Statement on Conversion Therapy

Independent Forensic Expert Group*

Introduction

Conversion therapy is a treatment or set of practices that aim to change, “repair” or “cure” an individual’s sexual orientation or gender identity. It is premised on a belief that an individual’s sexual orientation or gender identity can be changed and that doing so is a desirable outcome for the individual, family, or community. Other terms used to describe this practice include a gay cure, reparative therapy, reintegrative therapy, reorientation therapy, ex-gay therapy, and sexual orientation change effort.

Conversion therapy is practiced globally in all regions of the world. We have identified sources confirming or indicating that conversion therapy is performed in over 60 countries.1

In those countries where it is performed, a wide and variable range of practices are believed to create change in an individual’s sexual orientation or gender identity. Those include: talk therapy or psychotherapy (e.g., exploring life events to identify the cause), group therapy, medication (including anti-psychotics, anti-depressants, anti-anxiety, nausea-inducing, and psychoactive drugs, and hormone injections), Eye Movement Desensitization and Reprocessing, (where an individual focuses on a traumatic memory while experiencing bilateral stimulation such as eye movements), electroshock or electroconvulsive therapy (ECT) (where electrodes are attached to the head and electric current is passed between them to induce seizure), electrocution (including to the hands and genitals), exorcism (e.g., beating the individual with a broomstick while reading holy verses or burning the individual’s head, back, and palms), force-feeding or food deprivation, forced nudity, behavioural conditioning (e.g., being forced to dress or walk in a particular way), isolation (sometimes for long periods of time; this may include solitary confinement or being kept from interacting with the outside world), verbal abuse, humiliation, hypnosis, hospital confinement, beatings, and “corrective” rape.

Conversion therapy appears to be performed mostly by health professionals, including medical doctors, psychiatrists, psychologists, sexologists, and therapists; but it is also conducted by spiritual leaders, religious practitioners, traditional healers, and community or family members. Conversion therapy is provided both in contexts under state control, e.g., hospitals, schools, and juvenile detention facilities; as well as in private settings like homes, religious institutions, or youth camps and retreats. In some countries, conversion therapy is conducted based on the order or instructions of public officials, judges or the police.

The practice is undertaken with adults and often minors who may be lesbian, gay, bisexual, trans, and gender diverse. Parents are also known to send their children abroad, back to their country of origin to receive it. These therapies support the view that non-heterosexual orientations are deviations from the norm, reflecting a disease, disorder or sin. The practitioner conveys the message that heterosexuality is the normal, healthy, and preferred sexual orientation and gender expression.

The purpose of this medico-legal statement is to provide legal experts, adjudicators, health care professionals, and policy makers, among others, with an understanding of: 1) the medical and scientific validity of conversion therapy; 2) the likely physical and psychological consequences of undergoing conversion therapy; and 3) whether, based on these effects, conversion therapy constitutes cruel, inhuman, or degrading treatment or torture when individuals are subjected to it forcibly2 or without their consent.

This medico-legal statement also addresses the responsibility of states in regulating this practice; the ethical implications of offering or performing it; and the role that health professionals and medical organisations should take.

Definitions of conversion therapy vary: some include any attempt to change, suppress, or divert an individual’s sexual orientation, gender identity or gender expression. This medico-legal statement only addresses those treatments and practices that practitioners genuinely believe can effectively create a change in an individual’s sexual orientation or gender identity. Acts of physical and psychological violence or discrimination that aim solely to inflict pain and suffering or punish individuals due to their sexual identity are condemned as crimes against humanity.

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1 This statement considers an examination to be “forcibly conducted” when it is “committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person incapable of giving genuine consent.” International Criminal Court. Elements of Crimes. Art. 7(1)(g)-1. RC/11. 2011:8.
orientation or gender identity, are not addressed, but are wholly condemned.

