HEALING SPIRITUAL HARMS: SUPPORTING RECOVERY FROM LGBTQA+ CHANGE AND SUPPRESSION PRACTICES

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We are immensely grateful to the 35 survivors of LGBTQA+ change and suppression practices who generously shared their stories of harm and recovery with us. We would also like to express our gratitude to the 18 mental health practitioners who shared their experiences of supporting survivors' recovery and critically reflected on their professional practice. We are also grateful to the members of the steering committee for their guidance and insight into this work.

The majority of the interviews and meetings for this research took place on Zoom or by phone in mid-2020 during an intense period of the COVID-19 pandemic in Australia, and we acknowledge the extra burden that this placed on many participants. The research project from which this report draws is a partnership between the Brave Network, AGMC, the Victorian Government and researchers at La Trobe University and Macquarie University. The project is funded by the Victorian Government and the Australian Research Council.

SUMMARY

- This research report presents findings from a project conducted in partnership with the Brave Network, the Australian LGBTIQ+ Multicultural Council (AGMC) and the Victorian Government on recovery support needs of survivors of LGBTQA+ change and suppression (conversion) practices.
- Studies suggest that at least one in ten LGBTQA+ Australians are vulnerable to religion-based pressures and attempts to change or suppress their sexuality and/or gender identity.
- These practices may involve formal conversion programs or 'counselling' practices, but more often involve less-formal processes including pastoral care, interactions with religious or community leaders, prayer groups and other spiritual or cultural practices initiated within particular communities. Core to both these formal and informal change and suppression practices is the message conveyed to LGBTQA+ people that they are 'broken', 'unacceptable' to God, and need spiritual or psychological healing.
- LGBTQA+ people may initiate or seek out conversion practices in an attempt to 'heal' themselves, affirm their spiritual and religious identity, and sustain their connection and sense of belonging to faith, community, culture and family. They may also be coerced into undergoing conversion practices.
- Psychological research has demonstrated that LGBTQA+ change and suppression efforts do not reorient a person's sexuality or gender identity and an increasing body of literature has documented the negative impacts that these pressures and attempts have on LGBTQA+ people's lives. Little formal research evidence exists regarding what supports are needed to enhance the recovery of people who have been harmed by LGBTQA+ change and suppression practices.
- This study investigated survivors' experiences of recovery through interviews with survivors and with mental health practitioners. It is the first such study internationally to include research with mental health practitioners and has a significantly more diverse cohort of survivor participants than previous studies.
- The report provides a detailed account of survivors' support needs. Its findings are intended to inform health practitioners and others working to meet the support needs of LGBTQA+ people who are recovering from the harms associated with LGBTQA+ change and suppression practices.

KEY FINDINGS

1 Many people who experience attempts to change or suppress the LGBTQA+ elements of their selves are severely harmed by those attempts. Disengagement and recovery from LGBTQA+ change and suppression practices can be slow, and survivors may need long term support that is sensitive to the gravity and complexity of the trauma experienced.

2 Survivors commonly experience PTSD symptoms related to religious trauma and may require support with: integration of their self-concept; improving self-care; correcting misinformation about LGBTQA+ people and communities; repairing and rebuilding their social support and community networks; navigating their relationship with faith; and recovery from the impact involvement in conversion practices had on their civic and economic participation.

3 Survivors experience numerous barriers to accessing health support including: financial barriers; heightened mistrust of mental health professionals due to their experience of conversion practices; reluctance to disclose information about their involvement in LGBTQA+ conversion practices due to shame about those experiences; uncertainty about mental health practitioners' ability to deal with issues at the intersection of religion, culture, sexuality and/or gender identity.

4 Both survivors and health practitioners reported a reluctance to raise faith and spirituality in therapy. In order to support survivors' healing, mental health practitioners and other supporters need to be respectfully curious and open about survivors' connections to faith and experiences of religion-based trauma.

5 Survivors may have diverse goals for resolving trauma related to conflict between faith, culture, gender identity and sexuality. This may involve continued ambiguity about their faith, sexuality or gender identity. They may want to leave, retain or change their faith. Self-acceptance may also not always involve 'coming-out' publicly about their sexuality or gender identity, especially where survivors' LGBTQA+ status, culture and ethnicity intersect in complex ways.

BACKGROUND

In recent decades, there has been growing social awareness and acceptance of lesbian, gay, bisexual, transgender and gender diverse, queer and asexual (LGBTQA+) sexualities and gender identities.

This is reflected in significant legislative and regulatory changes to remove inequities faced by LGBTQA+ people and same-sex couples. From the 1970s, the most widely recognised psychiatric guidelines, the American Diagnostic and Statistical Manual (American Psychological Association, 1980, 1994, 2013; Drescher, 2015a) removed any reference to same-sex attraction as a condition that required diagnosis or treatment. LGBTQA+ people are no longer regarded as disordered or, in themselves, requiring ongoing treatment by secular health authorities (APA Task Force, 2009; Australian Psychological Society, 2010). Nonetheless, significant sectors of all religious traditions have yet to abandon attempts to change or suppress LGBTQA+ people's sexuality and/or gender identity in Australia through a range of formal and informal processes (Jones, 2015; Jones et al., 2018; Jones, 2020).[1]

These religion-based LGBTQA+ conversion practices are grounded in the false pseudo-scientific claims that all people are born with the potential to develop (a) heterosexual attraction, and (b) a gender identity that accords with that assigned to them at birth (ie, cisgender, rather than transgender or gender diverse) (Csabs et al., 2020).

Proponents of LGBTQA+ conversion practices claim that LGBTQA+ people suffer from 'sexual or relational brokenness' and can be cured of their 'affliction' to be made acceptable to God and their communities. Full membership and participation in faith communities can be dependent on LGBTQA+ people of faith committing to chastity and seeking 'healing' for their sexual brokenness. The ideology that informs LGBTQA+ conversion practices thus posits that LGBTQA+ subjectivity and spiritual belonging are incommensurable. This has led to the development of cultures that promote and engage in various practices directed at changing or supressing LGBTQA+ sexual orientations and gender identities. There is agreement in the literature that these practices do not work, and cause harm (APA Task Force, 2009; Beckstead, 2012; Drescher, 2015b; Przeworski et al., 2020; Serovich et al., 2008). So far, the focus of research on LGBTQA+ change and suppression efforts has been on their prevalence, ethics and effect. There has been insufficient attention to the contexts, nature and drivers of conversion practices outside of clinical settings, the harms attendant to LGBTQA+ conversion practices, or to survivors' support needs in recovery.

This report draws on social research with 35 survivors of LGBTQA+ conversion practices and 18 mental health practitioners in Australia. It analyses the life history of survivors and narratives of professionals working in this field to document experiences of recovery from the harms of LGBTQA+ conversion practices. It is intended to inform health practitioners and others seeking to support people who are recovering from the negative impacts of LGBTQA+ conversion practices.

