On Conversion Talk in Indian Clinical Contexts: A Pilot Venture

Aritra Chatterjee¹ and Tilottama Mukherjee²

Abstract
Conversion therapies are founded on the premises of altering one’s sexual orientation/gender identity to compulsory cis-heterosexuality. They target LGBTQIA+ individuals globally and negatively impact their psychosexual health and well-being. These therapies were not discredited explicitly in the Indian mental health context until 2020. In the current article, two case vignettes are sampled from self-identified transgender individuals who faced conversion efforts in various capacities, their families, and health care professionals being collateral stakeholders in the process. These case vignettes are shaped from first-person narrative accounts elicited from the participants in narrative inquiry format through virtual interactive sessions. The cases are critically discussed in the light of the present clinical-scientific consensus and future implications. The routes to more affirmative mental health ecosystems are explored through probable intersectoral linkages.

Keywords
Affirmative ecosystems, collateral stakeholders, conversion, LGBT issues, mental health

Introduction
The World Health Organization posits sexual health as a state of well-being in relation to sexuality that involves safety, respect, and freedom from violence and discrimination. It further underscores the necessity for respect towards the sexual rights of all persons. When the sexual health of Gender and Sexual Minorities (GSM) is flagged, it is essential to contextualize it within systems of health care, where parallel sexualities/gender-expressions/gender-identities were historically pathologized. Sexual health of these communities is therefore a very politically charged enterprise involving a lot of unsaid tensions between the health care structures and these communities.

In this pretext, the author(s) would like to draw attention to conversion therapies that are a violent infringement on sexual autonomy, psycho-sexual health, dignity, and human rights of GSM. Conversion therapies are practices that aim to alter or change an individual’s sexual orientation/gender expression/gender identity perceiving such alterations as a desirable end for family, society, and community. Conversion therapies are continually practiced by licensed professionals, religious ministries, lay counselors, and community or family members, ironically often with state support. Documented evidence of conversion attempts for “male” homosexuality date back to the 1800s through practices such as ordered visits to female sex-workers, shock therapy, and even castration. The current focus is toward less shocking and less extreme “talk therapy”; though apparently benign in scope such talk is no less associated with lasting psychological harm. For an already marginalized and stigmatized population, conversion therapy efforts pose increased mental health risks such as depression, anxiety, substance use, social withdrawal, loss of self-esteem, homelessness, and even suicidality.

By the 1990s, homosexuality was de-pathologized by the American Psychiatric Association and the World Health Organization. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders created a huge

¹ Department of Clinical Psychology, University of Calcutta, Kolkata, West Bengal, India
² Department of Psychology, University of Calcutta, Kolkata, West Bengal, India

Corresponding author:
Aritra Chatterjee, Department of Clinical Psychology, University of Calcutta, Kolkata, West Bengal 700009, India.
E-mail: jewelindcrown@gmail.com

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (http://www.creativecommons.org/licenses/by-nc/4.0/) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).
paradigm shift from Gender Identity Disorder to Gender Dysphoria by refuting the pathologization of alternate gender identity in itself and shifting focus to experienced discomfort, distress, and dysfunction because of incongruence between natal and experienced gender. However, it still retains Transvestic Fetishism as a diagnosis till date.

The current trend of passing of legislative protections for LGBTQ minors in the United States against conversion therapies also highlights the need for state intervention in this regard and the significance of attaching legal costs to such therapeutic oppressions to counter them effectively. However, these bans only target licensed mental health providers and not religious ministries and lay counselors that are flag-bearers of this practice. Globally, Brazil, Ecuador, and Malta have nationwide legislations restricting conversion therapies, while subnational jurisdictions have been implemented in parts of Canada, Spain, and the USA. In Argentina, Uruguay, Fiji, Nauru, and Samoa, mental health laws serve as indirect bans by prohibiting exclusive diagnosis on the basis of sexual orientation and/or gender identity. German law-makers have also voted to prohibit conversion therapy for minors, imposing fines on advertising or treatment.

Regarding the ethical implications of the conversion therapy, the American Medical Association raises questions of uninformed consent, confidentiality breaches, patient discrimination, patient blaming, and improper/indiscriminate treatment. What is perhaps even more ironical is that former conversion therapy proponents themselves discredited their practice and some even “came out” as a part of the LGBTQ community.