This medico-legal statement follows along the lines of our previous publications on Anal Examinations in Cases of Alleged Homosexuality and on Forced Virginity Testing. In those statements, we opposed attempts to minimise the severity of physical and psychological pain and suffering caused by these examinations by qualifying them as medical in nature. There is no medical justification for inflicting on individuals torture or other cruel, inhuman or degrading treatment or punishment. In addition, these statements reaffirmed that health professionals should take no role in attempting to control sexuality and knowingly or unknowingly supporting state-sponsored policing and punishing of individuals based on their sexual orientation or gender identity.

About the Authors

The opinions expressed in this statement are based on international standards and the experiences of members of the Independent Forensic Expert Group (IFEG) in documenting the physical and psychological effects of torture and other cruel, inhuman, or degrading treatment or punishment (also ill-treatment). Consisting of 38 preeminent independent medico-legal specialists from 21 countries, the IFEG represents a vast collective experience in the evaluation and documentation of the physical and psychological evidence of torture and ill-treatment.

The IFEG provides technical advice and expertise in cases where allegations of torture or ill-treatment are made. Its members are global experts on and authors of the Istanbul Protocol, the key international standard-setting instrument on the investigation and documentation of torture and ill-treatment.

IFEG members also hold influential positions in and act as advisors to governments, international bodies, professional health associations, non-governmental organisations, and academic institutions worldwide on forensics in general and more specifically on the investigation and documentation of torture and ill-treatment.

Medical and Scientific Validity

There is no empirical evidence to support pathologising or medicalising variations in sexual orientation and gender identity. Studies have found that variation in sexual orientation is ubiquitous and that there is substantial variability in patterns of sexual and gender expression both between individuals and within individuals across time. The World Medical Association (WMA) has strongly emphasised “that homosexuality does not represent a disease, but a normal variation within the realm of human sexuality.” Moreover, for almost half a century, the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1973) has stopped recognising homosexuality as a disorder. Similarly, for three decades, the World Health Organisation (WHO), which issues the International Statistical Classification of Diseases and Related Health Problems, has done so (ICD-10, 1990). In 2018, the WHO removed all remaining disorders correlated with same-sex attraction, such as ego-dystonic sexual orientation, which had been (mis)used in the past to justify conversion therapy, eliminating all medical bases correlated to sexual orientation that can be used to justify conversion therapy.

To our knowledge, there also are no credible scientific peer-reviewed studies that demonstrate that conversion therapy in any form can be effective. On the contrary, in 2009, the American Psychological Association conducted a systematic review of peer-reviewed journal literature on conversion therapy and concluded that “the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through [sexual orientation change efforts].” In 2016, the World Psychiatric Association issued a statement finding that “[i]t is not possible for a person to change their sexual orientation.”

Treatment and practices that purport to change an individual’s sexual orientation or gender identity therefore lack any foundation in science or medicine and are unlikely to be effective. Instead, they are based on a
profound and antiquated misconception about the nature of sexual orientation and gender identity.

**Physical and Psychological Effects**

Conversion therapy represents a form of discrimination, stigmatisation, and social rejection. Many conversion therapy methods 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, deprivation of food, isolation and confinement, forced medication, including administration of nausea-inducing drugs, verbal abuse, humiliation, and electrocution, including of the genitals. It is expected that these acts as well as the entire conversion therapy episode that includes them will subject individuals to significant or severe physical and/or mental pain and suffering.

The fact that a treatment or practice has a valid medical use does not mean that it is not physically and psychologically harmful. Nor does it lend any validity to its use to treat other conditions under different circumstances. For instance, ECT or electroshock therapy, which is reportedly used for conversion therapy in at least 12 countries, can cause extreme physical and mental pain and suffering. ECT applied with muscle relaxant and general anaesthesia is a recognised form of treatment for psychiatric patients suffering from particular disorders, such as treatment-resistant, life-threatening depression, but is unproven and medically invalid for conversion therapy. In some countries, ECT is administered in its unmodified form (i.e., without anaesthetic and muscle relaxants), which leads to violent convulsions commonly resulting in joint dislocations and bone fractures. In almost every instance, individuals also experience disorientation, cognitive deficits, and retrograde amnesia, which can be severely distressing.