1 Please note, religious LGBTQA+ change and suppression practices have not included forced medical interventions on people born with intersex variations, hence this report's focus on "LGBTQA+" but not "I" conversion practices. It is important to note that some intersex people are also LGBTQA+ and have been subject to religious LGBTQA+ conversion practices

LITERATURE REVIEW

Previous ethnographic, social research and clinical studies of LGBTQA+ change and suppression practices have demonstrated their lack of efficacy and established that such practices constitute a breach of professional ethics (Beckstead, 2012; Bennett, 2003; Drescher, 2015b; Erzen, 2006; Gerber, 2011; Serovich et al., 2008, Waidzunas, 2015; Wolkomir, 2006).

A number of recent studies have examined their prevalence in different international contexts and a smaller number of studies have examined the harms associated with experiences of LGBTQA+ conversion practices and the recovery support needs of survivors. This research on prevalence, harms and recovery is reviewed below.

PREVALENCE

Scholarship on the scope, nature and impact of conversion practices in Australia is currently limited. Our pilot study, conducted between 2016 and 2018, estimated that 10% of LGBTQA+ Australians are vulnerable to change and suppression practices (Jones et al., 2018). It provided a historical outline of the development of religion-based LGBTQA+ conversion practices in Australia, conducted 15 in-depth life history interviews with survivors, and legal analysis of the possibilities for regulatory change in Australian jurisdictions. Other Australian data has shown that LGBTQA+ change and suppression messages are still widespread. Jones (2015) showed that 7% of 3,134 same sex attracted and gender questioning Australians aged 14-21 were exposed to the message 'gay people should become straight' in school-based sex education. This was significantly higher in QLD (9.56%) and NSW (8.41%), but lower in Victoria which had more comprehensive anti-homophobia policies in place (4.44%). It was also significantly higher in Catholic (15.44%) and Other Christian (16.35%) schools, than in government/public schools (3.62%). In 2018, a combined online and offline national survey showed that 4.9% of 2,500 Australian students broadly (including mainly students who were cisgender and heterosexual, as well as same-sex attracted or gender diverse) were exposed to the message 'gay people should become straight' in their school-based sex education classes (Jones, 2020). The proportion rose to over 10% in schools which participants reported as taking an overall conservative approach to social values (Jones, 2020).

A number of large international studies have been published in the last three years which have shown that LGBTQA+ conversion practices continue to be widespread across the globe. These studies have sought to document the prevalence of conversion practices (Bishop, 2019; Blosnich et al., 2020; Higbee et al., 2020; Hurren, 2020; Madrigal-Borloz, 2020; Ozanne Foundation, 2018; Salway et al., 2020; Trevor Project, 2020; UK Government Equalities Office, 2018). For instance, a study by the UK Government Equalities Office (2018: 83-94) found that 7% of LGBT British adults had been advised to undertake conversion practices, with 2% of these having undertaken them. These figures rose to between 13% and 44% for particular ethnic and gender minority populations. Other studies in the UK, US and Canada have similarly shown between 8% and 11% of respondents had experienced formal conversion practices, with higher rates in ethnic and gender minority populations (Ozanne Foundation, 2018; Salway et al., 2020; Trevor Project, 2020). These studies have also shown that informal and religion-based practices are more prevalent than formal practices in clinical settings (Hurren, 2020; Ozanne Foundation, 2018; Salway et al., 2020). Higbee et al. (2020) reported higher rates of conversion practices experienced by younger cohorts in their US study.

They proposed that this may be related to the earlier ages of coming out among contemporary LGBTQA+ youth compared to older generations who grew up in more hostile social climates and learned to hide their sexuality or gender identity from others.

HARMS

A number of studies have shown the negative impact of LGBTQA+ conversion practices on people who experience them. The health impact reported by participants in our pilot study were marked (Jones et al., 2018). All experienced significant negative impacts on their mental health, including suicidal ideation. Recovering from conversion practices took many years, and many suffered ongoing problems with mental health, relationships, sexuality, sexual function and spirituality. They experienced grief at the loss of relationships with family, friends, and communities who did not accept them as LGBTQA+. They suffered financial impacts from the costs of conversion practices and recovery, and from delayed or impaired education, employment and civic participation. They also grieved the collateral damage experienced by family, friends and peers associated with their change and suppression efforts. In the interview data it was apparent that the spiritual harms of LGBTQA+ conversion practices were severe. Jones' (2020) study similarly showed that Australian students exposed to the message 'gay people should become straight' in their school-based sex education classes were considerably more likely to have negative educational impacts and engage in negative and harmful behaviours including increased thoughts of self-harm or suicidal ideation.

International clinical and survey studies have shown a range of negative impacts associated with experiences of conversion practices. These include suicidality, drug and alcohol use, homelessness, poor mental health, and poor economic participation (Blosnich et al., 2020; Haldeman, 2002; Higbee et al., 2020; Salway et al., 2020; Shidlo & Shroeder, 2002; Trevor Project, 2020). Studies of young people who have experienced conversion practices have shown impacts on their identity formation and their connection to family (Jones, 2019; Ryan et al., 2020; Trevor Project, 2020). Shidlo and Shroeder (2002: 256) identified several types of spiritual harm among their participants, such as loss of faith, sense of betrayal by religious leaders, anger at being taught punitive and shaming concepts of God, and excommunication or exclusion from religious community. Berg et al. (2016) note that the trauma from religion-based conversion practices is distinct from and compounds already established trauma related to heteronormativity, transphobia and homophobia. In addition to these harms, Schlosz (2020) identified further negative impacts: anger as a response to deceptive claims and mistreatment; grief over the loss of time, opportunity, and youth; a sense of shame; escalation of high-risk sexual behaviour; and impairment of self-concept due to iatrogenic counselling practices. Turban et al.'s (2020: 75) study of transgender adults showed that recalled exposure to change and suppression practices 'is associated with adverse mental health outcomes in adulthood, including severe psychological distress, lifetime suicidal ideation, and lifetime suicide attempts'.

As Haldeman (2002) observed, people's experiences of conversion practices can be mixed, with some gay men in his clinical practice reporting that failed attempts at change or suppression had the 'indirect beneficial effect' of supporting acceptance and solidification of their homosexual identity. Researchers have also identified the need for more research into the magnitude and character of harms occasioned by exposure to conversion practices (Flentje et al., 2014; Haldeman, 2002; Meanley et al., 2019). Przeworski et al. (2020) additionally identified the need to address the lack of racial, ethnic and gender diversity in existing research and to address the significant lack of research on the impacts of change and suppression practices applied to gender identity.

SURVIVOR SUPPORT AND RECOVERY NEEDS

There is a small body of literature reporting on research about recovery from LGBTQA+ conversion practices (Haldeman, 2002; Horner, 2010; Lutes & McDonough, 2012; Schlosz, 2020; Shidlo & Schroeder, 2002). A review of this literature shows a number of consistent themes regarding the support needs of LGBTQA+ conversion practices survivors: restoring trust in mental health services; support for grief and loss; education responding to misinformation received in conversion practices; support to establish affirming social networks; support for issues regarding intimacy and sexual dysfunction; and support to integrate spirituality, gender identity and sexuality.