**Contextualizing Conversion Therapies in India**

In post-Independent Indian society, homosexuality continues to be perceived as an “un-Indian” import, attributable conveniently to both British and Mughal colonization that led to the degeneration of an otherwise sexually normative Indian society. Yet ironically, in histories of medical imagination, Euro-American techniques are emphasized in psychiatric literature to “cure” such non-normative sexual practices and behaviors. A published protocol of such treatment in the *Indian Journal of Psychiatry* using aversive stimuli with 13 patients “motivated” to treat their homosexuality may be alluded to in this instance.

Kalra in the *Indian Journal of Medical Ethics* reported a case of a 26-year-old gay man, who was subjected to conversion therapy at a reputed psychiatric institute by being prescribed full-year medications and was advised to visit a female commercial sex worker. The timeline of publication reveals clearly that even after the global de-pathologization of homosexuality, conversion efforts continue to be practiced by licensed professionals in India.

A recent case of family-endorsed forcible conversion attempts of a 26-year-old bisexual woman, Anjana Harish, at two de-addiction institutions in Kerala, that allegedly led her to die of suicide, reinforces such a claim. The Anjana Harish case succeeds the decriminalization of consensual same-sex encounters by the Supreme Court of India in a landmark judgment in September 2018. It marks an important shift in medical standpoint against conversion therapy as it was followed by position statements of condemnation of conversion therapy from leading mental health professional bodies in the country such as the Indian Psychiatric Society, Indian Association of Clinical Psychologists, Association of Psychiatric Social Work Professionals, and Centre of Mental Health Law and Policy. Yet, there are reputed mental health professionals who openly pathologize queer identities on a public forum and advocate for conversion.

Even though India is still miles away from anticonversion legalities, some legal entry-points to contest it are conceptualized as follows:

1. The Yogyakarta principles included in the NALSA judgment of the Supreme Court of India (2014) recognize an individual’s right to be protected against medical or psychological harm on the basis of their gender identity or sexual orientation.
2. The Supreme Court of India in its landmark 2018 judgment (decriminalizing homosexuality) categorically stated the need for affirmative counseling practices for homosexual clients and holding mental health professionals accountable for the same.
3. The Mental Healthcare Act, 2017, specifically mentions patient discrimination on grounds of gender identity/sexual orientation, and not only makes a strong case for “informed consent” before treatment but also extends liabilities to the state or medical practitioners, when often primary perpetrators of conversion efforts are family members, relatives, and lay “experts.”

Section 106 of the Act states: “No mental health professional or medical practitioner shall discharge any duty or perform any function not authorized by this Act or specify or recommend any medicine or treatment not authorized by the field of his profession.”

Against this backdrop, the current study aims to critically discuss case vignettes of conversion efforts sampled from spontaneous narratives of two-self identified transgender individuals in the light of the present clinical-scientific consensus and future implications.

**Method**

**Sample: N = 2 self-identified transgender individuals selected by convenience sampling.**

Both the participants are young adults (24-25 years), graduates, and Indian citizens who self-identify within the transgender spectrum of identities. Gender identity refers to
“a person’s deep felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; [or another] gender.”22 Self-determination was therefore given weightage as the basis of recruitment of participants as per accepted international standards.

**Tools Used**

Case vignettes based on a participant’s spontaneous narrative of the experience of conversion therapy were used in the current study. In clinical research, vignettes23 can provide scope for critically unpacking clinician behavior, judgment, and decision-making, useful specifically in the cases where accessibility to clinical decision-making with real clinicians in health care settings raises both ethical/feasibility concerns. Rather than presenting hypothetical situations that might have poor external validity, basing a case vignette on situations that are actually rooted in real-life encounters gives it an immediate practical relevance.

**Procedure**

Informed and voluntary verbal consent was obtained from the participants beforehand, which included informing them about the risks and benefits of the study, and assurance of protection of confidentiality regarding identifying information. The participants were deemed free to withdraw their consent at any point during the study if they so felt. Consent was also taken for audio recording disclosed information. Ethical approval for this study has been obtained from the departmental ethical clearance body of the Department of Psychology, University of Calcutta, India.