Medication is also used in conversion therapy and can cause significant physical and mental pain. When it is medically inappropriate or used forcibly or without the individual’s consent, it 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. Neuroleptics, anxiolytics, and antidepressants (including thioridazine, citalopram, fluoxetine, and risperidone) have been used on individuals to diminish their sexual desire; and they are often prescribed due to the false belief that psychosis or other mental disorder is the underlying cause of an individual’s particular sexual orientation or gender expression. These anti-depressants, mostly from the selective serotonin reuptake inhibitor group, may cause sexual dysfunction, while anti-psychotic medications may cause extrapyramidal symptoms and other movement disorders, mental slowing, tiredness, memory problems, numbness of the body, weight gain, and sexual dysfunction, among other effects, which serve only to compound an individual’s distress and suffering.

All forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering. Treatment for conversion is inherently humiliating, demeaning, and discriminatory. The combined effects of feeling powerless and extreme humiliation generate profound feelings of shame, guilt, self-disgust and worthlessness, which can result in a damaged self-concept and enduring personality changes. The injury caused by conversion therapy begins with the notion that an individual is sick, diseased, and abnormal due to their sexual orientation or gender identity and must be treated. This begins the process of victimisation. Individuals who have undergone conversion therapy experience 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, their rate of suicide attempt is several times higher than in other lesbian, gay, bisexual, trans and gender diverse populations who have not been exposed to the practice.

Individuals who have experienced conversion therapy feel intense guilt, reinforced by the idea that they are ill, unacceptable, incurable, and a burden to their families.

Children and minors are particularly vulnerable. In children and minors exposed to conversion therapy, psychological symptoms are expressed in a significant loss of self-esteem, school dropout, and a sharp increase in suicidal or depressive tendencies. These often lead to the adoption of high risk behaviours, self-destructive behaviours, and increased drug and alcohol use. One can observe a delay in sexual and personal development, which leads to depression, increased feelings of guilt and stress, and can also bring about social isolation and social rejection. Minors, who were mentally healthy prior to exposure, are at a higher risk to develop serious psychological disorders afterwards, due to the loss of self-esteem, negative feelings toward oneself, self-loathing, feelings of debasement, and the forced rejection of one’s own identity.

In both adults and minors, the fact that the conversion therapy will not be successful (as there is no evidence to suggest that any treatment or therapeutic practices can alter one’s sexual orientation or gender identity) is likely to exacerbate the individual’s feelings of inadequacy, self-worthlessness, and shame.

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13 Jack L. Turban, Noor Beckwith, Sari L. Reisner and Alex S. Keuroghlian, ‘Association Between Recalled Exposure to


14 Ibid.
When health professionals are involved in the performance of this harmful act, in our experience, their involvement is likely to increase the pain and suffering experienced by individuals given the betrayal it represents of the social norm of trusting health professionals.15 Betrayal of the fragile trust between patient and clinician in the psychotherapy setting can have severe consequences, leading to feelings of guilt, rejection, and humiliation. The individual can lose self-esteem and may exhibit anger or withdrawal, which will negatively transform their future interpersonal and romantic relationships and professional life.

Where conversion therapy is ordered, conducted, or supported by public authorities, the experience of being betrayed by the law adds additionally to the individual’s mental pain and suffering and their psychological symptoms. Common points can be found with the causes and effects of posttraumatic stress disorder. Youth retreats and camps for conversion therapy often incorporate highly traumatic elements such as exorcisms, exposure to physical and verbal abuse, pornography and sexual abuse, humiliation, and burnings. Psychotherapy itself can become a repeated and traumatic event. Session after session, the individual is confronted with their own “deviancy”, while repetition and duration increases its intensity and importance. We have seen that conversion therapies can lead to avoidance behaviours, hypervigilance (e.g., difficulty falling asleep or staying asleep and traumatic nightmares), and other symptoms of posttraumatic stress disorder.