Trust: Shidlo and Schroeder (2002: 258) emphasised the difficulties survivors may experience in recovery due to 'heightened mistrust of mental health providers' based on their experience of conversion practices. They reported that clients who were unsuccessful in their attempts to reorient their sexuality (or gender identity) may feel unsafe being truthful about their sexual desires or behaviours. They 'may also be angry if they view prior therapy as having caused them harm and may fear additional injury' (2002: 258). They may have become accustomed to lying to practitioners during involvement in conversion practices and may be experiencing ambivalence about their gender identity or sexuality. Haldeman (2002: 122) emphasises that it is important to reinforce the notion that the treatment of people post-conversion practices does not require the person to switch to a pro-LGBTQA+ perspective. Ambivalence about gender identity and sexuality need not be hidden and should be welcomed as an element in a client's journey (Lutes & McDonough, 2012).

Grief: Haldeman (2002) emphasised that survivors will need support with grief work to deal with depression related to loss of former self-concept, family relationships, faith and previously supportive environments. For survivors who were coerced (or forced) into heterosexual marriage as a change or suppression practice, they may need support with grief at the resultant family dysfunction and increased stress experienced by spouses, partners and children (Beckstead & Morrow, 2004; Drescher et al., 2016). Streed et al (2019: 502) note that many 'survivors of conversion therapy will need treatment for post-traumatic stress disorder and post-religious trauma'.

Misinformation: The literature recommends that survivors of change and suppression practices may need to be provided with accurate information about their psychological development and about LGBTQA+ communities. A common element of LGBTQA+ conversion practices is the provision of 'fraudulent and damaging information' about LGBTQA+ people (Shidlo & Schroeder, 2002: 258). As Haldeman (2002) notes, clients in conversion practices are frequently taught that the LGBTQA+ aspects of their personality result from arrested psychological development or moral insufficiency. The availability and sensitive provision of accurate information will aid in recovery.

Self-Acceptance of Sexuality and Gender Identity: Internalised shame and guilt about sexuality and gender identity is common among survivors of conversion practices. This includes a likelihood of self-blame for failure to successfully change or reorient gender identity and sexuality. Lesbian or gay survivors whose conversion practices involved gender normative behavioural conditioning may also need support accepting changes to their gendered self-concept and interpersonal relationships associated with acceptance of a lesbian or gay identity (Haldeman, 2002). Acceptance should not be taken to involve an imperative to 'come out' and should be culturally and socially sensitive (Hammoud-Beckett, 2007).

Affirmation: The literature also notes that LGBTQA+ conversion practice survivors may need assistance in establishing affirmative support networks to facilitate a sense of belonging in society. Studies have shown that family and community acceptance of LGBTQA+ people results in greater resilience and integration (Ghazzawi et al., 2020). Survivors may experience difficulties connecting to supportive LGBTQA+ environments because of the social distance from their previous communities, have misconceptions about LGBTQA+ communities, and have 'shame about having been through conversion therapy'. Shidlo and Schroeder (2002: 258) observe that peer organizations that support survivors 'may be a helpful support system for postconversion clients'.

Intimacy: Survivors may need help resolving intimacy avoidance and problems with sexual function, related to internalised stigma about their sexuality and gender identity or specific conversion practices. Haldeman (2002) noted that internalised homophobia led some of his clients to seek either unattainable or unsuitable relationship connections. These unstable relationships were grounded in clients' lack of acceptance of themselves as gay men, despite believing that they had resolved the shame and self-recrimination they had experienced about being gay during involvement in conversion practices. Haldeman observed that the failures experienced in heterosexual dating during change efforts were mirrored in post-conversion dating experiences. Other clients, particularly those who had experienced more severe forms of conversion practices, experienced conflict and confusion about sexual arousal and required treatment for sexual dysfunction.

Spirituality: Survivors will often need assistance navigating spirituality and religion after conversion practices. Haldeman (2002: 126) noted that this could be the most difficult aspect of post-conversion support, as 'deeply help religious and spiritual beliefs can be as important an aspect of the self as sexual orientation…When religion and sexuality are in conflict, a tremendous obstacle to integration of the self is created'. Horner (2010: 15) similarly found that the biggest challenge in working with survivors lies in the fact that 'clients need guidance in resolving the tension between their religious conviction and their sexuality, a very precarious task for the clinician'. Cataldo (2010) discusses the complexity of mourning the loss of religion and the religious self in the context of a client negotiating a transgender identity. Finding supportive spaces that affirm sexuality, gender identity and faith can help integrate historically conflicted aspects of self (Ghazzawi et al., 2020; Rosenkrantz et al., 2016; Weiss et al, 2010).

GAPS IN LITERATURE

There are some gaps and limitations in the current body of literature. The focus of research has predominantly been on the experiences of white, cisgender, gay and bisexual men of the global north. Such literature is particularly limited in its cultural and ethnic diversity and its representation of trans and gender diverse people, as well as of lesbians and asexual people (Mejia-Canales & Leonard, 2016; Wright et al., 2018). The purpose of much of the existing literature was to establish that the provision of LGBTQA+ change and suppression practices constitutes a breach in professional ethics and the data on survivors' experiences of harm and recovery in many of these papers are brief, anecdotal or rely on small participant cohorts (Ashley, 2020; Flentje et al., 2013; Flentje et al., 2014; Maccio, 2011; Schroeder & Shidlo, 2002). To date, there has been no academic research on the recovery experiences of LGBTQA+ Australians who have been harmed by LGBTQA+ change or suppression efforts. Neither has there been any research on the capacity of mental health practitioners to support survivors in their recovery.

RESEARCH AIMS

This research was designed in response to the need for greater knowledge of the support needs of survivors of LGBTQA+ change and suppression practices in the Australian context.

It expands on previous international studies by increasing the gender, gender identity, sexuality and ethnic diversity of the survivor participants, and by analysing a range of different health professionals' perceptions of the support needs of survivors. The study aims to improve understandings of the experiences of recovery for Australians who have been harmed by LGBTQA+ change and suppression practices in order to enhance the provision of support to survivors. It reports on both the recovery experiences and needs of survivors and the knowledge and education and training needs of health practitioners.

RESEARCH DESIGN AND METHODOLOGY

Our approach combined in-depth life history interviews with survivors of LGBTQA+ conversion practices, group interviews with survivors focussed on their experiences of support in recovery, and group interviews with a range of different types of health provider about their experiences and needs in supporting survivors in their recovery.

Ethics approval was obtained from the La Trobe Human Research Ethics committee (Human Ethics IDs: 16-003; HEC19384). Participants could discontinue or withdraw from interviews at any point without prejudice, and were provided with a list of support services they could utilise if required. Interviews were recorded and transcribed verbatim. Grounded theory qualitative analysis was applied to identify key themes and make findings.