Consecutive online interactive sessions were conducted with the participants over Google Meet where participants shared their spontaneous narratives of conversion-therapy experience. These interactive sessions were in narrative inquiry format which focused solely on the narrative aspect of communication and the meanings participants ascribed to their experiences of conversion efforts.25 This also shifts the power to the interviewee in keeping them at the center of their own stories in ways that are meaningful to them, while the researcher plays the role of a listener.

After contextualizing the research premise for the participants, the sample interview guide was along the following lines “Please tell me about your journey with conversion therapies”, and probes were inserted wherever deemed necessary. This of course presupposes the establishment of prior rapport and smooth interactional flow so that the narrative process can progress unhindered. No time limit was provided to the participants. Basic sociodemographic information was also obtained from them as per their willingness for disclosure. Audio recordings were done with their consent for record-keeping.

After sampling these cases of interest from the community, brief case vignettes were prepared that outlined the pertinent features of the case. These vignettes are then critically understood in conjunction with current clinical-scientific consensus.

**Case 1**

P1 (preferred pronouns: they/them) is a self-identified male-assigned-at-birth nonbinary transgender person, 25 years of age, currently a postgraduate student of gender studies. They are also involved in social work and belong to a nuclear, Tamil Brahmin family.

When they came out to their parents as nonbinary and bisexual in a rather candid and matter-of-fact fashion, their parents expressed open disgust toward them which made it uncongenial for them to continue staying at their natal home. In this pretext, P1 suggested that their parents go for therapy to understand their identifications. However, the parents interpreted this as P1’s willingness to subject themself to therapy and get better from this critical situation in their life.

P1’s dad visited a big name psychiatrist associated with a prominent suicide helpline, who claimed to know exactly what his “son” is and promised that his “son” can be cured. However, he promised cure only if P1 goes out of touch with the LGBTQ community, framing the engagement as ill-influence. P1 feels that the psychiatrist has made it effectively impossible for their father to come around and accept their trans-ness. Rather, they have confirmed the seed of doubt in P1’s dad’s mind that this is indeed some kind of influence and therefore fixable.

Altercations continue between P1 and their dad post this visit, and P1’s dad became impossibly abusive to them. P1 took upon their own to find a suitable therapist again to deal with this in a more resolved manner.

**Case 2**

P2 (preferred pronouns: she/her) is a self-identified male-assigned-at-birth nonbinary trans-woman, 24 years of age, currently seeking employment. She is Bengali-speaking, a graduate student, and hails from a nuclear family.

She had initially left her hometown and switched cities during the COVID-19 lockdown to live out her trans-self away from family, but after a year of separation had to visit home again because of repeated persuasion of family members. Erstwhile, she reported being convinced by her family to believe that her “masculinity” is compromised and she took unprescribed sperm-count increasing medications, which further worsened her dysphoric feelings.

Upon visiting her family, she was forced to consult a homeopathic practitioner over call for cure, about which
Greater prevalence of clinical interactions with health care professionals amongst transgender individuals for medical and surgical affirmation makes them more prone to experiencing conversion attempts. It is also pertinent to flag that in the Indian context indigenous imaginations of GSM also guide health care delivery as there exists socioculturally institutionalized identities outside the Western gender-binary such as the Hijras, Aravanis, Jogtis, and other native subcultural identities.

In case 1, the mental health professional advertised cure for the participant’s gender identity/sexual orientation to their father through elimination of peer and community support. He conducted a clinical interaction with the participant’s father on the fundamental assumption that the participant’s alternative gender/sexuality is flawed and undesirable. The American Psychological Association Resolution on Gender Identity Change Efforts prohibits dissemination of inaccurate information regarding gender-diversity, including making claims for cure. Such talk has the potential to reinforce transnegativity, stigma, and has mental health risks alongside social consequences. This interaction also made the participant vulnerable to abuse from their father and produced interpersonal dysfunction between them. In P1’s narrative,

But that’s the actual damage he did, he was the first person my dad went to in confusion, panic and transphobia… And he confirmed the one thing that’d make him impossibly abusive, that this is “fixable”…my dad came home and told me to go to him and I decided never to be in the 5km radius of his clinic.

