGBTIQ+ people.[72]

Thus, despite decades of attempts to successfully alter the sexual orientation of same-sex attracted persons, proponents of conversion practices have simply failed to produce evidence to support the efficacy of these practices. As a result, the prevailing position is that conversion therapy is unnecessary and ineffective. Instead, the medical and psychological profession have as early as the 1960s

68 American Psychological Association 'Resolution on appropriate therapeutic responses to sexual orientation' (1998) 53 American Psychologist 934–935.

69 BS Anton 'Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors' (2010) 65 American Psychologist 385.

70 Anton (n 69 above).

71 Anton (n 69 above).

72 IPsy-Net (n 49 above) 5.

supported interventions aimed toward assisting homosexuals to accept their sexual orientation and to 'assist the homosexual patient through professional efforts to re-educate public views and thus reduce societal and legal condemnation of homosexuality'.[73]

b. Conversion practices in the African context

In 2019, OutRight Action International, in partnership with three partner organizations – The Initiative for Equal Rights (TIERS) in Nigeria, galck+ in Kenya, and Access Chapter 2 (AC2) in South Africa – commenced a project to document and end conversion practices that impact LGBTQ+ people.

The study explored the impact of conversion practices in Nigeria, Kenya and South Africa.[74] A total of 2,891 LGBTQ+ respondents from the three countries were surveyed, and more than half of the respondents indicated that they had undergone some form of conversion practices. The key findings are as follows:

- Conversion practices take various forms, including talk therapy, exorcism, drinking herbs, prayer, laying of hands for healing, beatings, and rape or another form of sexual assault.
- Frequently, several forms of conversion practices are combined in an effort to change the identity or sexual orientation of one person, either simultaneously or over different periods. As a result, most of the respondents in this survey indicated that they endured more than one form of conversion practice.
- Practices against LGBTQ+ individuals increase in intensity from the moment of discovery, starting wit family talks and conversations and escalating to counselling or prayer, and then to violence, economic duress, and/or ostracization when other methods do not work.
- Conversion practices are often perpetuated over a long period of time with the aim that change occurs, and they usually do not end until the victims affirm that they have been changed and are now heterosexual and/or cisgender (cisgender describes or relates to a person whose sense of personal identity and gender corresponds with their birth sex).
- Religious leaders, mental health practitioners, and family members were found to be the main perpetrators of conversion practices, while family members were found to be the initiators of conversion practices. However, some LGBTQ+ individuals seek out these practices.
- Conversion practices can have a negative impact on the physical and mental health of LGBTQ+ survivors. The research found that many survivors of conversion practices

73 See for example Acosta (n 58 above); W Churchill Homosexual Behavior Among Males (1967) and M Schofield Sociological Aspects of Homosexuality (1965). As a result, some countries have banned or plan to ban conversion therapy entirely. See here for a list of those countries: https://www.stonewall.org.uk/about-us/news/which-countries-have-already-banned-conversion-therapy

74 Converting Mindsets, Not our Identities. Summary of the Research Findings on the Nature, Extent, and Impact of Conversion Practices In Kenya, Nigeria, and South Africa, July 2022

suffer from depression, social anxiety, substance abuse, and thoughts of or attempts of suicide.

These findings suggest that conversion practices are a widespread and complex issue that take various forms and are often perpetuated for a long period of time. It highlights the negative impact of conversion practices on the physical and mental health of LGBTQ+ survivors, and underscore the need for further research and intervention in order to address and prevent these harmful practices and their long-term, destructive consequences.

c. Conversion practices as a form of torture or cruel, inhuman or degrading treatment

Besides being ineffective, counselling and treatment aimed at 'correcting' same-sex attraction or gender identity is considered cruel, inhuman and degrading. This is especially so when the patient has not consented to treatment and undergoes treatment as a result of coercion or duress, for example, due to family pressure or by order of a court.

Some forms of conversion practices are physically harmful, such as those involving electroshock therapy, arduous exercise, beatings and the administration of medications to cause severe nausea or paralysis in an attempt to force patients to form negative associations with same-sex attraction.[75] Additionally, the practices of administering hormones, steroids and medication, surgically removing sexual organs and even, historically, conducting lobotomies (a surgical operation performed on the brain to sever the connection between the frontal lobes and the rest of the brain) are clearly dangerous.[76]

For instance, the Inter-American Commission on Human Rights has reported that lesbian women in clinics in Ecuador have been shackled, beaten, subjected to force-feeding or food deprivation, forced nudity, isolation and solitary confinement, restrained for days and raped as part of conversion attempts as recently as 2015.[77]

These methods cause immense pain, injury, might result in mutilation, brain death and even, in some instances, death.[78]

