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INTERSECTIONS 2.0

A deep dive into the FRA LGBTIQ III Survey results on Conversion Practices

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INTRODUCTION

Conversion practices, previously also called so-called "conversion therapies" are interventions which purport to change the sexual orientation or gender identity[1] of a person. These have regularly been described as harmful practices and they may amount to torture or cruel, inhuman, or degrading treatment.[2]

In its 2023 LGBTIQ III Survey, the European Agency for Fundamental Rights (FRA), which had over 100,000 LGBTIQ respondents from the 27 EU Member States plus Albania, North Macedonia, and Serbia, asked respondents about their exposure to conversion practices for the first time using 2 questions. The first question (C18[3]) asked if respondents had had any of a series of experiences that could amount to conversion practices, including intervention by family members; prayer, religious ritual or religious counselling; psychological or psychiatric treatment; medication; physical violence (such as beatings); sexual violence; or verbal abuse or humiliation. The second (C19[4]) asked if respondents had given consent freely, had given consent due to pressure or threats, or had not given consent. [5]

This briefing looks deeper into the responses to the two questions on conversion practices to assess the likelihood of these experiences for various groups and the correlations between experience of conversion practices and other kinds of marginalisation.

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[1] In the 2023 LGBTIQ III Survey, FRA refers to conversion practices based on sexual orientation and gender identity in the questions assessed for this report. Thus the definition used here reflects the relevant data.
[2] A/HRC/44/53, available from: https://documents.un.org/doc/undoc/gen/g20/108/68/pdf/g2010868.pdf
[3] See https://fra.europa.eu/sites/default/files/fra_uploads/fra-2025-eu-lgbtiq-survey-iii-questionnaire_en.pdf
[4] Ibid.
[5] Notably, the Council of Europe Commissioner for Human Rights, in a 2024 human rights comment, noted that consent is not possible:

> *"[T]he fact that they may have supposedly consented is a misnomer. SOGIE conversion practices falsely claim to be able to cure something which is not an illness. The persons who seek such practices are often also driven by prevalent anti-LGBTI prejudice and hatred in their community or family. These are factors which may affect individuals' ability to give free and fully informed consent."[5]*

However, as the survey asked this question, this report also includes analysis on the responses.

BACKGROUND & METHODOLOGY

The purpose of this analysis was to determine which personal characteristics (e.g. sexual orientation and gender identity, as well as other characteristics such as age, sex characteristics, and other minority status) correlate with increased exposure to and consenting to conversion practices based on SOGI, as well as with respect to being open about being LGBTI and exposure to violence.

To understand the respective prevalence, a Reference Profile was created based on two factors: the respondent type with the lowest exposure to conversion practices, relatively, and respondent type with the largest number of responses. These two factors led to a Reference Profile which is a cisgender endosex[6] lesbian aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who is able to make ends meet easily. This Reference Profile allows for establishment of respective prevalence of various experiences among the respondent population – in most cases, the Reference Profile is more likely to have those experiences, and in a few cases, less. The Reference Profile was then used to develop odds ratios to others.

For example, if 5% of Group 1, the Reference Profile, (all cisgender endosex lesbians aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who are able to make ends meet easily) experienced conversion practices, the odds ratio tells us how much more or less likely persons in Group 2 (all **trans** endosex lesbians aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who are able to make ends meet easily) were to have experienced conversion practices. Thus, if the odds ratio is 120% (compared to Group 1), one can extrapolate that 11% of Group 2 persons (5% + (120% x 5%) = 5% + 6% = 11%) have experienced conversion practices.

[6] "Endosex" refers to persons who do not have variations of sex characteristics that differ from the male or female norms; in other words, to a person who is not intersex.

EXPOSURE TO CONVERSION PRACTICES

The FRA LGBTIQ III Survey used one question to establish if respondents had been exposed to conversion practices as well as to disaggregate what kinds of practices they had experienced. Question C18 [7] reads:

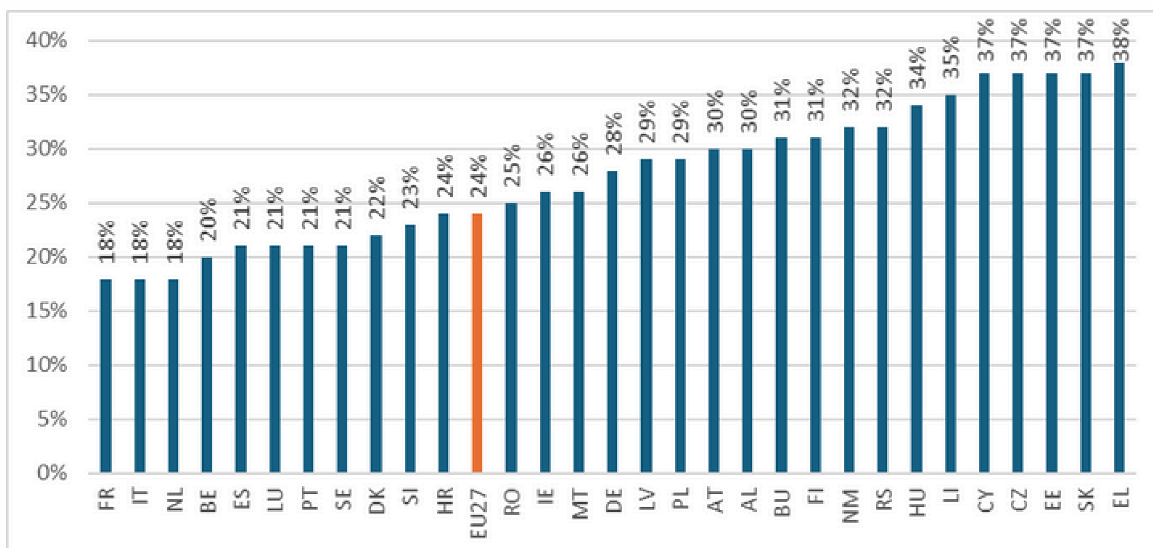
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING INTERVENTIONS TO CHANGE YOUR SEXUAL ORIENTATION AND/OR GENDER IDENTITY? SELECT ALL THAT APPLY

- Intervention by family members
- Prayer, religious ritual or religious counselling
- Psychological or psychiatric treatment
- Medication
- Physical violence (such as beatings)
- Sexual violence
- Verbal abuse or humiliation
- Other
- None of the above
- Prefer not to say
- Don’t know

Using this question, it is possible to assess the overall prevalence of exposure to conversion practices based on those who selected “None of the above” and to look more closely at the various types of conversion practices among those with these experiences.