Gender diversity is not a pathological outcome that needs to be modified at all. In fact, trying to change a core and stable component of one’s identity such as experienced gender can have adverse mental health outcomes including suicidal attempts and ideations for a lifetime. In this case, it is the first consultation that the participant’s father accessed from a position of incomprehension and inexperience with the issue and, therefore, it is singularly important in shaping perspectives. By advocating in favor of alienating the participant from community and peer support, the professional propagated an overt anti-LGBTQ stance. He engaged in patient-blaming in the sense that the participant’s choices of social support are stigmatized and held responsible for their queer identity.

Rock et al. outlines affirmative therapy as an approach that takes a positive view of LGBTQ identities, validates and authenticates them, and shifts the gaze to prejudice, discrimination, and stigma that impacts these lives squarely. From an affirmative standpoint, this clinical encounter could operate on the following lines:

1. Psycho-educating the participant’s father about gender diversity and different kinds of sexualities
2. Checking with the father’s belief systems and challenging stereotypes and misinformation
3. Working on building interpersonal flow between the participant and their father and facilitating perspective-sharing
4. Promoting community and peer support as resource for the participant’s well-being and coping with social hurdles
5. It would be also wise on behalf of the professional to review their own heterosexism, homonegativity and transnegativity so that they can provide more competent services.

In case 2, the participant was prescribed maleness-inducing drugs by a homeopathic practitioner despite stating her self-identified gender as a transwoman and disclosing her desire to transition. It is a consultation sought out of family pressure and reiterates how families can be collateral stakeholders in conversion efforts. The practitioner was also ignorant about the nuances of transgender and intersex identity and conflated the two. However, when confronted over clinical misinformation, he put the participant at the receiving end of more uncomfortable questions. This is a common conversion tactic, where the expression of the client’s experiences/ emotions is rejected by the practitioner. As the practitioner does not hold a registration number, it becomes effectively difficult to counter such medical harm legally. Simultaneously, it must be mentioned how the participant’s family forced her to take the prescribed medications and cut her access to resources upon noncompliance.

Role of the Family in Conversion Efforts

In both the cases, the clinical encounters are contextualized against a desire of the participants to negotiate conflicting
relationships with their families regarding their gender/sexuality. Discomfort with nonconformity of gender accounts for much of the caregiver’s and parent’s motivations for conversion efforts.31 Parental proactive involvement in conversion therapy is often motivated by a host of genuine concerns such as helping the individual “fit in,” responding to religious and sociocultural values, trying to keep families from falling apart, and protecting the individual from harm.32 However, such efforts from caregivers clearly come across as familial rejection for the queer individual, doing more harm than good, and are associated with multiple poor health and adjustment indicators in young adulthood.31 Interpersonal dysfunction between the families and the participants as an outcome or mediating factor of conversion talk is evident in the case vignettes.

The family is a sacrosanct unit in the collectivistic Indian culture, and individual goals are subordinated to collective goals of maintaining family integrity, honor, and prestige. It is easy for professionals to be divided into their loyalties to the family over the queer individual as collectivistic values drive Indian cultural imagination, from which the professionals themselves are not free. At its worst, it can lead to polarization of interests and professional vindictiveness toward the queer person, as can be seen in the presented instances. However, it falls on the professional to foster the acceptance of the family toward the queer person, work on interpersonal barriers, and promote collective well-being. It is also necessary to look at and address the familial rejection within the broader social context of social, cultural, and religious influences and the author(s) reiterate the need for multicultural educational resources for families to understand best ways of supporting their LGBT members within unique value-embedded contexts.33

Imagining Alternative Mental Health Ecosystems

It is important to question power asymmetries in clinical relationships that enables and validates conversion attempts as “expert-led.” Peer support-driven34 practices, where mental health support is provided by persons with similar life experiences may be useful in imagining alternative mental health ecosystems that challenge the power hierarchy between clients and professionals and offer queer-affirmative possibilities of support. It might also be useful to compile resources for affirmative therapists and health care practitioners with feedback and review mechanisms to facilitate the process of affirmative care. In this context, the American Psychological Association recommends the dissemination and development of gender-affirmative multicultural educational resources to inform mental health professionals, the community-at-large, and educational and mental health institutions about the harms associated with efforts to change gender identity.27

Specific anticonversion legislations may be a welcome change in the Indian state that would make it easy for LGBTQIA+ citizens to safeguard themselves and take the violence to the court. It is necessary for these laws to cover not just licensed health care professionals but also unregistered medical quacks, faith-healers, and other institutional agents who may be involved in such practices.