SURVIVOR INTERVIEWS

Three sets of survivor interviews were used in this report. Data from 15 in depth life-history interviews with survivors of conversion practices conducted in 2016 were analysed for those survivors' experiences of recovery (table 1). A further seven in-depth life-history interviews were conducted with survivors of conversion practices from diverse cultural, ethnic and religious backgrounds in 2020 (table 2). They were purposively recruited through invitations distributed to multicultural LGBTQA+ organisations to augment the narrower cultural, religious and ethnic parameters of the cohort interviewed in 2016 for the pilot study. In addition, we conducted group interviews with 15 survivors involved in survivor peer support groups (table 3). Two group interviews were conducted with seven people in one group and eight in another. Two of the in-depth life-history interview participants also participated in the survivor group interviews on recovery. Participants in group interviews were recruited through invitations distributed through four LGBTQA+ community and support groups. Group interviews focused on experiences of conversion practices and recovery, as well as aspects of each person's historical engagement with faith and religion. To protect the anonymity of participants, ethnicity and religion are indicated in the tables below but not attributed to quotations.

Table 1: 2016 Life History Interview Survivor Characteristics (*n*=15)

Sexuality: gay (9); lesbian (3); bisexual (2); other (1)
Gender: cisgender male (9); cisgender female (3); non-binary/gender queer (3); transgender female (1); transgender male (1)
Religion: Protestant Christian (13); Jewish (1); Buddhist (1)
Ethnicity: Anglo-Australian (13); South-East Asian (1); Mediterranean (1)
Age: 20s (3); 30s (5); 40s (4); 50s (3)

Table 2: 2020 Life History Interview Survivor Characteristics (*n*=7)

Sexuality: gay (2); bisexual (2); lesbian (2); queer (2)

Gender: cisgender male (3); cisgender female (2); transgender female (2)

Religion: Orthodox Christian (2); Protestant Christian (2); Maronite Christian (1); Druze (1); Jewish (1); Mormon/LDS (1); Muslim (1)

Ethnicity: Middle-Eastern Australian (3); Anglo-Australian (1); Greek (1); North African (1); South-East Asian (1)

Age: 20s (5); 30s (1); 40s (1)

Table 3: 2020 Group Interview Survivor Characteristics (*n*=15)

Sexuality: gay (6); bisexual (4); lesbian (3); asexual (2); pansexual (2)

Gender: cisgender male (8); cisgender female (4); non-binary/gender queer (2); transgender female (1)

Religion: Protestant Christian (15)

Ethnicity: Anglo-Australian (11); Anglo/European (2); Anglo/Maori (1); European (1)

Age: 20s (6); 30s (5); 40s (2); 50s (2)

HEALTH PRACTITIONER INTERVIEWS

Four group interviews were conducted with mental health professionals. A total of 18 mental health professionals participated (table 4). Interviews focused on participants' understandings of conversion practices, understandings of support needs of survivors, and the training needs for themselves and/or their sector with respect to improving service provision to support survivors. Health practitioner participants were recruited through advertisements to a generalist psychologists' bulletin board, through invitations sent to LGBTQA+ health services, and through invitations sent to a pool of practitioners known to survivor support groups as being experienced and skilled at supporting survivors.

Table 4: 2020 Health Practitioner Group Interviews (*n*=18)

Modalities: Psychologist (9); Counsellor (6); Alcohol and Other Drugs (2); Social Worker (1); Narrative Therapist (1); Family Therapist (1); Psychotherapist (1); Occupational Therapist (1)

Practice: Private Practice (10); LGBTQA+ specialist practice (8)

Participants worked in diverse mental health professions and had a range of professional qualifications: counsellors, psychologists, social workers, pastoral care workers, and occupational therapy. Participants worked in mainstream services, private practice and LGBTQA+ specialist services. Some participants were highly experienced working with survivors of conversion practices while a few had not knowingly worked with a survivor before.

All participants were LGBTQA+ affirming, and many identified as LGBTQA+. People with current religious faith and practice were overrepresented in the group interviews (*n*=9, 50%), as were people with formal religious or theological training (*n*=6, 33%). The likely reason for this is that people with a personal history or interest in this project or topic were inclined to volunteer to participate. Interviews used a question schedule that was formulated collaboratively by our team. The experiences of survivor peer-support leaders were used to curate and adapt a range of exemplar questions located in existing literature. These questions were used flexibly throughout data collection.

DATA ANALYSIS

Grounded Theory approaches were used to analyse interview data. Themes which had been identified in the literature were known to researchers doing the analysis, but a formal coding frame was not used so that the researchers could approach the data in a way that enabled openness to new or un-identified themes (Braun & Clarke, 2006; Charmaz, 2006; Charmaz & Bryant, 2011; Kenny & Fourie, 2015).

The analysis process included several phases. In the first phase, the research team (which included all authors on this report who had all been involved in data collection) read through the individual and group interview transcripts and then met to discuss their observations of the data and identify core themes. In the second phase, individual researchers independently went through the data line by line to identify themes. Themes were identified as important if they were stressed as significant by participants, if they were recurrent within one particular interview, if they were recurrent across several interviews, or if they were significant to a group of participants (such as people from a particular religious faith, gender identity, or sexual identity). The findings of phases one and two of the analysis process were written up and reviewed by the whole research team as a process of cross-checking interpretation of the data. As a final process, the data were entered into qualitative software program Leximancer on automatic settings to generate concept data. The Leximancer findings were cross-checked with the themes identified by the research team as a process of ensuring rigour in the analysis and checking that all relevant themes were identified.

FINDINGS

The findings of this study highlight the complexity of disengagement and recovery from LGBTQA+ change and suppression practices, the significance of the social structures in which those practices occurred, and the need for sensitive and informed supports.

We begin with a discussion of survivors' experiences of recovery, both positive and negative, and what support needs they identified as being most important in their journeys. This is followed by a discussion of the knowledge and experiences shared by health practitioners, and the needs they identified in supporting survivors. We conclude with some recommendations for health workers and others seeking to support LGBTQA+ people who have been harmed by change and suppression practices in their journey of recovering.

SURVIVORS' EXPERIENCES OF RECOVERING

Participants in survivor interviews had engaged in a range of formal and informal conversion practices for differing amounts of time. The practices ranged from teaching, prayer, informal counselling and other religious practices, to formal programs and therapy with registered health practitioners. Their period of engagement in change and suppression efforts ranged from one to thirty years.

They were motivated to participate in the research because they felt that their involvement in these practices had been personally damaging, and they wanted to improve the care of LGBTQA+ people in faith communities and to improve the supports for fellow survivors. All participants described experiencing severe harms in their religious communities, and a large proportion of them maintained a strong sense of faith or religious identity.

From engagement to disengagement:

All participants had been taught that being LGBTQA+ was not compatible with membership of their religious community. The majority of participants had internalised this message and voluntarily engaged in change and suppression efforts in order to sustain religious membership and maintain relationships with faith, family, and community. Many survivors engaged in periods of self-directed change or suppression efforts, guided by the ideological messages they had internalised from informal or formal conversion practices at an earlier point in time. A minority of participants were pressured, coerced or tricked into engaging in conversion practices by religious leaders or family members, including being sent overseas to undergo conversion practices. Participants who had voluntarily engaged in conversion practices were commonly highly motivated in their efforts and only gave up on attempts to change or suppress their gender identity or sexuality when life 'had become unliveable'. When asked about the reasons or process by which they came to disengage from conversion practices, there were a range of responses.