Firstly, on overall exposure, there are large difference between EU member States as well as Albania, North Macedonia, and Serbia, as Figure 1 shows.

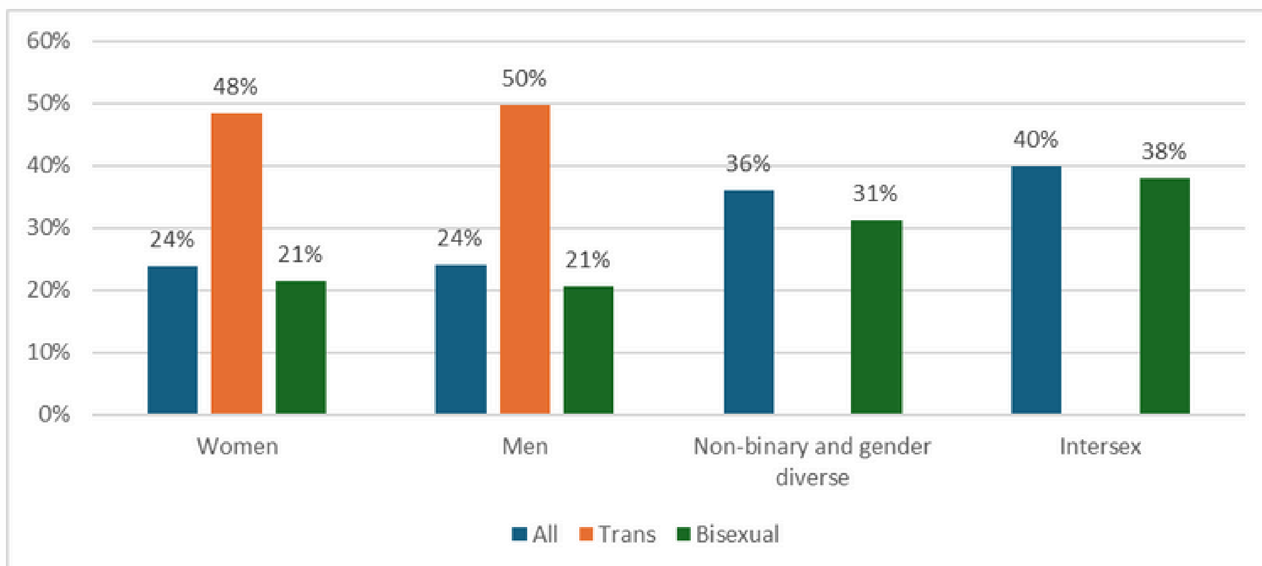
FIGURE 1 PREVALENCE OF CONVERSION PRACTICES BY STATE, INCLUDING 27 EU MEMBER STATES, EU27, ALBANIA, NORTH MACEDONIA, AND SERBIA



[7] Available from: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2025-eu-lgbtiq-survey-iii-questionnaire_en.pdf

Figure 2 displays the percentage of various respondent groups that have been exposed to **any kind** of conversion practice in their lifetimes, revealing that trans, non-binary, and intersex respondents experienced greater exposure than cis endosex respondents.

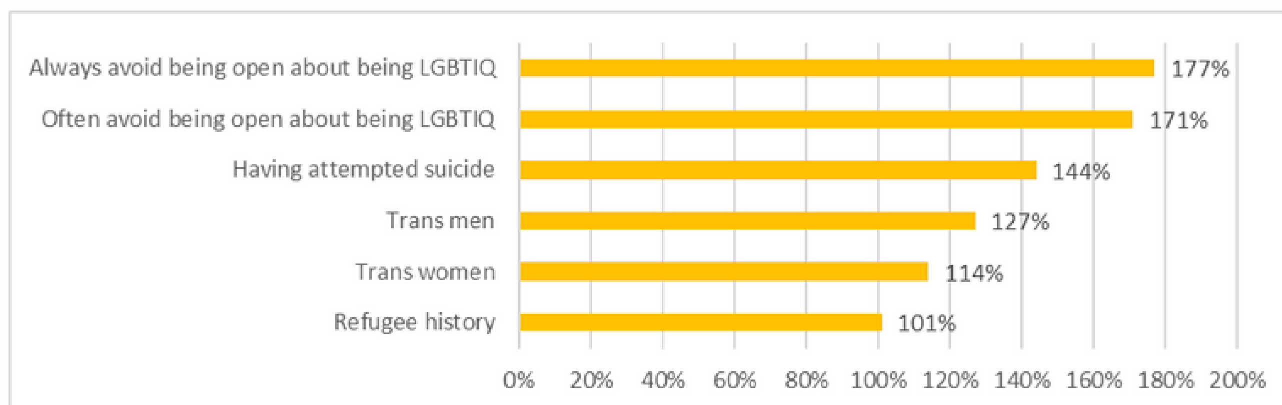
FIGURE 2 EXPOSURE TO CONVERSION PRACTICES (CI8)



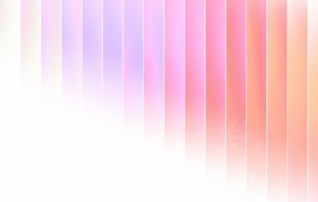
As Figure 2 indicates, trans, non-binary, and intersex respondents experienced greater exposure than cis endosex respondents.

Odds ratio analysis [8] further looked into how various identity and experience components impact exposure to conversion practices. The experience factors that had the greatest increase in correlation with exposure were being trans women (+114%), being trans men (+127%), often (+171%) or always (+177%) avoiding being open about being LGBTIQ, having attempted suicide (+144%), and being or having been a refugee (+101%). In all of these cases, respondents with these characteristics had more than double the odd of having experienced conversion practices with respect to the Reference Profile, with strong statistical significance.

FIGURE 3 ODDS RATIOS FOR THOSE WITH STATISTICALLY SIGNIFICANTLY HIGHER ODDS OF HAVING EXPERIENCED CONVERSION PRACTICES THAN THE REFERENCE PROFILE (CI8)



[8] The Reference Profile is a cisgender endosex lesbian aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who is able to make ends meet easily.



Several other factors also had smaller but statistically significant impacts on the odds ratio, which are listed in Table 1; notably age at the time of the survey and whether or not a respondent had a variation of sex characteristics did not have significant impacts on the odds ratios.