Limitations of the Current Study

This study can be replicated with a larger sample size to facilitate the content analysis of conversion therapy experiences/narratives and archive evidence for the same. Moreover, this study did not incorporate female-assigned-at-birth perspectives, where there could be unique social pressures on the basis of assigned sex, gendered socialization, and patriarchal value systems. The perspectives of conversion experiences on the ground of religious values may also be taken up for exploration and the role of faith-healers can be studied in that context.

Conclusion

The author(s) sampled two cases of conversion efforts in the Indian context faced by self-identified transgender individuals. The study is at best a pilot venture and far from conclusive. The author(s) does not intend to extrapolate the findings of the study beyond case-specific deliberations. This study provides an insight into the more benign elements of conversion talk that often get downplayed to more extreme forms of conversion attempts such as aversion therapies, detention or imprisonment, being forced to practice celibacy, exorcism, and the likes. The author(s) remains thankful that the participants were not subjected to the latter.

Since clinical interactions are not divorced from social context, it is necessary to look at them from a context-informed lens. Given the pervasive stigma and marginalization of gender and sexual minorities in the Indian context, specific academic/professional training for health care providers, raising community-awareness, encouraging peer-support-based practices, intervening affirmatively with families, and working toward legal safeguards may be some of the routes to imagine more affirmative ecosystems of care.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Aritra Chatterjee https://orcid.org/0000-0002-4336-3309
References

1. World Health Organization. Defining Sexual Health: Report of a Technical Consultation on Sexual Health, 28-31 January 2002, Geneva. WHO Press; 2006.

2. Alempijevic D, Beriashvili R, Beynon J, et al. Statement on conversion therapy. J Forensic Leg Med. 2020;72:101930.

3. Murphy TF. Redirecting sexual orientation: techniques and justifications. J Sex Res. 1992;29(4):501–523.

4. National Center for Lesbian Rights and Human Rights Campaign Foundation. Just as they are: protecting our children from the harms of conversion therapy. 2017, September. https://www.nclrights.org/wp-content/uploads/2017/09/just-as-they-are-sept2017-1.pdf. Accessed April 23, 2021.

5. Peters S. Mental health, child welfare & education orgs back legislative efforts to protect LGBTQ youth. Human Rights Campaign. 2018, April 17. https://www.hrc.org/press-releases/national-child-welfare-orgs-back-legislative-efforts-to-protect-lgbtq-youth. Accessed April 19, 2021.

6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. American Psychiatric Press; 2013.

7. Cangany W. Extending hoosier hospitality to LGBTQ youth: why Indiana should pass a conversion therapy ban to protect and promote mental health outcomes for LGBTQ youth. Indiana Health Law Rev. 2021;18(1):155-187.

8. George MA. Expressive ends: Understanding conversion therapy bans. Ala Law Rev. 2016;68(3):793-853.

9. Paletta D. “Conversion therapy”: ILGA world releases extensive global research into laws banning the discredited practice. ILGA World. 2020, February 26. https://ilga.org/Conversion-therapy-global-research-ILGA-World. Accessed June 4, 2021.

10. Lavietes M. Factbox: Germany bans “gay conversion therapy” for minors as more nations eye laws. Reuters. 2020, May 9. https://www.reuters.com/article/us-usa-conversion-therapy-german-ban-fac-idUSKBN22K2OT. Accessed June 5, 2021.

11. American Medical Association. LGBTQ change efforts (so-called “conversion therapy”). American Medical Association. 2019, December. https://www.ama-assn.org/system/files/2019-12/conversion-therapy-issue-brief.pdf. Accessed April 24, 2019.

12. Gajanan M. “I was a religious zealot that hurt people.” After coming out as gay, a former conversion therapy leader is apologizing to the LGBTQ community. Time. 2019, September 14. https://time.com/5668351/mckrae-game-comes-out-gay-conversion/. Accessed April 25, 2019.

13. Fitzsimons T. “Doesn’t surprise me”: Conversion therapy survivors on another ex-therapist coming out. NBC News: Out Community Voice. 2019, September 4. https://www.nbcnews.com/feature/nbc-out/doesnt-surprise-me-conversion-therapy-survivors-another-ex-therapist-n1049781. Accessed April 27, 2021.

