‘Gay cure’ therapies: some facts to consider

A reply to Jayne Ozanne’s Private Member’s Motion – with reference to the commonly raised issue of suicide, suicidality and bullying.

By Edmund Mann

Jayne Ozanne, a leading gay activist in the Church of England, wants the spiritual healing practised by charismatic evangelical churches to be rejected as unethical and harmful for abusing LGBTIs. Instead, it is necessary to embrace and ‘celebrate who we are.’

Does this just apply to spiritual healing to move people away from homosexuality, or is it a call for a comprehensive ban covering *any* circumstances or purpose?

Ozanne’s condemnation of what is described as happening in certain types of churches and network groups, particularly those that believe in being ‘baptised in the Holy Spirit’, is difficult to distinguish from that on churches or the Church generally for creating ‘turmoil and pain’ by not endorsing the LGBTI agenda.

Ozanne wants government to add ‘spiritual abuse’ to its list of abuses – physical, sexual, emotional and neglect. This extends to lay forms of psycho-therapy for those who wish to leave homosexuality (often called ‘conversion therapy’). She wants a total ban on what has “no place in the modern world, is unethical, harmful and not supported by evidence”. Attempts to change sexual ‘orientation’ are condemned as part of the stigma and prejudice that precipitate mental health problems and lead to ‘lasting damage’.

Ozanne relates how her ‘spiritual abuse’ in a charismatic church led to a nervous breakdown rather than deliverance from homosexuality. Unless this is tackled, high rates of suicide, self-harm and depression among LGBTI Christians will continue unabated.

In Response.

Anecdotes and personal experiences are purely illustrative. A bane of science, they establish or prove nothing, despite the leverage of their emotional appeal. This easily leads to misguided policies which can cause more problems than they solve.

Even the substance of a heart-rending narrative should not be accepted at face value. Did Ozanne *have to go* to ‘spiritual healing’; what was the actual abuse and was her breakdown solely due to this or are there other underlying or contributory causes? Her word alone should not malign and forbid all interventions, secular and religious. Another anecdote could tell an opposing story. Studies found that leaving one’s religion is associated with ambivalent homosexuals *having* higher risks of depression and suicidality.[1]

There has been no thorough scientific investigation of outcomes for therapeutic attempts to change unwanted sexual attractions. There is certainly no 'evidence' of actual harm. Ozanne's assertions represent an ideological, not a scientific, standpoint. Research in some areas of same-sex issues is restricted by the advocacy interests who often dominate professional organisations. Anyone who produces objective results counter to LGBT perspectives is at personal and professional peril.

Elsewhere, there are many pseudo medical and psychiatric quack remedies for all manner of ills. These do not work and some can cause great harm – think of 'recovered memory' practices. Shouldn't these be banned, if anything is? Even a proportion using run-of-the-mill psychotherapies get worse with treatment and many do not benefit from AAnon etc. Insisting that no change is possible or wrong to explore for unwanted sexual inclinations is at odds with interventions for many other behaviours and propensities people wish to change. Succeed or not, it is totalitarian to forbid help to anyone seeking to withdraw from same-sex relationships. It takes away freedom, choice, civil and human rights. Similarly, no one should have to 'celebrate' anyone for anything they might not wish to endorse.

According to large scale, representative studies, considerable proportions of those who earlier report same-sex experience or 'orientation' are later predominantly or exclusively heterosexual. Such fluidity suggests that psychiatric help might contribute to change for some who want this.

Only one way has become acceptable where, if anyone is 'unsure' or 'questioning', then they should be encouraged to accept their homo/bisexuality. There is a serious risk here of erroneously 'affirming' those who are only experimenting or experiencing temporary confusion.

Not only is the range of socially acceptable opinions narrowing in our times, but what is acceptable as 'fact'. There needs to be more questioning of the substance and validity of the claims or 'evidence' that identity and interest groups and charities use to push their agendas. The 'evidence' may not exist, or is build up from poorly conducted 'studies'. People committed to causes are often not impartial sources.

The multi-dimensional, mono-cause of homophobia or the malevolence of others and the surrounding heterosexist social context is typically used to explain multifarious ills affecting LGBT minorities.[2] There is an ocean of papers of varying quality examining its purported aspects and injurious outcomes. As used by Jayne Ozanne, suicide is the most serious and oft quoted consequence.

