
REPARATIVE THERAPY

Trans reparative therapy is an umbrella term for sustained efforts that seek to discourage behaviors associated with a gender other than the one assigned at birth and/or promote gender identities that are aligned with the person's gender assigned at birth. It is predicated on the view that being transgender or markedly gender nonconforming is pathological and that transitioning should be avoided if at all possible. Reparative therapies are known by many names: conversion therapy, reparative practices, the corrective approach, the psychotherapeutic approach, and the pathology response approach. Different terms highlight different aspects and subtypes of reparative therapy. This entry addresses the practices' current social context, the differences and similarities between reparative therapy targeting sexual orientation versus gender identity, the defining features of contemporary approaches, the practices' harmfulness and unethicity, and the legal regulation of reparative therapy.

Social Context

Although reparative therapy targeting sexual orientation is no longer described as clinically acceptable in the scholarly literature and most commonly takes the form of unlicensed faith-based practices, trans reparative therapy remains unfortunately common among licensed professionals. In the

United States, 9% of trans adults have reported that a professional tried to stop them from being transgender.

Trans reparative therapy by licensed professionals primarily targets prepubertal children because of the belief that gender is no longer malleable after puberty. However, recent years have seen a worrisome increase in clinicians seeking to justify extending reparative practices to adolescents and adults. The unsupported hypothesis of rapid-onset gender dysphoria, which posits that social pressures and mental vulnerability are leading adolescents to suddenly and falsely believe that they are trans, is being used by some clinicians and scholars to shed doubt on the identities of trans adolescents and delay or deny access to transition-related care. The leading international trans health organization, the World Professional Association for Transgender Health (WPATH), was the subject of a 2018 controversy when it elected a treasurer who had recently coauthored a paper arguing that trans reparative therapy on consenting adults can be ethical. Despite strong opposition by individuals working in trans health, the board of directors dismissed the concerns as unfounded, ideologically motivated, and defamatory.

Targeting Sexual Orientation Versus Gender Identity

Reparative therapy targeting sexual orientation and gender identity is often distinguished. Their histories diverge notably with regards to the age of patients, their relationship to faith, and whether they were theorized through peer-reviewed publications. However, neither solely targets sexual orientation or gender identity. Practices pathologizing same-sex attraction also pathologize being trans, while leading trans reparative practices target gender-nonconforming behaviors regardless of whether the children express a clear trans identity. One of the leading historical figures of trans reparative therapy, George Alan Rekers, figures in both traditions. Rekers employed behavioral techniques to prevent gender-nonconforming children from growing up gay or trans. He was motivated by religious belief and later served on the board of a leading gay reparative therapy organization, the NARTH Institute. While contemporary forms of trans reparative therapy reject the prevention of

homosexuality as a legitimate clinical goal and do not adopt faith-based justifications, Rekers had a strong influence on their development. Rekers's coauthor, Ole Ivar Løvaas, is known for developing applied behavior analysis, which has been likened to reparative therapy for autistic children.

Defining Features

Trans reparative therapy commonly applies an etiological lens to trans care, looking for external causes under the belief that marked gender nonconformity and/or identification with a gender other than the one assigned at birth reflects abnormality rather than atypicality. This belief is often reflected in the language used, referring to people as their gender assigned at birth (e.g., calling straight trans women "male homosexuals") and labeling their gendered self-understanding "gender confusion" or "gender identity problem." The influence of psychoanalytic thought on trans reparative therapy is evident in the tendency to attribute to fault parents and especially mothers for causing or fostering patients' gender identities or expressions. Other proposed factors include social contagion, attitude toward rough-and-tumble play, past trauma, conflation of gender nonconformity with gender identity, co-occurring mental illnesses, sexual orientation, and cognitive development. Some authors have suggested that some children assigned as male at birth may prefer feminine toys and names because their lower cognitive development make them uncompetitive in masculine play. For adults, suggested causes include desire to attract gay men (among queer transmasculine people), desire to attract straight men or internalized homophobia (among straight transfeminine people), and paraphilic heterosexual self-eroticization (among queer transfeminine people). While biological factors are often acknowledged, they are downplayed in the analysis and treatment recommendations.

Whereas the trans reparative therapy espoused by Rekers and Løvaas employed behavioral techniques such as a token economy for punishments and rewards, contemporary approaches tend to employ a broader variety of techniques under the belief that behavioral approaches may fail to alter internal gender schemas. For adolescents and adults, systematic misgendering, psychotherapy

aiming at identifying causes for gender identity, and undue delays or barriers to transition are commonly employed. For children, suggested psychosocial interventions include play psychotherapy, parental counseling, and interventions in the naturalistic environment. Parents are encouraged to limit, discourage, and/or ignore gender-nonconforming behaviors at home while supporting and/or encouraging gender-conforming ones. Peer relationships with people of the same gender assigned at birth are also encouraged.

Proponents of trans reparative therapy claim that their approach is justified by the reduction of peer ostracism, the treatment of underlying mental illness, and the prevention of trans outcomes for its own sake. Early important statements of the approach viewed these justifications as obviously valid and consistent with prevailing ethics and as a result mobilized little effort in fleshing out their justificatory matrix.

The goal of preventing trans outcomes is associated with claims that the desire to medically transition is too radical to be part of normal human diversity, that the distress inherent to gender dysphoria makes it psychopathological, or that having a gender identity that does not correspond to one's gender assigned at birth is inherently a marker of distress. Proponents do not typically present empirical evidence that trans reparative therapy leads to better psychosocial outcomes than affirmative approaches, instead using vague references to common sense or clinical experience for theoretical support. The proposed ethical underpinnings of trans reparative therapy remain sorely undertheorized and appear to take root in gender normativity. If they were obviously consistent with the ethics of 1995—and this author would argue otherwise given contemporaneous critiques—they are certainly not so today.