14. Spitzer RL. Spitzer reassesses his 2003 study of reparative therapy of homosexuality. Arch Sex Behav. 2012;41(4):757–757.

15. Price R. Medical imagination: homosexuality in the Indian Journal of Psychiatry, 1970-1980. En-Gender! 2020;3(2):1–15.

16. Pradhan PV, Ayyar KS, and Bagadia VN. Male homosexuality: a psychiatric study of thirteen cases. Indian J Psychiatry. 1982;24(2):182–186.

17. Kalra G. Pathologising alternate sexuality: shifting psychiatric practices and a need for ethical norms and reforms. Indian J Med Ethics. 2012;9(4):291–292.

18. Kappal B. The pain and cruelty of ‘conversion therapy’. Mint. 2020, June 4. https://www.livemint.com/mint-lounge/features/the-pain-and-cruelty-of-conversion-therapy-11591975439448.html. Accessed April 23, 2021.

19. Jeet. Several Indian mental health associations oppose ‘gay conversion therapy’. Youth Ki Awaaz. 2020, May 22. https://www.youthkiawaaz.com/2020/05/several-indian-mental-health-associations-oppose-gay-conversion-therapy/. Accessed April 24, 2021.

20. Moulee. How ‘influencers’ who claim to be LGBTQI+ allies harm people with unscientific claims. The News Minute: Voices. 2019, March 1. https://www.thenewsmint.com/article/how-influencers-who-claim-be-lgbtqi-allies-harm-people-unscientific-claims-97571. Accessed April 24, 2021.

21. Pratap A. Why we need a law against ‘conversion therapy’ in India. Deccan Herald. 2020, June 16. https://www.deccanherald.com/opinion/why-we-need-a-law-against-conversion-therapy-in-india-850084.html. Accessed April 24, 2021.

22. American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. Am Psychol. 2015;70(9):832-864.

23. Evans SC, Roberts MC, Keeley JW et al. Vignette methodologies for studying clinicians’ decision-making: validity, utility, and application in ICD-11 field studies. Int J Clin Health Psychol. 2013;15(2):160–170.

24. Kathiresan J and Patro BK. Case vignette: A promising complement to clinical case presentations in teaching. Educ Health (Abingdon, England) 2013;26(1):21–24.

25. Huber J, Caine V, Huber M, and Steeves P. Narrative inquiry as pedagogy in education: The extraordinary potential of living, telling, retelling, and reliving stories of experience. Rev Res Educ. 2013;37(1):212–242.

26. Turban JL, Beckwith N, Reisner SL, and Keuroghlian AS. Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. JAMA Psychiatry. 2020;77(1):68–76.

27. American Psychological Association. APA resolution on gender identity change efforts. 2021, February. https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf. Accessed June 7, 2021.
28. Drescher J and Pula J. Ethical issues raised by the treatment of gender-variant prepubescent children. *Hastings Cent Rep*. 2014;4(44):S17–S22.

29. Higbee M, Wright ER, and Roemeran RM. Conversion therapy in the Southern United States: Prevalence and experiences of the survivors. *J Homosex*. 2020;1–20. https://doi.org/10.1080/00918369.2020.1840213

30. Rock M, Carlson TS, and McGeorge CR. Does affirmative training matter? Assessing CFT students’ beliefs about sexual orientation and their level of affirmative training. *J Marital Fam Ther*. 2010;36(2):171–184.

31. Ryan C, Toomey RB, Diaz RM, and Russell ST. Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment. *J Homosex*. 2020;67(2):159–173.

32. Maslowe KE and Yarhouse MA. Christian parental reactions when a LGB child comes out. *Am J Fam Ther*. 2015;43(4):352–363.

33. Ryan C. *Helping families with lesbian, gay, bisexual, and transgender (LGBT) children*. Marian Wright Edelman Institute, Family Acceptance Project, San Francisco State University; 2009.

34. Team MHI. *Building capacities for peer support practice within the LGBTQIA+ community*. Mariwala Health Initiative. https://mhi.org.in/voice/details/peer-support-practice/. Accessed April 25, 2021.