The long-term duration of many conversion therapies can be particularly harmful. They create chronic stress, which has been known to result in many negative health consequences, including stomach ulcers, gastrointestinal disorders, skin diseases, sexual and eating disorders, and migraines. Psychosomatic symptoms can be especially pronounced in children who are unable to speak about their difficulties and may manifest their distress through eczema breakouts, insomnia, sleep disorders, vomiting, asthma, and impaired growth or development. Psychological symptoms can become chronic; despair, disillusion and shame can last for many years. Even into adulthood, studies have found that exposure to conversion efforts results in adverse mental health outcomes, including severe psychological distress, lifetime suicidal thoughts, and lifetime suicide attempts.16,17

Cruel, Inhuman, and Degrading Treatment or Torture

Torture and other forms of cruel, inhuman or degrading treatment or punishment are unequivocally prohibited, without exception, by the UN Convention against Torture 18 as well as other international and regional human rights instruments. The UN Committee against Torture, the UN Special Rapporteur on Torture, the UN Subcommittee on Prevention of Torture, and the Office of the High Commissioner for Human Rights (OHCHR) have stated that conversion therapy contravenes the prohibition against torture and other cruel, inhuman or degrading treatment or punishment. In its 2015 annual report, the OHCHR stressed that states “have an obligation to protect all persons, including LGBT and intersex persons, from torture and other cruel, inhuman or degrading treatment or punishment” and found that conversion therapy breaches this duty.19

In May 2018, the UN Independent Expert on Sexual Orientation and Gender Identity observed that: “The violence reported against persons on the basis of their actual or perceived sexual orientation or gender identity also includes ... so-called ‘conversion therapy’. Considering the pain and suffering caused and the implicit discriminatory purpose and intent of these acts, they may constitute torture or other cruel, inhuman or degrading treatment or punishment in situation where a State official is involved, at least by acquiescence.”20 Subsequently, the UN Special Rapporteur on Torture in July 2019 affirmed that: “given that ‘conversion therapy’ can inflict severe pain or suffering, given also the absence both of a medical justification and of free and informed consent, and that it is rooted in discrimination based on sexual orientation or gender identity or expression, such practices can amount to torture or, in the absence of one or more of those constitutive elements, to other cruel, inhuman or degrading treatment or punishment.”21

Based on these findings, the UN Committee against Torture, the UN Independent Expert on Sexual Orientation and Gender Identity, the UN Special Rapporteur on Torture, and the OHCHR have all respectively called upon states to ban the practice. In 2016, the UN Committee against Torture recommended that a state take “the necessary legislative, administrative and other measures to guarantee respect for the autonomy and physical and personal integrity of lesbian, gay, bisexual, transgender and intersex persons

16 Ozanne Foundation. Supra note12.
17 Jack L. Turban, Noor Beckwith, Sari L. Reisner and Alex S. Neuroghlian. Supra note13.
21 UN General Assembly. Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Relevance of the prohibition of torture and other cruel, inhuman or degrading treatment or punishment to the context of domestic violence. 12 July 2019. A/74/148. para. 50.
and prohibit the practice of so-called ‘conversion therapy’.\(^{\text{22}}\)

**State Involvement and Responsibility**

The UN Convention against Torture and other international and regional human rights instruments not only prohibit torture, but oblige states to prevent public authorities from “directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in any acts of torture” and other cruel, inhuman or degrading treatment or punishment.\(^{\text{23}}\) In several countries, we have found that public officials are directly involved in the provision of conversion therapy. In some cases, the therapy is offered and performed by medical personnel in state hospitals, public clinics, schools, and juvenile detention centres. Sometimes, the therapy is performed pursuant to an order by public officials, judges, and the police. This would seem to contravene these states’ international legal obligations.