Several reported a breaking point when becoming aware that their 'ex-gay' leaders or role-models had not reoriented, but were merely suppressing, their LGBTQA+ sense of self. Some disengaged when they became aware that they had been given misinformation about LGBTQA+ people, lifestyles and communities. Others, tragically, were motivated to disengage from their change efforts by the loss of peers to suicide, or their own suicidality. Others had not yet disengaged from change and suppression efforts at the point that they sought mental health support for the turmoil they were experiencing, which became a path to disengagement from change efforts and to self-acceptance.

Finding Support: All participants described needing to find a range of different supports to help them deal with the conflicts, hurts and traumas of their time engaged in LGBTQA+ change and suppression practices. A significant number of participants had found help in peer support groups with people who shared and understood their experiences. Peer support groups would often provide resources that would help them develop new understandings of the relationship between their faith, gender identity and sexuality. All participants sought professional psychological assistance as part of their journey, but finding appropriate affirming health care was challenging for many.

Financial barriers to accessing psychological assistance were a feature for several participants. Some found the limited sessions available on Medicare-supported mental health care plans were insufficient. Others were dependent on financial support from their parents. For those without affirming and supportive parents, this could be perilous. One 2020 life-history interview participant's parents directed her to a non-LGBTQA+ affirming psychologist who attempted to reorient her sexuality through hypnotherapy. She recalled, "We're in Australia aren't we? I thought, surely there is an ethical board or someone. Do they allow this practice?" [cisgender lesbian, age 28, 2020]

Others were able to cobble together single free counselling sessions from queer affirming services, but the utility of such fragmented support was limited, particularly when viewed in light of the deep work required to repair self-concept noted in the work of Schlosz (2020) and Haldeman (2002).

Several participants also struggled to find LGBTQA+ affirming health care. Difficulties accessing LGBTQA+ affirming healthcare in Australia, including with non-inclusive practices and anticipated discrimination, have been reported as an ongoing problem (Waling et al, 2019). For our participants, who were seeking health support related to conflicts from their non-LGBTQA+ affirming religious backgrounds and contexts, having the confidence and skills to find affirming health care could be even more challenging than for the wider LGBTQA+ community.

> *I remember just the difficulty of having to go to each person and try and work out, what do I tell them, what do I not tell them? Are they supportive or are they not? And I didn't realise how traumatising that experience is.* [cisgender gay man, age 35, 2020]

> *The main thing that I had to explain was asexuality, and that ended up being quite, actually, traumatising.* [asexual non-binary person, age 21, 2020]

All participants reported finding that the experience of searching for and accessing appropriately supportive health care was a particular challenge.

Unhelpful Experiences: Participants also reported having unhelpful experiences once they had accessed professional mental health support. This included difficulties with health professionals who were unsympathetic to faith or religion, or who held misconceptions about the nature of conversion practices, disengagement from them, or their impacts on survivors.

Several participants described LGBTQA+ affirming health practitioners who thought that having faith and being LGBTQA+ were incommensurable. These views unhelpfully mirrored the ideological basis of the conversion practices that our participants were seeking assistance to recover from. In a number of cases, health practitioners' lack of understanding of LGBTQA+ affirming faith and religion led to participants withdrawing from or delaying seeking further health support.

> *There's almost a binary view. It's like, "Oh, great, you're out of that. …You don't want any of that religious stuff. Let's help you to be a balanced secular person", rather than embracing the whole spectrum of faith and where you are.* [cisgender gay man, age 35, 2020]

> *An unhelpful experience I had was meeting my first psychiatrist who tried to convince me that being religious was delusional. I never went back to see her.* [transgender bisexual woman, age 26, 2020]

> *I think that that lack of understanding was really detrimental to me seeking help from an actual qualified professional until much later.* [cisgender gay man, age 33, 2020]

If the survivor had other sources of support or was further into their journey of processing their conflict between religion, gender identity and sexuality, they may have had the capacity to educate the health practitioner about their goals and the possibilities of resolution in this area.

> *In terms of my psychologist, there was some confusion initially around the fact that I was queer and wanted to be Christian.* [asexual non-binary person, age 21, 2020]

All participants affirmed that they needed health and mental health practitioners who could respect their religion and cultural background, and support survivors' faiths and faith goals.

For participants from minority cultural backgrounds, finding professionals who understood the importance and complexity of family and cultural dynamics could be a further challenge. Several minority culture participants described that they needed support to negotiate the cultural consequences that embracing their LGBTQA+ selves would have on their parents and siblings. This could include religious consequences for family, decreasing the marriageability of siblings, and family cultural shaming.

> *My guilt stemmed from my family, how they would feel and their relationship with their faith, and their relationship with their communities…I did try and see a psychologist when I first started dating, when I was in my first ever relationship in university…I only saw her a handful of times, but she didn't really understand the dynamics that were at play with my family.* [cisgender lesbian, age 33, 2020]

A transgender participant in our 2016 cohort from a minority cultural background described going through several years of extreme hardship because their psychiatrist had pushed them into coming out to their family when it was not safe to do so. For many participants from minority cultures, meeting their therapeutic goals did not involve Western style 'coming-out', but rather 'letting people in' when it was safe to disclose LGBTQA+ aspects of themselves and their lives.

Other participants reported experiences of health practitioners who did not appreciate the difficulty of the task of disengaging from change and suppression practices and integrating their faith, gender identity and sexuality. They reported a range of negative experiences of primary health practitioners rushing them through disengagement before they were ready, exoticizing them, or making uninformed assumptions about their experiences.

> *Secular health [services] need to better understand, within their training spaces, what conversion practices can look like, so that when they do have a client come in, they're not just going to assume that "It's going to be like* Boy Erased*" or "It's going to be like this thing I read". But it can be more subtle. It can be this lifelong ideology just breaking you down as a human.* [non-binary bisexual person, age 28, 2020]

> *He was beside himself with concern that I'd been brainwashed and wanted to know all about that…I was aghast.* [cisgender gay man, age 37, 2020]

All participants discussed that recovery could take 'years' and could involve multiple general practitioners, psychologists, counsellors and support group sessions over time to ensure the healing work was effective for their recovery.

Successful support experiences: Recovery approaches were more successful for many survivors if they could experience affirming people with whom to be free and be themselves – especially health and mental health practitioners, family and friends, and survivor support groups. The relief in participants' voices when they described finding appropriate support was palpable.

> *Honestly, life-changing because this psychologist understands me on an unbelievable level in terms of culture, sexuality, religion and how that all interplays.* [cisgender lesbian, age 28, 2020]

> *If it hadn't been for my ability to access really good-quality professional counselling I would have killed myself several times over by now* [cisgender lesbian, age 50, 2016]

Sometimes survivors needed time away from segments of their religious communities that supported conversion, or needed a break from a particular version or aspect of faith, or from faith itself. For a therapeutic goal to enhance a survivor's journey of healing and recovery, they needed to be the determining party for the goal. Survivors needed considerable time for support to be effective and needed the right support to be able to use the time constructively.