Electroshock therapy, for instance, causes significant disorientation, cognitive deficits, and retrograde amnesia, which can be severely distressing even when administered properly.[79] It can even lead to violent convulsions when administered without anaesthetic and muscle relaxants, often resulting in joint dislocations and bone fractures.[80] Medication administered is generally medically inappropriate or

75 Gans (n 29 above) 223 and Report of the Independent Expert (n 29 above) para 43-46.
76 Gans (n 29 above) 223 and Report of the Independent Expert (n 29 above) para 43-46.
77 Inter-American Commission on Human Rights 'Violence against Lesbian, Gay, Bisexual, Trans and Intersex Persons in the Americas' (2015) para 200.
78 Centre for Human Rights University of Pretoria 'Report on Current Practices in Conversion Therapy, Emerging Technology, and the Protection of LGBTQ+ Rights in Africa' (2021) 8-9.
79 Independent Forensic Expert Group 'Statement on conversion therapy' (2020) 72 Journal of Forensic and Legal Medicine 3.
80 Independent Forensic Expert Group (n 78 above) 3.

used forcibly or without the individual's consent, and is 'likely to intensify the psychological terror or trauma related to the experience of conversion therapy and has been recognised as a method of torture or other cruel, inhuman, or degrading treatment'.[81] These medications cause sexual dysfunction, movement disorders, mental slowing,tiredness, memory problems, numbness of the body, weight gain, among other effects.[82]

Even seemingly more benign forms of therapy, such as cognitive behavioural therapy or 'talk' therapy may often have harmful side effects. Patients are subjected to what often amounts to verbal abuse and humiliation as 'session after session, the individual is confronted with their own "deviancy," while repetition and duration increase its intensity and importance'.[83] These forms of conversion practices cause inner-conflict over patients' self-identity and may lead to negative self-image, trauma responses and suicidal ideation, sometimes resulting in individuals committing suicide.[84]

These practices can also cause avoidance behaviours, hypervigilance, difficulty falling or staying asleep, intrusive flashbacks, traumatic nightmares, and other symptoms of post-traumatic stress disorder.[85] Many patients experience depression, guilt, intimacy avoidance, sexual dysfunction, and religious and spiritual conflict lasting long after conversion therapy has ceased.[86]

The United Nations' Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity has concluded that common methods of conversion practices are 'conducive to psychological and physical pain and suffering'.[87]

The Independent Forensic Expert Group of the International Rehabilitation Council for Torture Victims, a group of preeminent international medico-legal specialists from 23 countries, has found that

> Conversion therapy represents a form of discrimination, stigmatisation, and social rejection. Many conversion therapy practices bear similarity to acts that are internationally acknowledged to constitute torture or other cruel, inhuman, or degrading treatment or punishment. Those include beatings, rape, forced nudity, force-feeding, isolation and confinement, deprivation of food, forced medication, verbal abuse, humiliation, and electrocution.[88]

The Group has concluded that 'all forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering', leading to feelings of powerless,

81 Independent Forensic Expert Group (n 78 above) 3.
82 Independent Forensic Expert Group (n 78 above) 3.
83 Independent Forensic Expert Group (n 78 above) 3.
84 Centre for Human Rights (n 77 above) 9-10.
85 Independent Forensic Expert Group (n 78 above) 3
86 DC Haldeman 'Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies' (2002) Journal of Gay and Lesbian Psychotherapy 120.
87 Report of the Independent Expert (n 29 above) para 55.
88 Independent Forensic Expert Group (n 78 above) 3.

extreme humiliation, shame, guilt, self-disgust, and worthlessness, which result in:

> a decrease in self-esteem, episodes of significant anxiety, depressive tendencies, depressive syndromes, social isolation, intimacy difficulties, self-hatred, sexual dysfunction, and suicidal thoughts. In many studies, the rates of suicidal ideation and suicide attempt are several times higher than in other lesbian, gay, bisexual, trans, and gender diverse populations who have not been exposed to conversion therapy.[89]

As a result, prevailing medical opinion is emphatic that conversion practices should be avoided, and many psychiatric associations condemn the practice in the strongest terms.[90] Subjecting a person to conversion 'therapy' as a result of a court order, where that person has not voluntarily sought out the therapy, would also amount to a gross breach of professional ethics.

