

Protecting Canadian sexual and gender minorities from harmful sexual orientation and gender identity change efforts

A brief submitted to the Standing Committee on Health for the Committee's study of LGBTQ2 Health in Canada

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Summary

Sexual orientation and gender identity change efforts (SOGICE)^a, are pseudo-scientific practices intended to change, repair, convert, or otherwise suppress unwanted feelings or expressions of sexual attraction to members of the same gender or unwanted feelings or expressions of incongruence between one's biological sex assigned at birth and gender identity.

SOGICE are not only ineffective at changing sexual orientation and gender identity but are associated with numerous psychological harms, including poor self-esteem, self-hatred, depression, anxiety, problematic substance use, and suicide ideation and attempts. For this reason, SOGICE have been unequivocally denounced by numerous health professional bodies nationally and internationally. Despite these denouncements, SOGICE continue in Canada today. More than 20,000 sexual minority Canadians are estimated to have been exposed.

We therefore recommend:

- 1. A federal ban on SOGICE through the criminal code;**
- 2. Provision of resources to support and heal SOGICE survivors;**
- 3. Investment in research to further develop evidence-based strategies to decrease the mental health impacts of SOGICE.**

Problem statement

While various forms of “aversion therapy” have been used with sexual and gender minorities for over a century, the development and delivery of modern forms of SOGICE accelerated in the wake of the American Psychiatric Association's decision to remove homosexuality from the Diagnostic and Statistical Manual (DSM) in 1972.^{1,2} “Sexual Orientation Disturbance” subsequently replaced homosexuality in the DSM, categorizing homosexuality as a mental illness *if* same-gender attraction caused an individual distress and change was desired.³ This now discredited framing of homosexuality as changeable ushered in modern SOGICE and gave these practices a foothold during the 1970s.³ By the 1990s, rigorous psychological research had accumulated, showing severe and lasting negative health effects of SOGICE.¹

Public awareness of and response to the continued harmful practice of SOGICE has lagged behind this scientific research. Although some Canadian provinces have taken action in recent years, a federal response to SOGICE has been absent, leaving tens of thousands of Canadians, particularly youth, vulnerable.^{4,5}

SOGICE are delivered under many names and labels and by many different organizations and individuals. For example, the “ex-gay” movement has been led by multiple organizations including Exodus Global Alliance, New Directions Ministries, and Journey Canada (formerly called Living Waters), and while the names and roles of these organizations have changed, the practices continue in Canada today.⁵

Moreover, historic practices of SOGICE have left an indelible imprint on several generations of sexual and gender minority Canadians who continue to struggle with the effects of receiving

^a SOGICE are also known as “conversion therapy” or “reparative therapy”.

SOGICE. This is because the health consequences of SOGICE are not limited to the period immediately following attendance but rather may continue for years or decades after.¹ As such, SOGICE are substantial contributors to the multiple health inequities—particularly those relating to mental health and substance use—that burden sexual and gender minority^b Canadians.^{6–11}

The severe and sustained negative health outcomes resulting from SOGICE require action.

Most significantly, one third of SOGICE survivors have attempted suicide.¹² Research on SOGICE has identified the following additional negative health consequences for those who received SOGICE:

- Suicide ideation and self-harm^{1,13–15};
- Anxiety^{12,15}
- Depression^{13–15}
- Poor self-esteem; self-hatred^{1,15,16}
- Problematic substance use^{12,13}
- Social isolation and loneliness¹²

Youth are especially vulnerable to being coerced or compelled to attend SOGICE against their will.¹⁷ Parents or guardians living in environments that lack adequate resources to support families with sexual or gender minority youth (e.g., PFLAG) may turn to SOGICE in response to distress expressed by youth, or through parents' own observations.¹⁴ The appeal of SOGICE is further heightened in the context of gaps in the availability of sexual and gender minority-affirming spaces for youth in Canada—such as gay-straight alliances or gender and sexuality alliances (GSAs).¹⁸ Thus, SOGICE are inextricably linked to structural supports available for sexual and gender minority people and their families.

Prevalence and nature of SOGICE

SOGICE were gradually marginalized within medical and psychological professions after the American Psychiatric Association's decision to remove homosexuality from the DSM in 1972—a result of both shifting understandings of homosexuality as part of normal human diversity, and strong evidence that SOGICE are ineffective and that sexual orientation cannot be changed.^{1–4} This marginalization, however, has unintentionally driven SOGICE underground and into settings beyond healthcare providers' offices, notably including religious organizations.^{16,17} Today SOGICE are unequivocally denounced by the Canadian Psychological Association¹⁹, the American Psychiatric Association²⁰, the American Psychological Association²¹, the American Academy of Pediatrics, the National Association of Social Workers, and numerous other health professional bodies.¹⁶

Unfortunately, these denouncements have not brought an end to SOGICE. In Canada, a recent survey of over 8,000 sexual minority men (*Sex Now*) estimated that 4% have been exposed to SOGICE at some point during their lifetime.¹² This estimate corresponds to a population of at least 20,000 sexual minority men in Canada who have attended SOGICE.²² Countless more sexual and gender minorities of diverse gender identities have been exposed.¹⁷