While the literature acknowledges that gender identity is not malleable in adolescence and adulthood, it is more difficult to establish whether altering gender identity or preventing trans outcomes prior to puberty is possible. Early theorizations of trans reparative therapy relied on case reports as evidence of the malleability of gender identity, gender expression, and sexual orientation. Contemporary trans reparative therapy appeals to the research program known as *desistance research* as evidence that gender identity is malleable, since most children

referred to gender identity clinics do not go on to medically transition. However, these studies have been starkly criticized for their failure to distinguish between youth who expressed a trans identity and youth who did not. Gender nonconformity frequently motivates gender clinic referrals. Data suggest that transgender and cisgender children sharing the same gender identity are highly similar and that childhood gender identity is a strong predictor of later gender identity. Critiques of desistance research have, however, challenged the usefulness of predicting adult gender identity, favoring an affirmative, flexible, and nonjudgmental approach.

Harmfulness and Unethicality

Trans reparative therapy appears to be harmful regardless of whether the person remains or grows up to be trans. Evidence of harm primarily appears in the self-report of ex-patients of clinics engaging in trans reparative practices. Drs. Sé Sullivan and Karl Bryant have recounted and theorized the harm they experienced at the hand of these clinics, and Erika Muse has testified before the Ontario legislature in support of a law prohibiting reparative therapy. Bryant (2006) explained that although he grew up to be cisgender and gay, the approach “made me feel that I was wrong, that something about me at my core was bad, and instilled in me a sense of shame that stayed with me for a long time afterward” (p. 25). Because the practices target gender nonconformity and negatively affect parental attachment, negative psychological outcomes are not dependent on later gender identity. Shame and parental attachment problems are strongly correlated with self-esteem problems, anxiety, depression, and suicidality. Kirk Murphy, who was lauded as evidence of the success of Rekers's approach in 17 of his publications, completed suicide in adulthood. His family has blamed Rekers's approach for his suicide.

Quantitative evidence of the harm of trans reparative therapy is rarer, and no randomized controlled studies exist. Trans adults having undergone reparative therapy show much higher levels of suicidality and depression, an effect that is even starker among those who underwent reparative therapy in childhood. By contrast, studies suggest that the gender-affirmative approach leads to lower psychopathology than reparative approaches.

Notably, trans children who socially transition show levels of anxiety and depression comparable to cisgender peers. While no randomized controlled trial exists comparing the two approaches, the currently available evidence suggests that trans reparative therapy leads to worse outcomes than alternatives.

Critiques of reparative therapy are not solely predicated on harm, however. Many leading professional associations oppose trans reparative therapy as unethical and maybe harmful, distinguishing the question of ethics from that of overall harm. Trans reparative therapy is arguably inherently demeaning of trans people. The validity of parental consent to reparative practices is also questionable, since they often hold transphobic beliefs or are misled by well-credentialed clinicians. Some of the proposed justifications of trans reparative practices are reminiscent of eugenic and victim-blaming logics. Given professionals' duty to respect the dignity of their patients and avoid unnecessary harm, the transphobic nature of trans reparative therapy and anecdotal accounts of harm are sufficient grounds to declare it unethical.

Legal Regulation

Many jurisdictions have passed laws prohibiting trans reparative therapy. These laws typically prohibit reparative therapy targeting sexual orientation, gender identity, and gender expression. While laws have a limited impact on practice, notably because of their ambiguous scope, they contribute to culture changes and offer trans communities an additional advocacy tool. In Canada, the 2015 Ontario law was instrumental to the closure of the long-criticized Toronto CAMH Gender Identity Clinic for Children and Youth.

Bans on reparative therapy have been accused of violating therapists' freedom of speech and of violating familial religious freedom, parental authority, or patient autonomy. Court challenges have been unsuccessful. Psychotherapy is considered an action rather than mere speech, since it seeks to effect a change in the patient rather than persuade them of something. While familial religious freedom, parental authority, and patient autonomy are relevant to health care decisions, they can only grant a right to refuse treatment. No right to demand a specific treatment exists. It is

legally well established that governments can prohibit treatments that have not been shown to be safe and effective. Indeed, courts have not only refused to invalidate bans on reparative therapy, but some have begun to understand repeatedly discouraging and opposing transition as a form of family violence.

In the absence of reparative therapy bans, professional liability law and codes of ethics may provide a means of sanctioning trans reparative therapy. Professionals must act competently and respect the standards of care of their profession. Since many leading professional associations and the leading standards of care in trans health consider trans reparative therapy unethical, engaging in reparative practices may give rise to legal liability and disciplinary measures. However, effectively discouraging trans reparative therapy depends on effective enforcement and shifts in professional culture.

Political polarization and the rise of conservatism are unfortunately beginning to seep into trans health. Care for transgender youth has grown, increasingly receiving mainstream attention in recent years. The new, unsupported theory of rapid-onset gender dysphoria is being used to oppose affirmative care for adolescents, and newspapers in the United Kingdom are attacking the national gender clinics for allowing youth to transition, despite their approach falling on the conservative side of trans health. After a steady decline over the past decades, trans reparative therapy may be heading toward a dangerous revival.

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See also Affirmative Theory; Anti-Trans Theories; Cisgenderism; Desistance; Gender Affirmative Model; Medicine; Therapy/Therapist Bias; Transphobia; WPATH

Further Readings

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