Accusations of driving people to self-harm and death (shroud waving) or threats of mass suicide often accompany demands, complaints and drives for rights and prerogatives. Such were used to clampdown on public debate across the world in run ups to same-sex marriage. A Cornish MP spoke of a group of gay teenagers who committed suicide because of the homophobia its absence represented. No information was provided after repeated requests. There is a suppression of speech over LGBTI issues on the pretext that words have lethal consequences. Medics are now accused of putting lives at risk by stalling over sex change treatment.

Suicide is something that is virtually unmatched for the contrast between the certainties proclaimed and the actual realities on the ground. Ozanne does not present evidence for her claims about high rates of LGBTI suicide, Christian or otherwise. She is unlikely to have any, as this simply resounds in a grand echo chamber. A suicide rate of 30% (even 50%) is often used inter-changeably for the gay proportion of suicides in the population total; that LGBTs are 30% of all *young* suicides or that 30% of all LGBTs or LGBT youngsters kill themselves.

1. Suicide cannot be 'related' to 'sexual identity' because this is not on death certificates.
2. Suicidality (ideas and attempts) and self-harming are frequently cashed into actual suicides. These are *not* the same. Rates may be higher for 'gay' compared to 'straight' youth but this is a complex issue (see below).
3. Particular cases cannot tell us about actual suicide rates for any group.

The gay suicide narrative originated with San Francisco homosexual social worker Paul Gibson's document for a 1989 report by a special federal task force.[3] He used non-random reports of troubled and runaway youth from 'drop-in' centres and agencies: translated attempts into completions and multiplied his figures by Alfred Kinsey's estimate that homosexuals were 10% of the population to produce 30% of *all youth suicides.* There has never been any evidence or professional agreement for anything resembling Gibson's 'epidemic. One biased paper resulted in a flawed corpus of claims and surge in misinformed policy-making.

While the overall UK suicide rate has varied little over time, that for males is nearly four times that for females (19 per 100.000 to 5.1). The rate for men aged 45-59 is at the highest level for more than 30 years.

The antecedent and precipitating drivers are mental and personality disorders, (70% - 90%) alcohol abuse, financial loss, disease, chronic pain, a family history of suicide and exposure to examples and methods. These have hardly changed over time.[4] In a pattern of cumulative risk, factors present to different degrees and interacting in different ways may lead to a "final straw" event, like a broken relationship. The Samaritans organisation emphasises: "the cause of any [particular] suicide can rarely be stated simply: Over-simplification of the causes or
perceived 'triggers' …can be misleading and unlikely to reflect accurately the complexity…"[5]

Since Gibson's time there have been *studies* where sexual identity is recorded.

1.In longitudinal representative mortality data from a US cohort of 5574 men aged 17 to 59 years, suicide mortality was *no*t raised for MSM (men having sex with men).[6] Later figures using a national data set *(*17,886 respondents), followed for an average of 11.6 years found no differences for MSM suicides compared with heterosexual men. A slightly higher risk of suicide for WSW than heterosexual women made no difference to their all-cause mortality.[7]

2. Autopsy work on young victims, like that in Quebec, found no significant differences between suicide victims and controls for same-sex orientation and no apparent intimidation related to minority sexuality. Any with same-sex orientation were more mentally ill.[8]

3. A cautious overview fronted by 27 researchers from the gay study area disappointingly failed to find higher LGBT suicide rates.[9]

4. Should there not be a big difference in overall levels between more or less 'gay' friendly countries? Rates for 2015 (WHO) give 9.4 per 100,000 people for the Netherlands: Norway

9.3: Sweden 12.7: Denmark 9.1: New Zealand 12.3 and Canada 10.4.[10] Bahrain is 6.9: Turkey 8.6: Jordan 3.9: Singapore 8.6: Bangladesh 6.0: Italy 5.4 and Spain 6.0.