TABLE 1 STATISTICALLY SIGNIFICANT FACTORS† CORRELATED WITH EXPOSURE TO CONVERSION PRACTICES (C18)

	Odds ratio (%)#	Significance‡
Trans women	114%	***
Trans men	127%	***
Non-binary	34%	***
Bisexual	-26%	***
Others	-13%	***
Intersex	22%	*
Avoidance: Rarely	76%	***
Avoidance: Often	171%	***
Avoidance: Always	177%	***
Suicidality: Ideation only	45%	***
Suicidality: Attempt	118%	***
Lower education	13%	***
Minority status: ethnicity	69%	***
Minority status: refugee	101%	***
Minority status: religious	74%	***
Minority status: disability	29%	***
Health status: Good	6%	*
Health status: Fair	24%	***
Health status: Bad	38%	***
Health status: Very bad	28%	*
Socioeconomic status: With great difficulty	72%	***
Socioeconomic status: With difficulty	58%	***
Socioeconomic status: With some difficulty	40%	***
Socioeconomic status: Fairly easily	24%	***
Socioeconomic status: Easily	10%	**

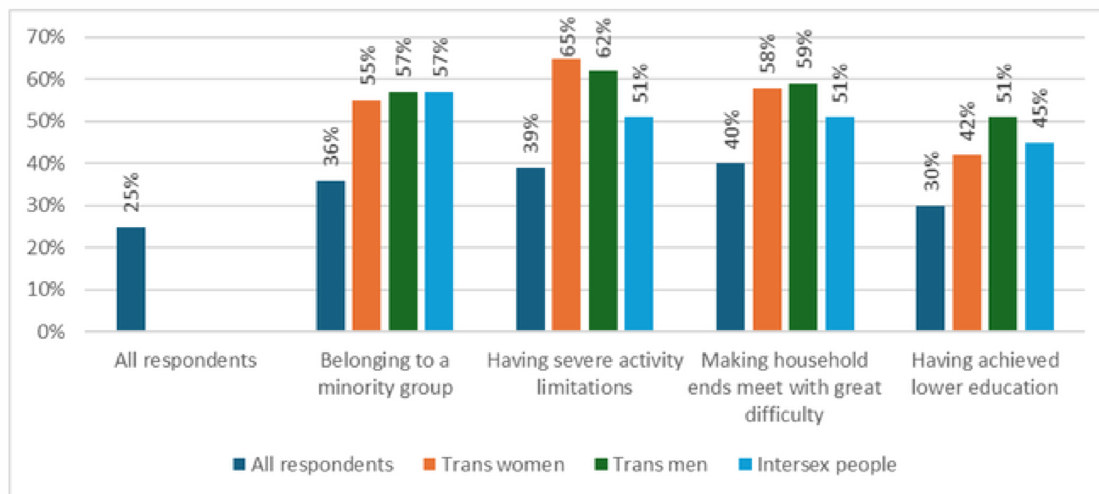
 # Positive odds ratios indicate an increased likelihood of exposure; negative indicate a decreased likelihood of exposure.
‡ Significance level indicated by stars; more stars showed higher significance. The table includes only those factors with at least limited statistical significance.
† Note: Table 1 includes the data included in Figure 3.

As Table 1 makes clear, many personal factors impact exposure to conversion practices. Further, people with intersectionally marginalised experiences appear more at risk of experiencing conversion practices in ways linked to that intersectional experience.

KINDS OF CONVERSION PRACTICES EXPERIENCED

Respondents were also asked about whether they were marginalised in society in any way other than being LGBTIQ; Figure 4, based on excerpts from the Data Explorer, shows how these additional marginalisations impact exposure to conversion practices for select groups.

FIGURE 4 EXPOSURE TO CONVERSION PRACTICES FOR THOSE WITH INTERSECTIONAL MARGINALISATION (C18)



There is little impact of where respondents live currently (e.g. in a big city, a small town, a village, or the countryside); neither does the fact of whether people are unemployed or in work at the time of the survey does not have any impact, neither does their age at the time of the survey.

Figure 5 shows the impact of different kinds of conversion practices have on current choices and behaviors of people – respondents were asked if they avoid certain places, and this figure shows the total percentage of those who rarely, often, or always avoid certain places. This avoidance is notably higher for respondents who had been exposed to verbal abuse or humiliation, sexual violence, and physical violence, compared to other forms of conversion practices. These data make clear the need to access to support services for survivors of conversion practices.

FIGURE 5 RESPONDENTS WHO HAD EXPERIENCED CONVERSION PRACTICES WHO AVOIDED CERTAIN PLACES FOR FEAR OF BEING ASSAULTED, THREATENED, OR HARASSED BECAUSE OF BEING LGBTIQ (B4) – RARELY, OFTEN, OR ALWAYS RESPONSES