^b We define sexual minority people as those with non-heterosexual identities, sexual behaviours, or romantic or sexual attractions.⁴¹ Gender minority people are defined as transgender and gender nonconforming people whose sex assigned at birth is different from their gender identity.⁴²

We believe that 4% is an underestimate of the prevalence of SOGICE exposure for the following reasons. First, in the *Sex Now* study, 30% of those exposed to SOGICE had attempted suicide; assuming this association extends to suicide deaths, many individuals who were exposed to SOGICE and subsequently died by suicide are unfortunately missing from the survey sample. Second, interviews with SOGICE survivors suggest that many SOGICE survivors remain reluctant to participate in LGBTQ2-branded spaces or events or even identify as a sexual minority; thus, SOGICE survivors are less likely than the average sexual minority individual to be recruited into the study (which relies upon sexual minority community organizations, websites, social media channels to recruit participants, and sexual minority identification).

Further supporting the notion that 4% is an underestimate of SOGICE exposure are data from the United States, which estimate that 7% of sexual and gender minority adults have been exposed to SOGICE.¹⁷ In this study, approximately 50% of SOGICE survivors were exposed during adolescence.

In the Canadian *Sex Now* survey, SOGICE exposure was prevalent in every age group—including the youngest members of the sample—and in every province—including provinces of British Columbia and Quebec, which have 40+ year histories of enacting legal protections for sexual minority people (Appendix A).²³ Clearly these legal protections have not extended to protect sexual and gender minority Canadians from harmful SOGICE practices.

In recent individual interviews with SOGICE survivors, three prominent and consistent themes were identified. First, all of the survivors were initially exposed to SOGICE in a religious (specifically Christian) context. Interviewees acknowledged that Christianity need not be at odds with a minority sexual orientation or gender identity. Indeed, at least one Canadian organization that previously practiced SOGICE has begun the work of reconciliation, enabling sexual and gender minority Christians who have been exposed to SOGICE to heal without abandoning their deeply held faith.²⁴ Nonetheless, the prevalence of Christianity and associated stigmatizing beliefs about sexuality and gender have undoubtedly contributed to the practice of SOGICE in Canada. Second, all survivors reported harmful psychological effects, ranging from mild distress to severe anxiety, self-hatred, and suicide attempts. In addition to inducing psychological suffering, SOGICE contributed to a delay in survivors' development of an integrated and positive sense of their sexual or gender identity. This delay in turn increased social isolation and reduced access of social supports—a significant loss given that many sexual and gender minority people find strength through some form of attachment to sexual and gender minority communities.^{25–27} Finally, survivors described the process of recovery from SOGICE as one that was ongoing, likely lasting for years if not a lifetime. In this sense, support for SOGICE survivors may follow models for other individuals exposed to trauma.²⁸

Given that professional bodies in Canada have largely self-regulated to ensure practitioners are aware of the harmful and ineffective nature of SOGICE, and based on recent interviews with Canadian SOGICE survivors, we conclude that SOGICE is predominantly occurring in settings outside of healthcare providers' offices in Canada. Indeed, in research from the US, more than 50% of SOGICE was practiced in religious settings, by religious leaders, pastoral counselors, or other religious community members without any designated leadership or professional

affiliations.¹⁵ We do not yet have systematic data to describe who is perpetrating SOGICE in Canada, where it is being conducted, or what survivors need to heal.

Legal and policy options

Existing responses to limit SOGICE have failed or fallen short. In Canada, the provinces of Nova Scotia, Ontario, and Manitoba have enacted laws to regulate SOGICE within the healthcare sector, through either disallowing public funds to be used (insurance billing restrictions) or else prohibiting SOGICE practice by healthcare providers (Appendix B).^{4,29,30} While these laws are a significant and necessary first step toward eradicating SOGICE from Canada, they are incomplete in that they do not extend to SOGICE practiced outside of healthcare providers' offices—such as religious settings—and inequitable in that they apply in some jurisdictions of Canada but not others. Thus, the current legal and policy situation in Canada fails to provide comprehensive protection for sexual and gender minority people—particularly youth.

Other countries—notably Australia, Ireland, Malta, and Taiwan—have recognized the broad and evasive nature of SOGICE and have therefore opted to classify SOGICE as a criminal offense or are in the process of considering amendments to federal criminal statutes (Appendix B).^{16,31,32} The current categories of offenses listed in the Canadian Criminal Code (e.g., kidnapping, forcible confinement, and assault) are insufficient to address the harms associated with SOGICE. SOGICE is a strike against identity—initiated and executed with the explicit intent of destroying another person's 'self'. That SOGICE is inflicted on minors who are at the mercy of their families or communities is particularly egregious. Many sexual and gender minorities exposed to SOGICE—and especially adolescents—are compelled to attend SOGICE sessions on the basis of familial or religious guilt, stigma, or unstated threats of withdrawing basic supports (including housing and familial/community care).¹⁵

There is a growing community of SOGICE survivors in Canada.²⁴ These survivors are increasingly speaking out about their experiences, and they consistently reinforce the importance of multi-level (federal, provincial, municipal) and comprehensive legal and policy efforts to ban SOGICE in all its forms across all of Canada.³³

Recommendations

Given that SOGICE continues to occur in Canada, contributing to ongoing epidemics of depression, anxiety, problematic substance use, and suicide-related outcomes among sexual and gender minority people, we recommend the following actions by the Canadian federal government, in the context of the Standing Committee on Health's Study of LGBTQ2 Health in Canada.