5. A recent, unique analysis of 145 actual or probable suicides in England by those aged less than 20 years during a 16 month period and based at Manchester University,[11] collected data from a range of official investigations. Ninety-two (71%) were male. Common themes: family problems (separation or divorce, physical or mental illness, domestic abuse, substance misuse); abuse and neglect: bereavement (often involving suicide of a family member or friend): bullying: suicide-related internet use: academic pressures (especially exams): social isolation or recent withdrawal. There are physical health problems with a social impact, along with excessive drinking, illicit drug use and mental ill health, suicidal ideas (often just before death) and relationship problems and breakups. Longstanding family adversity was often accompanied by difficulties elsewhere as well as complicated by mental health problems.
Four cases (3%) were recorded as also having "concerns about sexuality". Not 30%.

Exceptions? 6. Danish men in current or former registered partnerships and marriage have suicide risks nearly eight times greater *across the life span* compared to married or formally married heterosexuals and nearly twice those for never married men.[12] For women, the results are similar to those for the general population. For Sweden, there is a three-fold difference in rates for same-sex compared to different-sex married men.[13] How these findings relate to sexual minorities generally or people outside Scandinavia is unknown. Only two to six per cent of homosexuals use marriage or civil partnerships. Up to 40% of gay unions may be for immigration or citizenship purposes. There are high rates of abuse in 'gay' relationships.

It was alleged that the protective environment marriage provides for heterosexuals with less morbidity and mortality could be experienced by homosexuals. Even if they never used it, marriage would boost homosexuals' status and therefore their well-being.

Suicidality.

'Have you ever made a suicide attempt?' is bedevilled by different definitions. Proportionally more who severely harm themselves or make suicide attempts *may* eventually kill themselves; the overwhelming majority do not.[14] Specialists even question whether suicide attempts, let alone ideation, are significant predictors for actual suicide.[15] Young females make suicide attempts or self-harm (three times) more than males and adult males are far more likely to kill themselves. The female pattern may be present for many 'gay' males. Suicidality levels for LGB youth are largely confined to adolescence and early adulthood-
perhaps more than for heterosexuals.[16] In one study, those aged 17 to 29 years accounted for 98% of those with same sex partners who reported attempts.[17]

Statistics vary enormously. Cross-sectional population-based studies yield far lower rates than convenience samples and similarly where there are tight definitions of sexual orientation. A fairly recent meta-analysis concluded that sexual minority youth were almost two times as likely to report suicidal ideation and more than three times as likely to report suicide attempts as heterosexuals.[18] *Most do not* attempt suicide. There is no indication that elevated rates of attempts recorded for sexual minorities are matched by raised suicide mortality.[19]

Suicidality, self-harm and depression for all youth increase in proportion with drinking, sexual activity, drug use.[20] There are also previous psychiatric problems, family histories of alcoholism and suicidality and disrupted backgrounds.[21]

Victimisation experiences (attacks and threats) have associations for youth, but the effects are difficult to disengage from alcohol and drug abuse and mental health problems. Severity matters and effects are mediated by family support.[22]

There is an inverse relationship between psychosocial problems, including suicidality, and the age at identification as homosexual. Each year of delay sees a significant decline.[23] Early disclosure of LGB identity might entail sexual experiences with older men along with harassment and abuse which relate to higher rates of attempted suicide.[24] Referring suicidal youngsters to LGBT organisations may be counter-productive. They need mainstream help.

Overall. The risks generally associated with suicidality may be stronger or more prevalent for sexual minorities than for similar heterosexual adolescents.[25]At the same time, independent connections between same sex behaviour/ orientation and suicidality are seen worldwide and after controls for other risks.[26] The evidence throws up many suggestions and it is premature to jump to conclusions about the factors involved in associations between suicidality and sexual orientation.[27]

Bullying.

According to identity groups, bullying in schools is a primary example of homophobia in action and cause of substantial tribulations. As 'experts' on the nature, origins and remedies, they have been given access to the education system and public resources.

This furthers sweeping interventions to overhaul educational endeavours and mentality of future generations, with lessons on alternative sexualities and families, parades and gay history months etc. Ofsted recommends LGBT supportive environments, encompassing all curricula and aspects of the wider school environment from sport to dressing up to books to posters to prize giving.[28] Ofsted's Safe at School Guidelines oblige school inspectors in England to see whether primary schools are teaching children about same-sex relationships and whether any child who would rather be the opposite sex, feels 'safe and included'. At secondary level they need to know if a 'gay pupil' is safely 'out' and if 'heteronormality' and 'heterosexism' are being countered. Model schools follow up any staff or pupils with "any anti-gay or anti-transgender attitudes" to make them "change their perceptions. There are "resources provided by external organisations [or Stonewall]" and staff trained (by Stonewall) in how to identify, record, report and tackle homophobia.