The Pan American Health Organisation in its 2012 position paper stated that:

> 'From the perspective of professional ethics and human rights protected by regional and universal treaties and conventions such as the American Convention on Human Rights and its Additional Protocol, [conversion therapy practices] represent unjustifiable practices that should be denounced and subject to corresponding sanctions.'[91]

This position is in conformity with international human rights law. The Special Rapporteur on the Right to Health has stated that 'attempts to "cure" those who engage in same-sex conduct are not only inappropriate, but have the potential to cause significant psychological distress and increase stigmatization of these vulnerable groups'.[92]

The Independent Expert summarises the approach to conversion practices in international human rights law as such:

> United Nations anti-torture machinery has concluded that they can amount to torture, cruel, inhuman or degrading treatment. The Committee against Torture and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment have issued explicit reproaches against the treatments that are forced, involuntary or otherwise coercive or abusive.[93]

The Independent Expert concludes that 'practices of "conversion therapy" comprise treatment that is degrading, inhuman and cruel in its very essence and on the risks that it creates for the perpetration of torture', which 'may engage the international responsibility of the State'.[94] The Independent Expert and Subcommittee on Torture

89 Independent Forensic Expert Group (n 78 above) 3.
90 Anton (n 69 above) 385; IPsy-Net (n 49 above) 5 and Pan American Health Organization (n 48 above) 1.
91 Pan American Health Organization (n 48 above) 1.
92 Report of the Special Rapporteur on the Right to Health (n 1 above) para 23.
93 Report of the Independent Expert (n 29 above) para 62.
94 Report of the Independent Expert (n 29 above) para 65.

recommend states ban conversion therapy. [95]

d. Alternative approaches

Some medical and psychological professionals continue to engage in conversion 'therapy' practices (often covertly) and espouse the efficacy of these practices, along with the view that that same-sex attraction is a pathology. While there have been historical justifications for the pathologizing of homosexuality, and attempts by conversion therapy practitioners to prove their efficacy of their methods, this briefing finds their arguments uncompelling for a number of reasons.

First, as detailed above, they are in the minority. The vast majority of research, authoritative sources and professional bodies maintain that homosexuality is not a pathology and cannot be cured with any measure of efficacy.[96]

Second, empirical evidence does not support the efficacy of conversion 'therapy'. In 2021 the government of the United Kingdom commissioned a study into conversion 'therapy' and found that there were no randomised controlled trials assessing the efficacy of conversion 'therapy', the 'scientific gold standard' for assessing treatment efficacy:

> Due to a lack of controlled prospective studies, a reliance on self-reporting, potential sampling biases, a lack of objective measures, a lack of follow-up data and the inclusion of various conversion therapy methods within studies, published research does not meet scientific "gold standards" for making robust claims about effectiveness. Therefore, there is no sound basis for claims that conversion therapy is effective at changing sexual orientation or gender identity.[97]

Indeed, many scholars have levelled similar criticism on conversion 'therapy' studies. Many of the studies purporting to show limited success of conversion 'therapy' techniques suffer from serious methodological flaws and thus are not sound sources.[98]

95 Report of the Independent Expert (n 29 above) para 87 and Report of the Subcommittee on Prevention of Torture (n 18 above) para 81.

96 This is set out in great detail in the sections above and is not repeated here.

97 Government of the United Kingdom 'Conversion therapy: an evidence assessment and qualitative study' 29 October 2021 https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/conversion-therapy-an-evidence-assessment-and-qualitative-study#fn:6 (accessed 22 March 2022).

98 See for example DC Haldeman 'The practice and ethics of sexual orientation conversion therapy' (1994) 62 Journal of Consulting and Clinical Psychology 221-227 and DC Haldeman 'Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy' (2002) 33(3) Professional Psychology: Research and Practice 261. Haldeman argues that 'it is nearly impossible to obtain a random sample of research participants who have been treated for their sexual orientation, and it is equally as difficult to assess outcomes in a way that does not contaminate the scientific process with social bias. This makes it difficult to make meaningful generalisations about these treatments'. Acosta (n 58 above) 19 calls this group 'a highly select and motivated population who voluntarily sought treatment' and warns that 'whether or not clinical patients all want to change their sexual orientation is another matter', likely to effect efficacy. Haldeman also points out that many studies rely on self-reporting, concerning because patients are 'especially susceptible to the influence of social demand in their own reporting of treatment success'. There is no scientifically sound way to determine the veracity

Third, even those therapists who are (or historically, were) proponents of conversion 'therapy' do not maintain its efficacy as a practice. Haldeman notes that even the most enthusiastic proponents of conversion 'therapy' can only claim an approximately 30% success rate.[99] Above, we have described a number of studies conducted, in many instances, by proponents of conversion therapy testing their own methods with dismal rates of success.[100]

Birk *et al*, who conducted rigorous testing on their own conversion therapy programme and found that only two out of eight patients recorded 'improvement',[101] conceded that conversion practices 'cannot be expected to lead to extinction of homosexual responses, but only to their suppression through punishment'.[102]

Thus, even among those who design and promote conversion 'therapy' (and thus have a vested interest in espousing the efficacy of the practice) and even given the serious methodological flaws of their studies as outlined above, there is a concession that conversion 'therapy' is capable of only very limited success.