1. A federal ban of SOGICE through the Canadian Criminal Code.

- a. We recommend that the Minister of Health work in partnership with the Minister of Justice to amend the Criminal Code.
- b. Such an amendment to the Criminal Code should take into account the diverse ways in which SOGICE is described, advertised, and defended. For example, a recent ban enacted in the state of Oregon defines conversion therapy as follows: “‘conversion therapy’ means providing professional services for the purpose of

attempting to change a person's sexual orientation or gender identity, including attempting to change behaviors or expressions of self or to reduce sexual or romantic attractions or feelings toward individuals of the same gender.” (Or. Rev. Stat. §675.850) Additional legal approaches to criminalizing SOGICE may be found in recent federal laws enacted in Malta and Taiwan.

- c. At the same time, an amendment to the Criminal Code should not increase barriers for sexual and gender minority people to access sexual and gender minority-affirming mental health services. This may be achieved by clearly stating practices that do not constitute SOGICE as legal (i.e., counselling that affirms and supports clients' minority sexual or gender identities).
 - d. A federal ban should not preclude legal and policy actions at other levels of government. Because SOGICE is practiced in multiple settings and sometimes advertised and delivered covertly, additional provincial and municipal measures should be developed in tandem to a federal ban.
- 2. Provision of resources to support and heal SOGICE survivors.**
- a. With the goal of healing and reconciliation, we recommend the allocation of funding to support counselling, therapeutic support groups, community education, and community networking opportunities for sexual and gender minority survivors of SOGICE.
- 3. Investment in research to further develop evidence-based strategies to decrease the mental health impacts of SOGICE.**
- a. Focused research is urgently needed, acknowledging the lack of systematic empirical study of SOGICE in Canada and the range of experiences of SOGICE reported in research from the US¹³⁻¹⁵.
 - b. Such research may be sponsored or administered by the Canadian Institutes of Health Research (CIHR), the Social Sciences and Humanities Research Council of Canada, and/or other federal agencies responsible for health (e.g., Health Canada) or mental health specifically (e.g., Mental Health Commission of Canada).
 - c. We recommend that research priorities and funding calls be developed with meaningful participation of SOGICE survivors in response to national initiatives, such as CIHR's Strategy for Patient-Oriented Research.
 - d. We additionally recommend that the Minister of Health work in partnership with the Minister of Justice to conduct a Justice Committee study on the practice of SOGICE in Canada. Such a study could be used to inform changes in the Criminal Code and other actions necessary to reduce the practice of SOGICE and the associated harms.

We conclude with the words of Canadian SOGICE survivor Jonathan Brower: *“I don't want healing anymore, not from who I am, I just want healing from the scars of trying to change.”*³⁴ In allyship with the tens of thousands of SOGICE survivors in Canada, we urge federal action to end and heal from SOGICE without further delay.

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Appendix A

Lifetime prevalence of exposure to sexual orientation change efforts (SOCE) among sexual minority Canadian men, *Sex Now* survey 2011-12, N=8388¹²

Variable	% exposed to SOCE (95% confidence interval)
Overall	3.5 (3.2, 4.1)
Age (at time of survey)	
< 20	3.2 (1.5, 6.4)
20-29	3.6 (2.8, 4.6)
30-39	3.8 (2.9, 4.9)
40-49	3.5 (2.8, 4.4)
50-59	4.1 (3.3, 5.2)
60+	2.9 (2.0, 4.1)
Region	
British Columbia	4.5 (3.6, 5.6)
Alberta	2.8 (1.9, 4.0)
Saskatchewan	2.8 (1.3, 5.6)
Manitoba	2.6 (1.3, 5.1)
Ontario	3.5 (2.9, 4.2)
Quebec	4.2 (3.1, 5.6)
Atlantic	2.9 (1.6, 5.1)

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Appendix B

Examples of international and interprovincial legislation aiming to end sexual orientation and gender identity change efforts (SOGICE)

Jurisdiction	Enacted (E) or proposed (P) (year)	Criminal code ban	Restrictions on regulated or publicly funded healthcare providers	Business license restrictions	References
International:					
Australia	P	X			35
Ireland	P	X			36
Malta	E (2016)	X			37
Taiwan	E (2016)	X*			32
Canadian:					
Manitoba	E (2015)		X		38
Nova Scotia	E (2018)		X		29
Ontario	E (2015)		X		39
Vancouver	E (2018)			X	40

* SOGICE offenses listed under Criminal Code and *Protection of Children and Youths Welfare and Rights Act*.