Bullying involves repeated, aggressive behaviour between peers intended to hurt or dominate another, physically or mentally; with the abuse of differential power on any pretexts.[29] Unless effectively challenged, bullying often becomes an accepted group norm.

Is LGB bullying the predominant or only bullying? For the year 9 age group (13-14) in the longitudinal Study of Young People in England which tracked more than 8,000 pupils, 94% was of heterosexual young people and 6% of LGBs.[30] this is similar to other results here and
abroad.[31] How is a child meant to be 'gay' or bisexual? Why are all who experience homophobic bullying assumed to be 'gay'? A reason for victimisation is not evidence for

an ‘orientation’. Boys who appear effeminate or ‘sissy’ may be more likely bullied and whatever they eventually are. Are LGBs bullied for reasons other than being ‘gay’? Are LGBs ever bullies? Bisexuals are disproportionately risk seekers and some may fit a ‘provocative’ characterisation and be both bullies and bullied.[32]

As homo/bi-sexuals are usually found to be under two percent of the population, this means that there may be one or two homo/bi-sexual children (sic) in a hundred and perhaps none in a class of 30.

In general, appearance predominates when it comes to being more likely to be bullied. This might mean being over or under-weight, wearing glasses or teeth braces, having ‘wrong’ clothing, hair or name etc., along with being slow or clever or having a disability and, in some contexts, race and religion. There is the recent surge in online abuse where insults are much about looks and sexual behaviour. Some have extended definitions to cover teasing, inappropriate comments, taunting, purposely leaving someone out, spreading rumours, embarrassing someone, making mean or rude hand gestures and so forth.

While inflicting misery or fear is wrong in itself, little is deducible from the scarce and contradictory studies dealing with the short and long term effects of (usually severe) bullying; with ones on sexual minorities rarer still. Problems identified often owe much to interactions with other social and personal characteristics.

In Ofsted’s investigation, only three primary and five secondary pupils were seemingly bullied over sexuality, so speculation was that friendship and appearance issues “may mask issues around perceived or actual sexuality”. It complained that some schools’ programs are ‘too general’ for not focusing on ‘incidents of homophobia’ – often involving casual use of the word ‘gay’.[33] That uttering a particular word amounts to intimidation or violence draws upon a growing emphasis on microaggressions. Whether a word should be used and in what context is one issue. Another is what happens to the hearers. There was no follow-up of children who somehow knew they were LGB and heard the word ‘gay’ at school and whether they were seriously affected.

Youngsters equally matter and bullying should be confronted on this principle; fairness decrees we remember the vulnerabilities of all youth. There are cases where children and families have been very badly let down by the prioritisation of one fraction for protection. While toleration and acceptance are important, anti-bullying programmes should not be used or confused with campaigns to promote and glorify particular lifestyles or sexual proclivities.

There **is other possible collateral damage**. Measures may not only be unfair and baseless in prevention terms, but encourage the immature to take potentially dangerous steps. What the *evidence does abundantly suggest* is how the earlier a boy ‘comes out’ to explore and engage in same-sex sexual behaviour, the more detrimental it is to mental and physical health – in terms of forced sex, serious sexual diseases, abuse, substance use, self-harm and later depression.[34] In illustration: for boys in the UK’s representative RIPPLE and SHARE school studies, the prevalence of unwanted sex, partner pressure, high levels of risk taking and regret were higher for homosexual contact (oral or anal) than with first intercourse for the exclusively heterosexual group.[35]

Homophobia is hardly the explanation for such troubles and it is time that sexual identity groups showed some responsibility. These have gained considerable power and influence at the highest levels throughout society; disproportionate to their population representation. They are successful because they single-mindedly devote so much of their

time and considerable resources to their agenda, along with achieving attention through accounts of victimhood, accompanied by aggressive putdowns of any who question.

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