Fourth, ideas and practices relating to conversion practices do no operate in a vacuum, and often reflect dominant ideas in a particular context. Social and cultural norms, religious values and legal regimens which declare sexual and gender minorities to be mentally ill, create an enabling context for conversion practices to thrive. Psychologists themselves reflect their social milieu and those who conduct these practices have failed in their duty to 'first do no harm' and are complicit in abuses of the victims of these unethical practices.

Finally, the uncontested contemporary medical and psychological evidence and human rights position is that it is cruel, degrading, inhumane treatment which may in some instances amount to torture.[103] Proponents of conversion practices have no good response to this point. Conversion 'therapy' breaches the commitment of medical and mental health professionals to do no harm and, thus, even if it were effective, it is not an acceptable medical or psychological treatment.

4. Conclusions

The briefing concludes that the criminalisation of same-sex relations is detrimental to the mental health of sexual minorities. Additionally, the briefing concludes that it is neither psychologically nor legally sound to

attempt to attempt to treat or cure

of these claims. Many studies simply take as fact the claims of men who are incentivised by society to say that they have been successfully treated, regardless of whether this is true. Finally, Haldemanpoints out that few conversion therapy studies offer any follow-up data. This is significant because follow-up data has revealed that the effects of conversion therapy are temporary and diminish within years or even weeks.

99 DC Haldeman 'Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies' (2002) 5 Journal of Gay and Lesbian Psychotherapy 119.

100 This is set out in great detail above and is not repeated here.

101 L Birk et al 'Avoidance Conditioning for Homosexuality' (1971) 25 Archive of General Psychiatry 322.

102 Birk et al (n 100 above) 323.

103 This is discussed in detail in section 3(b) of this report above and is not repeated here.

same-sex attraction through ounselling or 'therapy'.

Criminalising consensual same-sex conduct harms the mental health of sexual minorities by exposing arrested and detained sexual minorities to physical, verbal and sexual abuse as well as isolation and loss of support. Even those sexual minorities who are never arrested or detained under these laws suffer due to the creation of a hostile and unsafe social environment, which aggravates minority stress and leads to negative mental health outcomes. LGBTQI+ people and their communities are broken down by the hostile actions of state actors, leading to further well-documented harms.

The briefing further concludes that, besides a fringe minority of therapists, the established medical and psychological position, supported by a wealth of empirical evidence, is that it is not possible to genuinely alter the sexual orientation of a person and that therapeutic practices which claim to do so are both ineffective and harmful.

5. A note on terminology

The acronym LGBTIQ+ (which itself has variations) is widely used to describe sexual and gender minorities. It refers to people who identify as lesbian, gay, bisexual, transgender, intersex or queer and the (+) allows for other identities and expressions. While anti-homosexuality laws might be aimed specifically at people who identify as gay or lesbian, they can also be invoked against people who may be accused of same-sex sexual acts, even if they do not identify as such.

And indeed, as this briefing argues, such laws create a climate of fear for any person who expresses an alternative sexual or gender identity or who falls into the intersex category, simply because they are different. Acronym and other usage may differ in the report, depending on sources cited.

About the Centre for Sexualities, AIDS & Gender

The Centre for Sexualities, AIDS & Gender (CSA&G) is a 23-year-old transdisciplinary research and programming hub at the University of Pretoria that works at the interface of the humanities and social sciences. With the vision of "understanding power, exploring diversity and enabling inclusivity" the CSA&G has three main objectives for the next five years. They are: promoting and building sexual and gender justice; expanding transformation, diversity and inclusivity; and exploring the social and human dimensions of HIV and health.

About the Centre for Human Rights

The Centre for Human Rights (CHR) is an academic department of the Faculty of Law at the University of Pretoria, South Africa. It also doubles as a Non-Profit Organisation, therefore functioning as a teaching, training and research department as well as implementing human rights projects. Formed in May 2016, the Sexual Orientation Gender Identity and Expression and Sex Characteristic (SOGIESC) Unit is a project unit of the CHR with the mandate to advocate for and work towards equality, inclusion, non-discrimination, non-violence and non-heterosexism for lesbian, gay, bisexual, transgender, intersex, and other non-binary and gender-nonconforming people. The SOGIESC Unit has been responsible for presenting statements at the African Commission on Human and Peoples' Rights on LGBTIQ+ issues; organising a yearly advanced human rights short course on sexual minorities rights; and convening a strategic litigation and advocacy workshop for LGBTIQ+ human rights defenders in Africa.

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