Moreover, states have a responsibility to “prohibit, prevent and redress torture and ill-treatment in all contexts of custody and control,” not just those operated by public entities.\(^{\text{24}}\) We have found in almost 30 countries that conversion therapy is being committed, instigated or supported by private institutions and private individuals acting in official capacity and executing a state function. This includes when health professionals in private clinics perform conversion therapies or when private schools provide it. The UN Convention against Torture and other human rights instruments require that states oversee the provision of services that are in the public interest, such as health or education. As stated by the UN Committee against Torture, states have the special duty to protect the life and personal integrity of persons through regulating and supervising these services, regardless of whether the entity giving them is public or private.\(^{\text{25}}\) Accordingly, personnel in private hospitals and clinics as well as teachers are considered to act in official capacity on behalf of the state, as they are executing a state function\(^{\text{26}}\) and should similarly be prevented from directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in any acts of torture and ill-treatment, including conversion therapy.

In over a dozen countries, we found that conversion therapy practices, e.g., beatings, isolation, exorcisms, and “corrective” rape, appear to take place primarily in the private sphere by religious practitioners, traditional healers or sometimes by community and family members. These acts which are not originally directly attributable to the state (i.e., acts committed by private individuals) can nevertheless lead to state responsibility, due to the lack of due diligence to eliminate, prevent, investigate and punish acts of torture and other cruel, inhuman, or degrading treatment or punishment. The failure of the state to act in due diligence leads to a form of encouragement or *de facto* permission of those harmful practices.\(^{\text{27}}\)

The UN Committee against Torture has applied this principle to states that have failed to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking.\(^{\text{28}}\) A parallel can thus be drawn to the obligation to ban the practice of female genital mutilation which also takes place in a context of profound discrimination. As stated by the Special Rapporteur on torture: “*Domestic laws permitting the practice contravenes States’ obligation to prohibit and prevent torture and ill-treatment, as does States’ failure to take measures to prevent and prosecute instances of female genital mutilation by private persons.*”\(^{\text{29}}\)

Children enjoy special protection. An alarming number of minors are subjected to conversion therapy; possibly minors account for the majority of all cases.\(^{\text{30}}\) The UN Convention on the Rights of the Child requires the best interests of the child to be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies.\(^{\text{31}}\) The Convention on the Rights of the Child requires states to take all measures to “*protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*”\(^{\text{32}}\)

Conversion therapy, which is rooted in profound discrimination and lacks scientific and medical validity, is ineffective, and is likely to cause the minor significant or severe pain and suffering clearly violates these standards. When a minor is subjected to conversion therapy, in addition torture or other cruel, inhuman or degrading treatment, it may constitute a form of child abuse and neglect.

**Professional and Ethical Standards**

Conversion therapy is inconsistent with the fundamental ethical principles and professional duties of health professionals for the following reasons:

1) It is clear from the analysis that conversion therapy is a form of cruel, inhuman or degrading treatment when it is conducted forcibly on individuals

\(^{\text{22}}\) UN Committee against Torture. Concluding observations on the fifth periodic report of China. 3 February 2016. CAT/C/CHN/CO/5. para. 56.


\(^{\text{24}}\) Id., para. 15.

\(^{\text{25}}\) Ibid.

\(^{\text{26}}\) Id., para. 17.

\(^{\text{27}}\) Id., para. 18.

\(^{\text{28}}\) Ibid.

\(^{\text{29}}\) Ibid.


\(^{\text{32}}\) Id., Art. 19.
or without their consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted. International standards of professional ethics unequivocally prohibit health professionals from participating in or condoning any treatment or procedure that may amount to cruel, inhuman, or degrading treatment or torture. 33

2) Variation in sexual orientation and gender identity is not a disease or disorder. Health professionals, therefore, have no role in diagnosing it or treating it. The provision of any intervention purporting to treat something that is not a disease or disorder is wholly unethical. 34

3) Conversion therapy is ineffective and harmful. Health professionals must abide by their core ethical principles to act in the best interests of patients (beneficence) and to “do no harm” (non-maleficence). 35 The likely harm of conversion therapy cannot be outweighed by any clinical benefits, as there are none. Moreover, health professionals are prohibited from offering treatments that are beyond their areas of knowledge and skill, which would include conversion therapy. 36 Offering conversion therapy thereby constitutes a form of deception, false advertising, and fraud.