> *Yes, it's taken a lot… the work that I've done with [my psychologist] to get to that point where I can look at something and think, this is not about me. I actually don't need to let it affect me. And build strength in that sense. But it's been a long journey. It definitely didn't happen overnight. This has been years of practising.* [cisgender lesbian, age 33, 2020]

It was important to do the work of discussing and reconciling their identities and beliefs. Survivors outlined a range of resources and supports that had been important to them, particularly being able to talk about their experiences with peers and other supporters who had had similar experiences.

> *I want to feel comfortable with, perhaps letting go of this struggle [to become straight]. And start to take the rabbi's words on board saying that this, I have to just be happy with not being able to do, because it's not in my control to do.* [cisgender gay man, age 24, 2020]

Specifically, they endorsed health and mental health practitioners understanding survivors' faith goals rather than imposing any; and seeking training about faith, faith traditions, and LGBTQA+ change and suppression practices.

HEALTH PRACTITIONERS' EXPERIENCES OF PROVIDING SUPPORT

We interviewed 18 LGBTQA+ affirmative mental health practitioners working in Australia in four groups. We selected participants from as diverse a range of backgrounds as we were able (see table 4). Practitioners worked in different modalities, in different types of practice, and had been practicing for different lengths of time (2-20+ years). They also had different degrees of experience working with clients who had experienced LGBTQA+ change and suppression practices. Ten practitioners had significant experience working with survivors, while eight had some or no experience (that they were aware of). Two practitioners specialised in working with clients from migrant and minority cultural backgrounds, and eight worked in services that specialised in serving LGBTQA+ clients. Most health practitioners were able to discuss their experiences supporting clients at various stages of disengagement and recovery from LGBTQA+ conversion practices, bringing different insights into experiences of recovery to those we received in the survivor interviews. All survivors who participated in the research had experienced a significant period of professional support, and a majority had also benefited from involvement in a peer support group with fellow survivors. Having made progress in a journey of recovery from harm was a requirement for participation but also shaped their evidence, making them more articulate than many of the practitioners' clients described in this section. Practitioners were also enabled by the group interview format to reflect together on their practice and discuss their insights into their knowledge of the harms experienced by survivors and strategies (and pitfalls) to support healing.

Awareness of the problem: While all health practitioners' participation was motivated by a desire to improve supports for survivors of LGBTQA+ change and suppression practices, the differences in their knowledge of the phenomenon could be stark. Of the ten practitioners with significant experience supporting survivors, several had made it a specialisation in careers over decades, and considerable numbers of their clients had needed support recovering from harms associated with conversion practices. Three practitioners identified that they had never knowingly supported a survivor.

Practitioners who had limited experience or knowledge of clients with LGBTQA+ change and suppression efforts drew on popular culture references to elaborate their basic awareness and describe what they knew about associated harms and recovery. Several were also unaware that it was a significant problem in Australia, assuming that it was an American phenomenon.

> *I probably had the idea almost that [this is] something that really happened in America … I was just shocked [to learn it happened in Australia]. I just made this assumption that it didn't exist in Australia.* [clinical psychologist, private practice]

> *I don't think I've worked with any clients who've directly experienced it, so a lot of my knowledge comes from pop culture, movies,* Boy Erased. [counsellor and occupational therapist, LGBTQA+ practice]

> *A lot of my knowledge of it comes from pop culture. I also identify as queer [so] I've heard a few stories from friends as well. Then the main thing that I think of is a movie, I think it's,* But I'm a Cheerleader. [counsellor, LGBTQA+ practice]

The lack of awareness and limited sources of knowledge of these LGBTQA+ affirming professionals in a range of modalities, including in LGBTQA+ specialist practices, speaks to the need to enhance awareness of the phenomenon among health practitioners.

Complexity of Trauma: All participants understood that survivors may need support to negotiate their relationship with faith, sexuality and gender identity, as well as with negotiating their relationships with non-affirming family members and communities. There was some variation between practitioners in their perception, or articulation, of the nature and depth of psychological impact and trauma related to experiences of LGBTQA+ change and suppression practices. Experienced practitioners were able to articulate in detail the depth of the impact. They frequently described grief, loss, chronic and complex trauma, and the symptoms of PTSD.

> *There is always a significant level of grief in this journey. Even if someone steps out of a conversion program, says "No, I'm happy with who I am and my expression of spirituality"...there are still quite enormous amounts of grief that they carry. Grief over lost relationships, grief over lost beliefs, grief over certainty from the past, grief over lost community.* [counsellor, private practice]

> *Over time, what I find with survivors is that they've really learnt not to trust their own feelings and instincts. They've been taught that their feelings are wrong and that the way that they think about the world and the way that they think about themselves is wrong as well. I find a lot of survivors have a lot of difficulty trusting themselves and trusting their version of events, trusting their memory. It's a form of, basically, a complex trauma experience.* [clinical psychologist, private practice]

> *I see the refugees from those experiences, who just feel incredibly violated. I would say the symptoms would be of PTSD.* [narrative therapist and psychologist, private practice]

They described clients who had been harmed by LGBTQA+ conversion practices as suffering from complex trauma, indicating the need for longer term, sustained support. One practitioner likened it to the degree of support that Medicare recently extended to people recovering from eating disorders: 40 sessions per year.

Range of Presenting Issues: Clients needing support to recover from harms associated with change and suppression practices appeared with a range of presenting issues. Sometimes clients had specifically sought out health support to deal with their difficulties dealing with their conflict related to reconciling faith, gender identity and sexuality, or to the harms they experienced from specific change and suppression practices. However, all practitioners with experience supporting survivors noted that they have worked with many clients, with perhaps the majority who presented seeking support to manage their mental health not linking their presenting issues to their experience of conversion practices. As one practitioner described, this link was sometimes made by "just randomly stumbling across these issues when it comes up". Practitioners described these clients commonly presenting with anxiety and depression or sex and relationship issues, as well as issues with alcohol, drugs, and general self-care.

Reluctance to Raise Religion: Practitioners in all groups spoke of the difficulty that both clients and practitioners had in raising issues related to religion. This was a repeated, remarkable, and surprising theme, especially given the overrepresentation of mental health practitioners who identified as having a background in religion, actively practicing a faith, or even as having had formal theological training.

> *A lot of the time, we don't ask about spirituality. They come in because they've got anxiety, depression. And we might ask… about suicidality, we ask about substance use, but we need to take it further and ask about their spirituality … We ask about sex, which is really quite personal, and yet, a lot of time, I don't know, we're reluctant to ask about spirituality.* [psychologist, LGBTQA+ practice]

This 'reluctance to ask' is problematic because many survivors are also reluctant to disclose their experiences or address their complex feelings around faith and trauma. Numerous practitioners described versions of this reluctance.

> *For at least a few people who I've seen… there's also a bit of a sense of shame around still having Christian beliefs or still having religious beliefs despite knowing that they've been abused by the church or whatever. And I think that's really hard for people to reconcile.* [psychologist, private practice]

The main concern about survivors presenting for therapy with issues not immediately related to conversion practices or ideologies is that the impact of conversion practices may not be addressed in therapy if the client does not explicitly direct the practitioner toward it. This is particularly the case if the therapist is not comfortable or experienced in asking clients about their religious background or history with religion.