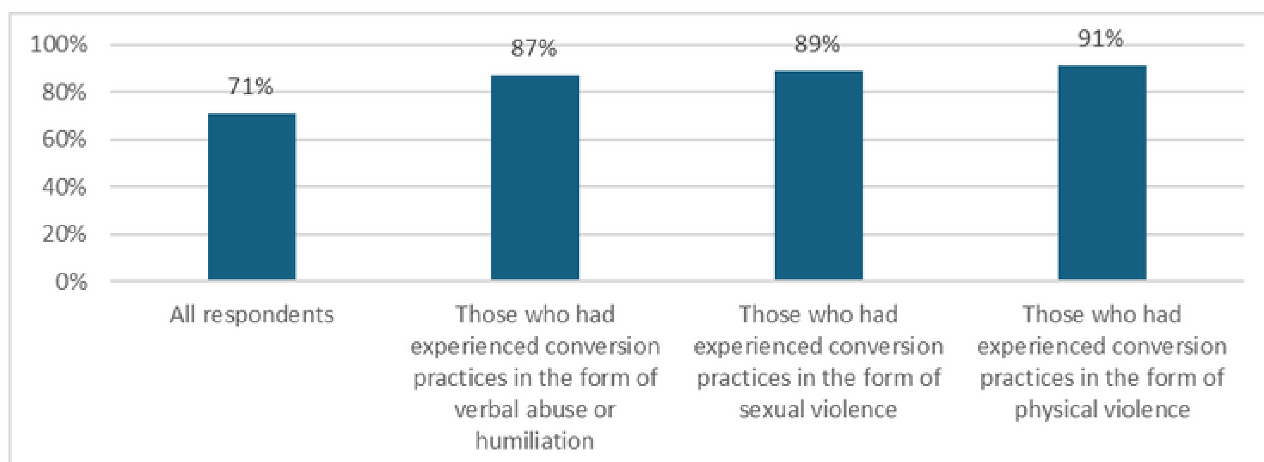
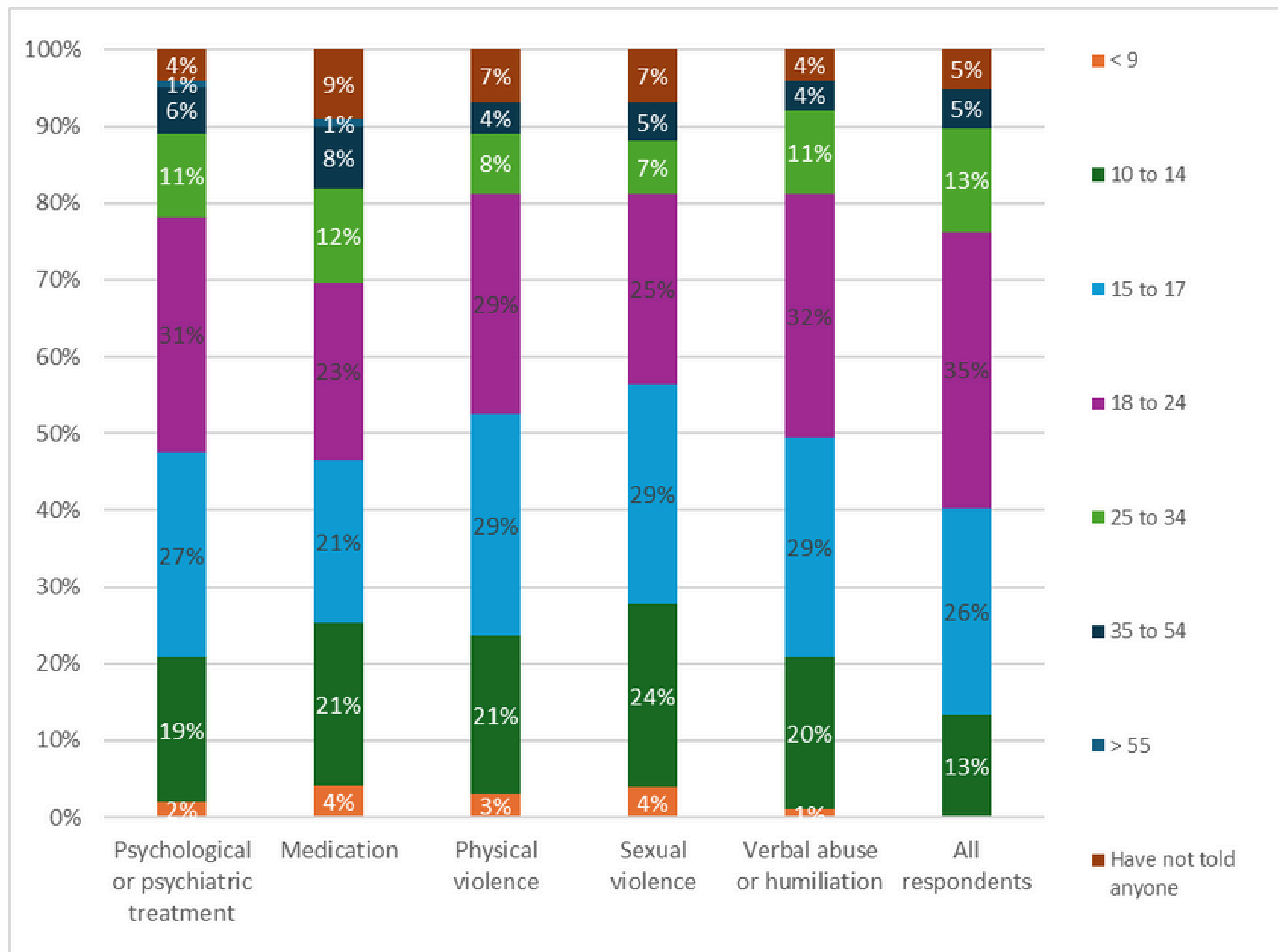


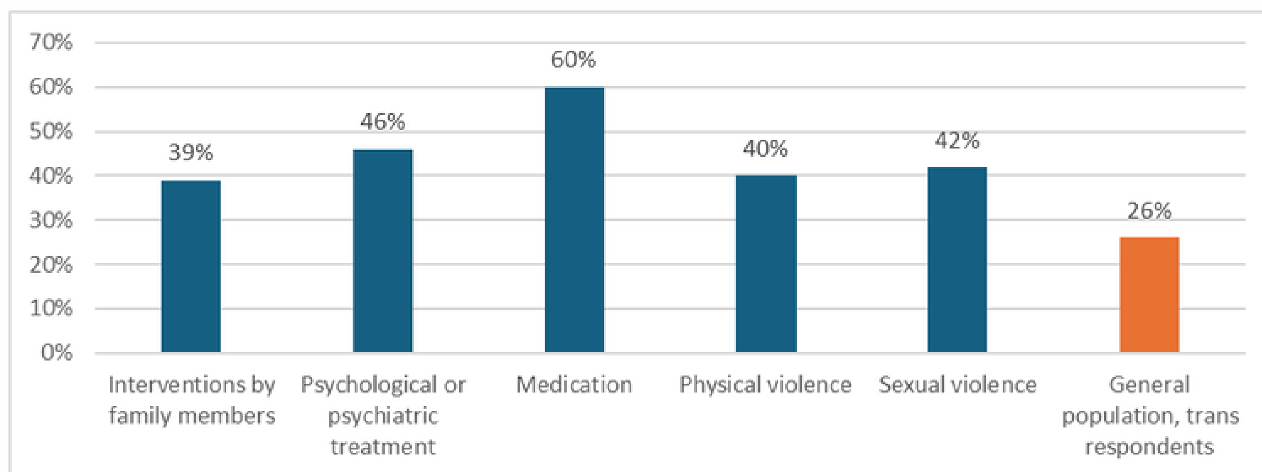
Figure 6 shows the relative prevalence of types of conversion practices based on when the respondent first told someone that they were LGBTIQ – the "All respondents" column shows the distribution of various ages for first telling someone. Notably, those who first told someone as children (17 or younger) are over represented among those who have been subjected to all of the types of conversion practices shown. Those who were young children when they told someone (9 years old or less), who make up less than 0.5% of the total respondents, are radically over-represented among those subjected to medication, physical violence, and sexual violence.