4) Ensuring informed consent may be impossible in most circumstances. As noted in previous statements, examinations based on profound discrimination may create situations where a person is incapable of giving genuine consent. 37 This is likely the case when conversion therapy is being conducted based on the order of a public authority or when the individual’s liberty is restricted. In the case of conversion therapy, informed consent would require not only that an individual is informed about the methods that will be applied, but also about the likely significant physical and psychological harm that will result, the ineffectiveness of the methods proposed, and the practitioner’s lack of competency to achieve the desired result. The individual’s consent must be considered invalid if acquired without this knowledge or as a result of false information; and it should be considered suspect nevertheless, particularly in the case of minors.

5) Conversion therapy creates a discriminatory environment. Even where an individual desires the therapy, the individual may be motivated by internalised phobia. It would be counter therapeutic for the therapist to add to that internalised phobia through therapeutic practice. The treatment would be ineffective in reducing the individual’s desire, which is different from practice, and leave the client with unexpressed feelings that have the potential to be very damaging. 38 Instead, psychiatric or psychotherapeutic approaches to treatment must not focus on the individual’s sexual orientation or gender identity, but rather on the conflicts that arise between their orientation, identity and religious, social or internalised norms and prejudices. 39

Role of Health Professionals in Policing and Punishing Sexual Orientation and Gender Identity

The practice of conversion therapy runs contrary to respect for the dignity, humanity, and rights of individuals, including to privacy, self-determination, and non-discrimination and to be free from torture and ill-treatment.

Most major medical and mental health organisations have repudiated the practice of conversion therapy, but it continues to be widespread and practiced by health professionals and others due to pervasive discrimination and societal bias against lesbian, gay, bisexual, trans and gender diverse individuals. This represents a challenge to individual health professionals and medical and mental health professional organisations.

Health professionals who are conducting conversion therapies are contributing to a social, cultural or state-sponsored system of profound repression and stigmatisation against their patients and others targeted on the basis of their sexual orientation and gender identity. Health professionals should understand that by providing these treatments, they are serving to perpetuate social customs and norms that are in conflict with their ethical obligations, respect for the rights and dignity of individuals, and that, ultimately, these health professionals may be facilitating or participating in cruel, inhuman or degrading treatment or torture.

The WMA has condemned conversion therapy as a violation of human rights and has called for its practitioners to be denounced and subject to sanctions and penalties. 40 It has also called on national medical associations to “promote ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly corrected, and the physicians guilty of ethical violations must be disciplined and rehabilitated.” 41

As more awareness is raised about the issue of conversion therapy both globally and nationally,


national medical associations should create accessible mechanisms for the public to register complaints against health professionals who offer conversion therapy or who have harmed them by performing this practice. Health professionals who conduct conversion therapies violate the basic standards and ethics of our profession and should be reported by their colleagues to the appropriate authorities. National medical associations should also encourage and support health professionals in doing so.

**Conclusion**

Conversion therapy has no medical or scientific validity. The practice is ineffective, inherently repressive, and is likely to cause individuals significant or severe physical and mental pain and suffering with long-term harmful effects. It is our opinion that conversion therapy constitutes cruel, inhuman or degrading treatment when it is conducted forcibly or without an individual’s consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted.

As a form of cruel, inhuman or degrading treatment or torture, states have an obligation to ensure that both public and private actors are not directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in conversion therapy. States also have a responsibility to regulate health and education services, which are promoting this harmful practice.

Health professionals that offer conversion therapy are violating the basic standards and ethics of our profession. Health professionals should understand that by offering these treatments, they are serving to perpetuate social customs and norms that are in conflict with respect for the rights and dignity of individuals; they are engaging in false advertising or fraud; and they may be facilitating and participating in cruel, inhuman or degrading treatment or torture. Where minors are concerned, in addition to torture and other cruel, inhuman or degrading treatment, they may be facilitating or perpetrating child abuse and neglect.

Health professionals should refuse to conduct conversion therapy and report their colleagues who advertise, offer, or perform them to the appropriate authorities. National medical associations should take steps to hold practitioners accountable and work with civil society and government officials to pass laws that ban conversion therapy.

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