Practitioners who had significant experience supporting survivors spoke about the importance of including religion in conversations in cautious and respectfully curious ways.

> *Sometimes we try to be value-free in the sense of religion free, but so much religion intersects with our world view, and our ideas of what humanity is and what it means to be human, and what we can change and what we can't change and things like that. So, it is really important to explore world views.* [psychologist, private practice]

> *I usually ask people about the circumstances in which they grew up, their family backgrounds, faith, culture, that kind of stuff.* [clinical psychologist, private practice]

> *You can dip our toe in and say, "I'm curious, has religion played a part?" to see what the response might be. And if someone says, "Absolutely not", well, then "I'm curious why not"…And if they say, "Yes, it definitely has", well then there's an entry point in trying to understand, "Help me understand what that looked like in your family".* [narrative therapist and psychologist, private practice]

Personal knowledge of the dynamics of a particular religious tradition or culture is not necessary to work successfully with survivors of conversion practices. However, experienced practitioners spoke about how being respectfully curious about religious dynamics—within a trauma-informed lens—is an important part of making sense of the history and context of a person's experience.

Recovering from Trauma: Practitioners described a range of tools that they had used successfully with clients needing support in recovery from change and suppression practices. Many of them commented that most of what is presented is a form of PTSD, and a well-trained counsellor in any of a variety of modalities will have tools to deal with trauma. They also emphasised that survivors usually need more sustained support than only dealing with the specific change and suppression practices or related family conflict. In many cases, clients are dealing with a lifetime of core identity conflict.

> *It's a life of being constantly bombarded with the message that you're not right or that you're broken or that you're flawed. And it has all the hallmarks of someone who's been to a war zone or something like that. It's this constant assault on a person's wellbeing…So I'd encourage anybody working with survivors to be really skilled in helping to treat and heal people that have post-traumatic stress disorder.* [counsellor, private practice]

Numerous practitioners spoke about success using narrative therapy to integrate challenging past conflicts, relationships to family and community, and damage to self-concept. A number also mentioned eye movement desensitisation and reprocessing (EMDR), as well as a range of other treatments that are commonly effective in helping clients heal from deep trauma.

Healing from Shame: Shame is often deeply connected to trauma and so it is not surprising that shame was a theme that was continually present in the narratives of both survivors and practitioners. Many practitioners spoke about their work as beginning to challenge and shift the deep and pervading sense of shame that many survivors carry. Shame was identified as a particular factor for survivors of conversion practices, compounding the harms from stigma about sexuality and gender identity experienced by the wider LGBTQA+ population. Supporting clients' 'de-shaming' was linked to their self-acceptance and freedom, improved self-care and healing.

> *The freedom to be you, to make your own choices, to have your own agency: I think it's just a huge thing, and from there I think many things flow better, like relationships and other areas of life. I bring a lot of emphasis to the self. It's a very gradual de-shaming process after about a trillion exposures to shame that have occurred for that person.* [clinical psychologist, private practice]

Practitioners spoke to the theme of challenging shame in different ways: through their therapeutic practice and therapeutic relationship with clients, through unpacking their beliefs, and through building connections that help people develop a more positive experience with their sexuality, gender identity and the LGBTIQA+ community.

Restoring belonging: Practitioners described how people who had been harmed from LGBTQA+ conversion practices commonly suffered impaired relationships with their families and community networks. They needed support in repairing and rebuilding their social support and community networks. This could involve establishing healthy boundaries with family, ethnic and religious communities in order to repair and sustain those significant relationships. This was particularly important for survivors from minority cultural backgrounds, where socio-political as well as clinical approaches were described as critical.

> *The young people that would say to me, if you marginalise my family, you leave me working solo here. You need to work as a collective, because we live in collectivist cultures.* [narrative therapist and psychologist, private practice]

Numerous practitioners also spoke about the significance of establishing new networks of LGBTQA+ support and belonging.

> *Community plays a really important role in healing. Part of the grief of people that have gone through conversion practices is that they've lost community. And so trying to reconnect with another community that is supportive and affirming and loving is a really important thing. What we don't want is somebody to move out of all this really horrible stuff but then be alone, lonely and isolated and still be at risk because there's no support there. We want to make sure that there are good supports around them. So community is really, really important.* [counsellor, private practice]

Finding a sense of belonging with other LGBTQA+ people was described as being important in correcting the misinformation about LGBTQA+ people and communities that survivors commonly receive during change and suppression practices. It also helps to combat the shame that they commonly still carry about being LGBTQA+.

For some survivors, connecting to the LGBTQA+ community could be a daunting process. Religious belief and experiences of conversion practices are often not well understood in many parts of the community. Peer support groups with other survivors were mentioned as being useful for some, but not all clients. The nature of peer support groups varies, and suitability for a survivor can depend on a group's structure, focus, oversight, and the expertise of facilitators.

> *I think peer groups are fantastic and can be quite healing…Some people do feel that they don't want to be outed or they feel overwhelmed at times, but with good facilitation usually they can be very healing spaces. Because again, it's an antidote to the isolation they've experienced through this process to go, "Oh my goodness I'm not alone through this journey". This has been healing for some. For others, it hasn't.* [narrative therapist and psychologist, private practice]

> *In those groups where it's not necessarily formal or supported by professionals, sometimes it can go both ways. People can certainly find support there. But I think sometimes in a group of so much trauma, and especially internalised shame and things like that, I find that sometimes people can have reactions within these groups towards survivors. Or people are triggered by other people's stories.* [clinical psychologist, private practice]

For practitioners, it was important to be mindful of what experiences people were having and support them if their peer-group experiences were challenging.

CONCLUSION

The primary purpose of this study was to improve understandings of the experiences of recovery for Australians who have been harmed by LGBTQA+ change and suppression practices in order to enhance the provision of support to survivors.

It reported on interviews with 35 survivors of LGBTQA+ conversion practices and 18 mental health practitioners operating in various modalities. The findings confirm and expand the findings of previous studies of recovery from LGBTQA+ change and suppression practices conducted in international contexts. This is the first study to include research on health practitioners' knowledge of support needs. It indicates areas where support capacity could be enhanced, some of which may be particular to Australia.

People who needed support to recover from experiences of LGBTQA+ change and suppression practices had commonly experienced severe harm and required long-term support to heal and recover. The harms LGBTQA+ people had experienced were not limited to specific change or suppression events. They were compounded by the social and cultural contexts that promoted change and suppression efforts. These contexts included sustained shaming, being fed misinformation about the causes or dysfunctional nature of their sexual orientation or gender identity, being told that they were broken, that they were not acceptable to God and that they did not belong in their community or religion if they were LGBTQA+.

In most cases, the internalisation of these messages had led to participants' involvement in change and suppression efforts and made it challenging to disengage from those efforts and seek support to improve their health. Disengagement and seeking help often only came after a crisis event. Health practitioners reported that survivors most commonly presented seeking mental health support without disclosing that their support needs were linked to experiences of religious trauma or LGBTQA+ change and suppression efforts.