FIGURE 6 TYPES OF CONVERSION PRACTICES EXPERIENCED BASED ON THE AGE OF THE RESPONDENT WHEN THEY FIRST TOLD SOMEONE THAT THEY WERE LGBTIQ (BI)



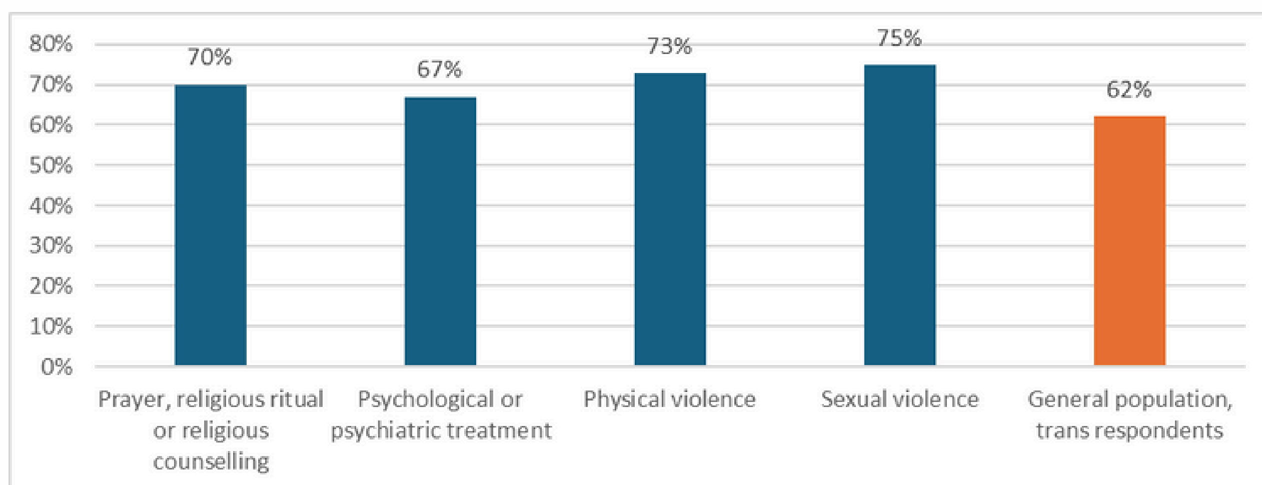
Specifically for trans respondents, the Survey asked if they had had interventions to change their bodies so they better match their gender identities (TR1) (otherwise known as trans-specific healthcare). As Figure 7 displays, when disaggregating kinds of conversion practices respondents experienced by these responses, the outcomes are stark – trans people exposed to any kind of conversion practice were more likely to have had interventions, with those exposed to medication as a form of conversion practices more than twice as likely to have received trans-specific healthcare.

FIGURE 7 TYPES OF CONVERSION PRACTICES EXPERIENCED BY TRANS RESPONDENTS WHO HAD RECEIVED TRANS-SPECIFIC HEALTHCARE (TRI)



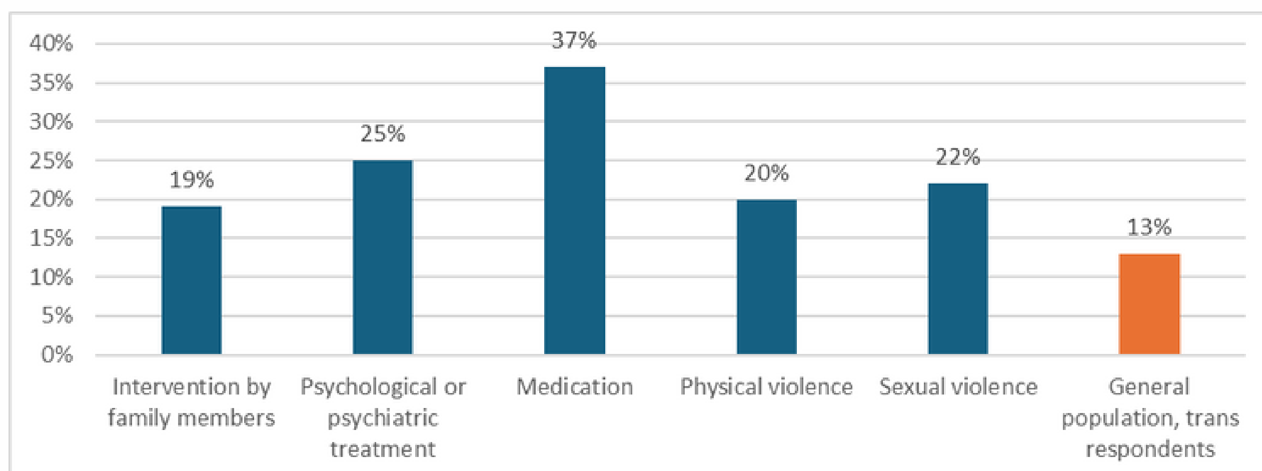
Trans respondents were also more likely to avoid expressing their gender through physical appearance (TR5) if they had experienced conversion practices, as Figure 8 shows.

FIGURE 8 TYPES OF CONVERSION PRACTICES EXPERIENCED BY TRANS RESPONDENTS WHO AVOID EXPRESSING THEIR GENDER IDENTITY THROUGH THEIR PHYSICAL APPEARANCE AND CLOTHING FOR FEAR OF BEING ASSAULTED, THREATENED, OR HARASSED (TR5)