Survivors' capacity to find the support that they needed was limited both by the nature of their problem and by the availability of appropriate support services. Coming from non-LGBTQA+ affirming contexts, survivors struggled to know how to access affirming services. This compounded the problems with access to health and support services that are experienced by the general LGBTQA+ population. In addition, they often did not have the financial resources to access the extent of support they required. When they did access services, they commonly found that health practitioners were poorly equipped to understand and support their need to process trauma related to faith or religion. Mental health practitioners reported a reluctance amongst themselves and their clients to raise faith or religion in therapy, leading to survivors' experiences with conversion practices not being addressed. When they did raise their experiences, many survivors reported that health practitioners assumed that being LGBTQA+ and having religious faith were not compatible, unhelpfully reinforcing the messages that survivors received in LGBTQA+ change and suppression practices.

Such negative experiences often led to survivors delaying seeking further professional support.

The main areas identified in this study with which survivors required support align with the areas identified in previous research (Haldeman, 2002; Horner, 2010; Lutes & McDonough, 2012; Pzeworski, 2020; Schlosz, 2020: Shidlo & Schroeder, 2002). They commonly needed support to deal with: grief at the loss or impairment of relationships with family, community, culture and with their spirituality; misinformation about sexuality and gender identity; shame about and affirmation of their sexuality and gender identity; sex and relationship issues; the integration of their faith, gender identity and sexuality; the restoration of community and support networks and establishment of new community and support networks; recovery from the impact that involvement in conversion practices had on their civic and economic participation. Both survivors and practitioners articulated the severity of the harms in terms of complex, chronic trauma, with the symptoms of PTSD. This characterisation of harms associated with LGBTQA+ change and suppression efforts in the terms of PTSD has been suggested in previous studies (Schloz, 2020; Streed et al., 2019), but not with the strength and clarity as by our participants.

This study expanded on previous studies by increasing the diversity of its participants, and the scope of change and suppression practices from which people were seeking health support to recover. Previous studies have focussed on the experiences of white, cisgender, gay and bisexual men experiencing conversion practices in clinical settings. We purposively included participants from minority culture backgrounds as well as more lesbian and bisexual women, transgender, gender diverse and asexual participants. Our analysis also included conversion practices outside of clinical settings because, as recent studies have shown, this is where the majority of LGBTQA+ change and suppression practices occur (Ozanne Foundation, 2018; Salway et al., 2020).

Such a widening the scope of study enables enhanced understandings of the impacts of both formal and informal conversion practices and of the cultural and religious contexts in which those practices occur.

Participants from minority culture backgrounds spoke of additional support needs relating to cultural competency and understanding the complexities at the intersection of culture, family, faith, gender identity and sexuality (Tang et al., 2020). For these participants, both survivors and practitioners, faith, ethnicity, family and community were closely intertwined. Finding ways to maintain these relationships was a greater priority than for participants from Anglo-Australian backgrounds and shaped their therapeutic goals. In addition, experiences of racism, Islamophobia, anti-Semitism and other socio-political factors may introduce additional barriers to addressing harms from LGBTQA+ conversion practices (Hammoud-Beckett, 2007; Mejia-Canales & Leonard, 2016). Our research suggests that supports for these survivors required both clinical and socio-political understandings. Finding mental health practitioners who appreciated the significance of socio-political factors could be an added challenge.

Cisgender lesbian and bisexual women did not report significantly different support needs to the cohort as a whole. Transgender, non-binary and asexual participants reported a range of experiences that may have been particular to their experience of recovery. In all previous studies that have included transgender and gender diverse people, they have been shown to be much more likely to report experiences of conversion practices (Turban et al., 2020). Survivors seeking support in recovery from gender identity change and suppression efforts may face more access barriers to gender affirmative health care than the wider trans and gender diverse population (Wright et al., 2018). They may also have to negotiate the false conflation of gender affirmation with LGBTQA+ conversion practices (Ashley, 2020). No previous studies have included asexual people's experiences of conversion practices.

Asexual participants in this study reported a number of experiences of conversion practices and access to supportive health care that were distinct from LGBTQ participants. Further research is needed into the particular support needs of transgender, gender diverse and asexual survivors.

LIMITATIONS OF THE STUDY

A significant number of survivor participants were recruited through survivor support groups. This means that they may have been more articulate about their experiences than other cohorts of survivors, due to a period of peer support and professional psychological assistance. Their involvement in peer support groups might indicate that they had experienced more harm than others with similar non-affirming religious experiences. Their involvement in these groups may also mean that they were more highly motivated to improve the care of survivors and the pastoral practices of non-LGBTQA+ affirming religious communities.

IMPLICATIONS

As social and political recognition of the continued harms of LGBTQA+ change and suppression practices continues to grow, concern is shifting from demonstrating the ethical problems with these practices to enhancing the supports for survivors of these practices to heal and recover. This study reports on experiences of recovery from the perspectives of survivors and mental health practitioners.

More clearly than previous studies, this report articulates the severity and complexity of harm experienced by survivors in the terms of complex trauma and PTSD. For survivors who seek formal mental health or counselling support for recovery, this process is often long-term and the current Medicare provisions may be inadequate. Understanding the nature and impact of LGBTQA+ change and suppression practices using a trauma lens is likely to be a useful tool to enhance mental health support for survivors.

Trauma informed practice is increasingly recognised as core to work with people who have experienced family violence or significant negative life events (Isobel et al., 2020). Most practitioners will be aware of this approach and be able to apply a trauma-informed lens if a client presents needing support recovering from LGBTQA+ change and suppression practices.

The importance of LGBTQA+ people's sense of belonging to family, faith and community featured centrally in their articulation of harm and their path to recovery. This was the case whether survivors maintained, changed or eschewed their religious affiliations or faith identity. It was particularly the case for survivors from minority cultural backgrounds, where there may be limited scope for alternative spaces of cultural or spiritual belonging. Strikingly, most survivors struggled to find mental health supports that appreciated the significance of their interconnected culture, faith and spiritual experiences. While mental health practitioners expressed confidence in dealing with cultural difference, most reported a reluctance in themselves and their clients to discuss faith and spirituality. McGeorge et al. (2014) found that mental health practitioners may need training in the integration of spirituality and LGBTQA+ identity. This report has shown that both cultural and religious awareness are vital factors in supporting survivors' healing and recovery.

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APPENDIX: STEERING COMMITTEE MEMBERSHIP

Ro Allen, Victorian Commissioner for LGBTIQ+ Communities

Sekneh Beckett, psychologist

Roz Bellamy, La Trobe University

Nicole Conner, Narrative Therapist

Chris Csabs, SOGICE Survivors

Maria Dimopoulos, Special Advisor, Multicultural Communities, DJCS

Roe Johnson

Teresa Ma, Acceptance Melbourne LGBT+ Catholics

Michelle McNamara, AGMC & TGV

Kenton Miller, DPC

Pamela Rodriguez, DHHS

Abanob Saad, QMEACA

Pastor Katecia Taylor, St Kilda Elsternwick Baptist Church

Anthony Venn Brown, ABBI

Rida Khan, Living Under Taboos

Rev. Dr Robyn Whitaker, University of Divinity