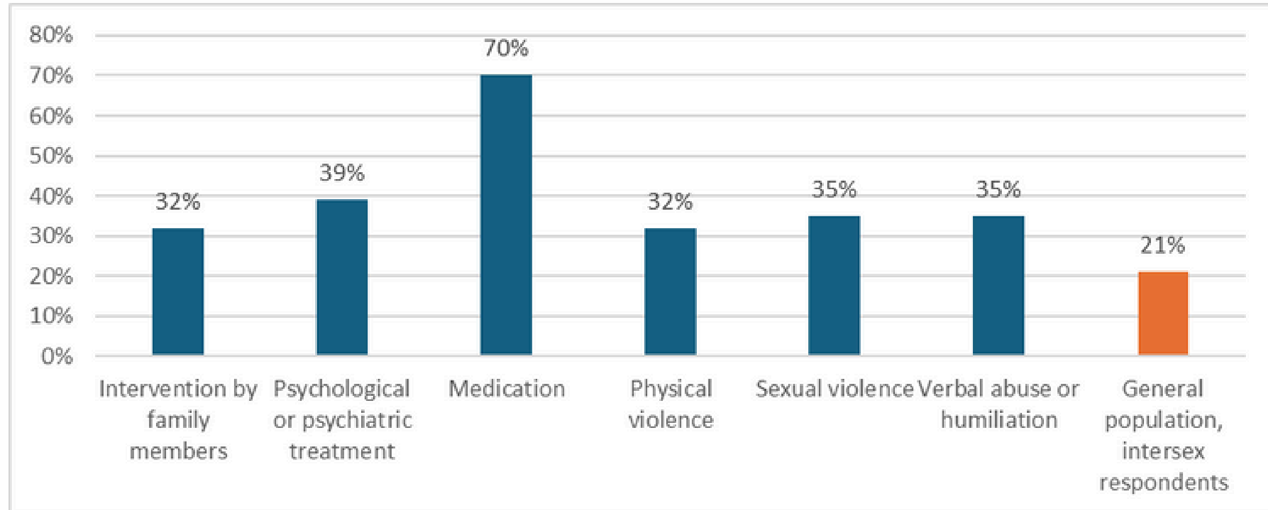
Additionally, trans respondents were more likely to have had their legal gender changed (TR6) if they had experienced conversion practices, as Figure 9 reveals. This association is strongest for those whose conversion practices were medicalised (medication, psychological or psychiatric treatment).

FIGURE 9 TYPES OF CONVERSION PRACTICES EXPERIENCED BY TRANS RESPONDENTS WHO HAVE HAD LEGAL GENDER RECOGNITION (TR6)



For intersex respondents to the survey, disaggregation is also interesting. Figure 10 shows how exposure to conversion practices relates to whether respondents had had any medical treatment or intervention to modify their sex characteristics.

FIGURE 10 TYPES OF CONVERSION PRACTICES EXPERIENCED BY INTERSEX RESPONDENTS WHO HAD EXPERIENCED INTERVENTIONS TO CHANGE THEIR SEX CHARACTERISTICS (IX1)



Further, Figure 11 and Figure 12 show how consent to medical interventions to modify sex characteristics (IX10) relates to exposure to conversion practices and who provided support to the intersex respondents (IX15), respectively. In Figure 11, it can be seen that intersex respondents who were exposed to conversion practices were also less likely than the general intersex population to have consented to medical interventions, and that those exposed to conversion practices in the form of medication were particularly low in their own participation in decisions about medical interventions (35% either gave consent themselves alone or with their parents, compared to 63% of the intersex general respondents).

FIGURE 11 INTERSEX RESPONDENTS' EXPOSURE TO VARIOUS KINDS OF CONVERSION PRACTICES, DISAGGREGATED BY THE TYPE OF CONSENT GIVEN TO MEDICAL INTERVENTIONS ON THEIR SEX CHARACTERISTICS (IX10)

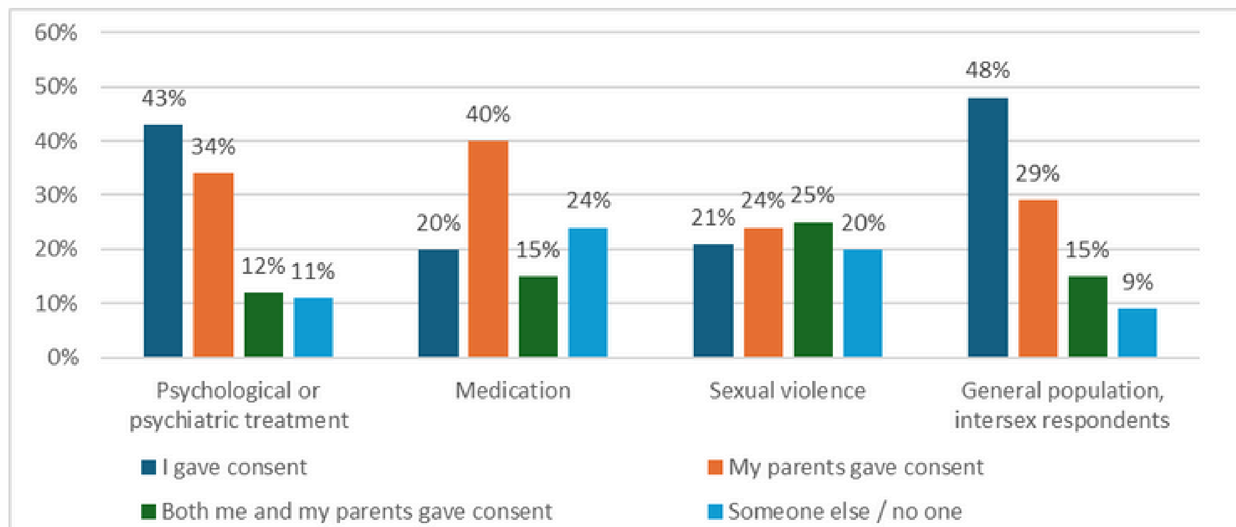
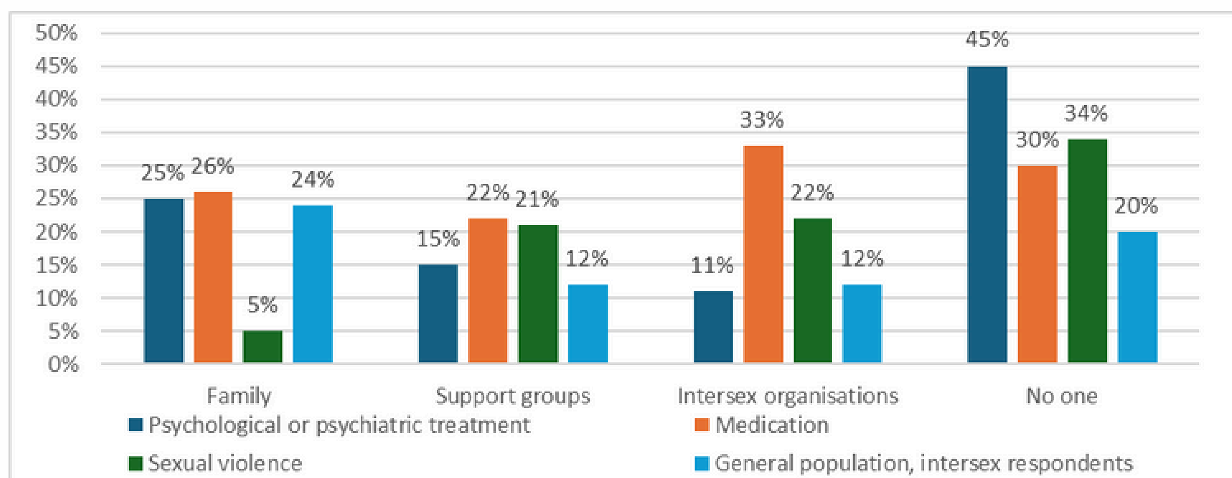


Figure 12 shows the serious impact on support-seeking and support-receiving among intersex respondents based on the kind of conversion practices to which they were exposed, if exposed at all. Indeed, while only 20% of intersex respondents received support from no one, this number is much higher for intersex respondents who experienced conversion practices in the form of medication, psychological or psychiatric treatments, or sexual violence. Shockingly, those intersex respondents who experienced sexual violence as a conversion practice received almost no support from family members, which may reveal the trust and safety implications of these practices.

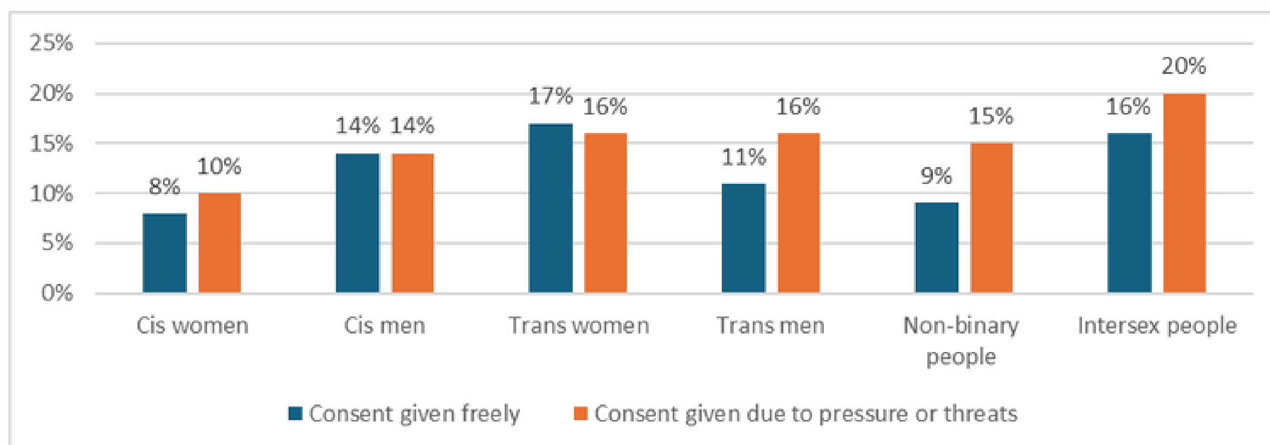
FIGURE 12 INTERSEX RESPONDENTS' EXPOSURE TO VARIOUS KINDS OF CONVERSION PRACTICES, DISAGGREGATED BY FROM WHOM THEY HAVE RECEIVED SUPPORT (IXI5)



GIVING "CONSENT" TO CONVERSION PRACTICES

The FRA LGBTIQ III Survey asked participants if they had provided consent to the conversion practices they experienced. [9] Among respondents who had experienced conversion practices, the Survey asked about their consent to those practices. Figure 13 describes the percentage of respondents who had experienced conversion practices who reported that they did provide consent.

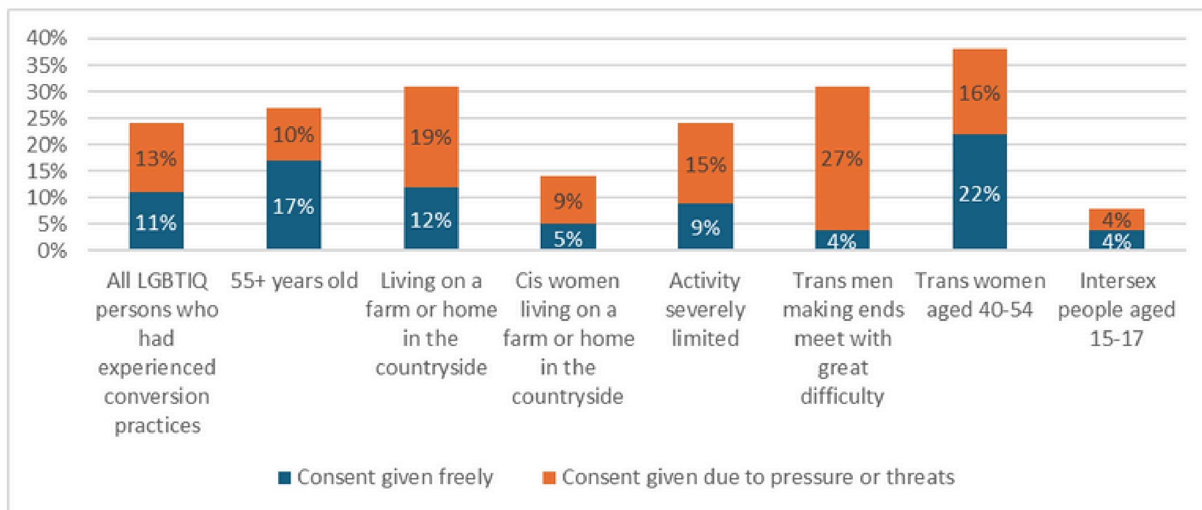
FIGURE 13 CONSENT TO CONVERSION PRACTICES



[9] As noted above, though the capacity of individuals to "consent" to conversion practices is challenged by human rights bodies, the survey used this formulation and it is reported here as such.

In Figure 14, which provides a selection of data from the Data Explorer, both high and low percentages of 'free' consent provide notable information about the respondents. The distributions both of what people state as total consent and of free versus pressured consent are interesting. For example, in the case of trans men with difficulty making ends meet, there is a very high representation of consent under pressure, where trans women aged 40-54 had a much higher percentage of free consent. These data may reveal a great deal about the social pressures that lead to consenting to conversion practices – for example that lower socioeconomic status for transmasculine people may correlate with increased financial pressure that can be used to leverage conversion practices, or that the social exclusion experienced by trans women may result in higher free consent to attempt to change their SOGI.

FIGURE 14 CONSENT TO CONVERSION PRACTICES FOR THOSE WITH INTERSECTIONAL MARGINALISATION (C19)



This analysis also created odds ratios for consent to conversion practices; Figure 15 and Table 2 show these data. It is particularly notable that trans women and cis men were much more likely to freely consent and consent under pressure than the Reference Profile, and this may stem from the societal pressure placed on individuals assigned male at birth to conform to gender norms for men and the resulting internalised homophobia or transphobia they experience.

FIGURE 15 ODDS RATIOS FOR THOSE WITH STATISTICALLY SIGNIFICANTLY HIGHER ODDS OF HAVING CONSENTED TO CONVERSION PRACTICES THAN THE REFERENCE PROFILE (C19)

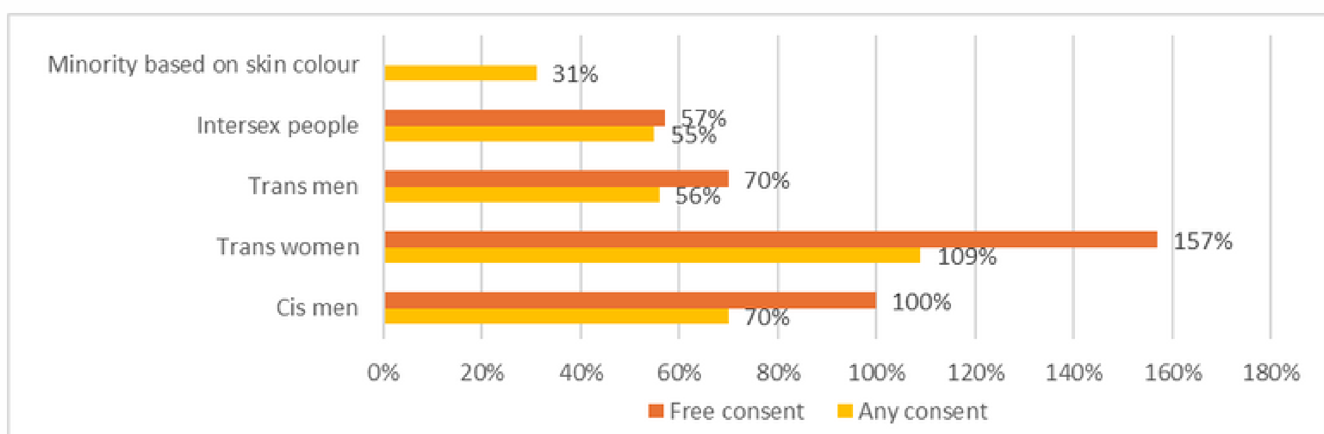


TABLE 2 STATISTICALLY SIGNIFICANT FACTORS† CORRELATED WITH CONSENT TO CONVERSION PRACTICES (CI9)

	Any consent		Free consent	
	Odds ratio (%)#	Significance‡	Odds ratio (%)#	Significance‡
Men cisgender	70%	***	100%	***
Trans women	109%	***	157%	***
Trans men	56%	***	70%	**
Non-binary	38%	***		
Intersex	55%	***	57%	*
Avoidance: Rarely	-29%	***	-40%	***
Avoidance: Often	-27%	***	-55%	***
Avoidance: Always	-24%	**	-59%	***
Suicidality: Attempt			-25%	**
Age group: 15-17			-32%	*
Age group: 18-24			-40%	***
Age group: 25-39			-41%	***
Minority status: Skin colour	31%	*		
Health status: Bad	-16%	**	-39%	*
Socioeconomic status: With some difficulty			-22%	*
Socioeconomic status: Fairly easily			-26%	**

 # Positive odds ratios indicate an increased likelihood of consent; negative indicate a decreased likelihood of consent.
‡ Significance level indicated by stars; more stars showed higher significance. The table includes only those factors with at least limited statistical significance.
† Note: Table 2 includes the data included in Figure 15.

Furthermore, there are significantly lower consent odds than the Reference Profile for those who avoid being open about being LGBTI at all (rarely, often, and always) and those with bad health statuses. This decreased likelihood of consent (both kinds) may mean that social pressures are lower for respondents in these situations because they are either not seen as LGBTI or not seen as sexual at all (for those with bad health status). Those who had attempted suicide or were anywhere from 15 to 39 at the time of the survey were also significantly less likely to have provided free consent along with those who make ends meet with some difficulty or fairly easily (along the middle of the scale of responses). For these respondents, decreased consent may thus mean that they did not have the social capital to reject conversion practices, even if they did not want them.

RECOMMENDATIONS

The data presented in this report make plain exposure to conversion practices and one's perception of whether consent was provided for those practices is very complex, with varying groups having different exposure to the practices as well as perceptions of their own agency. This is further complicated by intersectional marginalisation. As such, it is recommended that:

1. The European Commission, in its planned study on conversion practices in the EU, ensure that in-depth qualitative data are collected to build understanding on how victims come to experience conversion practices, their own agency in those experiences, and any factors leading to their providing "consent".

2. The EU and its member States fund awareness raising programmes for the general public as well as targeted sectors (e.g. mental health providers, religious bodies) on the harm caused by conversion practices.

3. States ensure that victim support services are prepared and equipped for victims of conversion practices and that victims have access to these services.

4. States conduct their own studies into the prevalence, causes, and consequences of conversion practices and do self-assessments of the availability of support services to victims.

5. Following the completing of the European Commission study on conversion practices in the EU, that the Commission prepare a Commission Recommendation on ending conversion practices across the EU using evidence-based policymaking to drive the contents of the Recommendation.

6. The EU Fundamental Rights Agency continue to collect large-scale data on conversion practices in future LGBTIQ surveys.

ILGA-Europe is the European and Central Asia Region of the International Lesbian, Gay, Bisexual, Trans & Intersex Association. ILGA-Europe is a membership-based organisation bringing together over 700 organisations from 54 European and Central Asian countries, making it an excellent platform for joint advocacy and movement development. As part of its mandate, ILGA-Europe both advocates for human rights and equality for LGBTI people in Europe and Central Asia and strengthens the LGBTI movement throughout its capacity building programme. www.ilga-europe.org

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