English Version

REPORT ON THE MENTAL HEALTH OF LGBT PEOPLE IN CHINA

Beijing LGBT Center
Institute of Psychology,
Chinese Academy of Sciences

Index

Part I: A Study of LGBT People's Mental Health Conditions

Part II: Conversion Therapy and the LGBT Community

Part I:
A Study of LGBT People's Mental Health Conditions

I. BACKGROUND

In China, the CCMD-3 (Chinese Classification of Mental Disorders 3, 2001) removed homosexuality from the diagnostic criteria of mental disorders. However, the existing perceptions by the Chinese public on homosexuality has not changed accordingly. A study of the public's attitude towards homosexuality in Wuhan area by Chen Shaojun et al. (2008) found that only 17.1% of the respondents considered homosexuality acceptable, and the vast majority of the respondents considered it absolutely unacceptable to have homosexual family members (Chen Shaojun, Dai Xinmin, Li Shunlai & Ji Hong, 2008).

As college students will be the mainstay of society, their attitudes will affect the level of social pressure on homosexual people in the future (Gong Qinghua, 2010). Thus many studies conducted in China have attempted to understand the public knowledge of and its attitudes towards homosexuality by surveying college students.

Comparatively speaking, despite the relatively tolerant attitudes of college students towards homosexuality, the proportion of students who find homosexuality unacceptable is also fairly large. For example, Liang Bin surveyed 1,762 college students in Chengdu about their knowledge of and attitude towards homosexuality. The results showed that 41.2% of the respondents considered that homosexuality did not comply with Chinese moral standards (Liang Bin & Kang Xudong, 2012), and the male students surveyed had even lower acceptance levels towards homosexuality (Fu Xiaolong et al., 2012). In another survey of 1,000 college students from eight colleges in Dalian about their knowledge of and attitude towards homosexuality, 38.5% of the male respondents and 53.4% of the female respondents considered homosexuality normal, but 60.4% of the male students and 46.7% of the female students considered it unacceptable to have homosexual children, family members or close friends (Fu Xiaolong, Su Ning, Mu Qi'er & Liu Anqi, 2012).

In 2012, Aibai Culture and Education Center conducted research on campus bullying related to sexual orientation and gender identity (SOGI) among high school students and college students in Guangzhou area. The results showed that about 44% of the respondents had suffered from verbal attacks, such as nicknames, derision and vicious jokes from schoolmates and even from teachers. Another report issued by Aibai on the Employment Environment for Chinese LGBT Employees (2013) showed that 60.9% of the respondents who had not come out worried that they would be alienated because of their sexual orientation; 51.71% of the respondents worried that their sexual orientation would affect their career development and 22.49% worried that they would be terminated from their jobs.

Based on the results of numerous studies about the public attitude towards homosexuality published in China in the last 10 years, as well as on the perception of social pressure by the LGBT people themselves, we have concluded that the public's acceptance of homosexuality is still relatively low, and that there is a difference in the acceptance level depending on the "distance" of the relationships: it is much easier for people to accept other people whom they do not know than to accept friends and family mem-

bers. The constant social pressure has caused harm to LGBT people's mental health (Cochran, Sullivan & Mays, 2003; Mays & Cochran, 2001; Meyer, 2003; Liu Huaqing, 1998).

A sense of self-efficacy refers to the general confidence level of people when they meet challenges in various environments or face new things, as well as the overall evaluation. Bandura puts self-efficacy at the center of all the changes in psychotherapy, saying that it is a feeling of powerlessness experienced in a stressful situation, rather than the stressful situation itself, that produces harmful physiological effects (Bandura, 1977; Chen Xiuli & Feng Wei, 2003). Individuals with a strong sense of self-efficacy believe that they can effectively control the potential threats from the environment, while those with low self-efficacy often experience strong stress reaction and anxiety, and resort to passive retreat or defensive behaviors (Tsang & Hui, 2006). Low self-efficacy may lead to depression, a sense of pressure and frustration, while high self-efficacy helps one meet various events in life with positive cognitive and behavioral patterns such as optimism, actively seeking help and solving problems, and therefore produces a sense of well-being and higher satisfaction with one's life (Ireland & Arthur, 2006; Tsang & Hui, 2006; Zhang Yan & Chen Fuguo, 2007). Considering the attitudes that college students have towards LGBT people, it is difficult to fundamentally improve the public's attitudes towards LGBT people in the short term, a situation made even worse by the fact that LGBT people have been living with the social pressure and bias. Therefore, it is particularly important for LGBT people to have high self-efficacy and to receive psychological support.

Based on the reasons above, this study has three main purposes: (1) To assess the depression level of LGBT people and reveal their mental health conditions and risks; (2) To assess the overall level of self-efficacy of LGBT people in order to understand their overall confidence level, as well as differences among sub-groups; (3) To understand the need of LGBT mental health services and to provide a reference to such services.

II. METHODOLOGY

(1) Sampling Methods

Considering the intrinsic complexity of homosexuality, the diversified social attitudes towards homosexuality and matter of privacy (Liu Huaqing et al., 2000), in order to improve the study's efficiency and reliability, we cooperated with a number of LGBT NGOs, which helped promote this study and recruited respondents on Weibo, Douban.com, their official webpages, WeChat, feizan.com, QQ groups and at various community events. We used anonymous, self-administered questionnaires to conduct the survey.

(2) Characteristics of Samples

This study collected 1,745 competed questionnaires, and 57 of them were trial questionnaires collected from an event held by the Beijing LGBT Center and 1,688 from online sources. Only the online survey's results were used. Among the 1,688 online questionnaires, 35 were from heterosexual people, 1,291 from homosexual people, 248 from bisexual people and 114 from those who were undecided about their sexual orientation. Due to the LGBT focus of this study, we excluded the 35 questionnaires from the heterosexual people, leaving final a sample size of 1,635. The following data is based on the analysis of these samples.

1. Gender

Among the 1,653 final samples, 958 were male, 675 female, and 20 intersex (Fig.1).

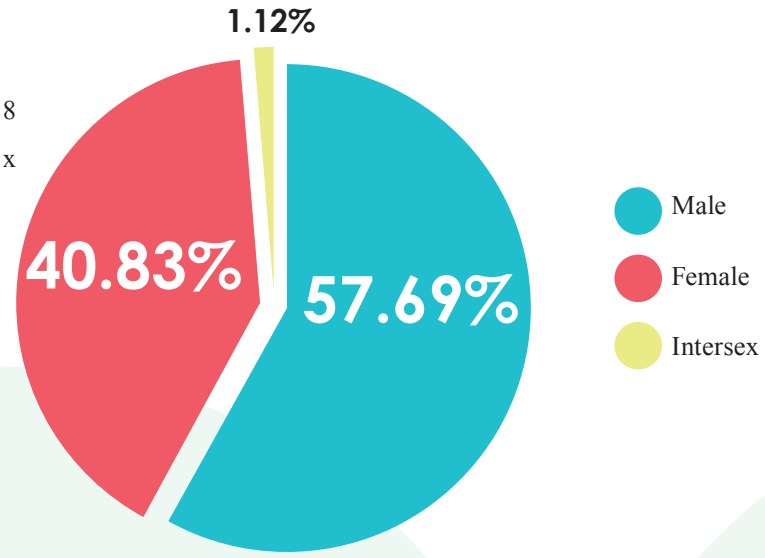

Fig.1 The respondents' sex distribution.

2. Age

1,625 people in this study reported their ages. The youngest respondent is 14 years old while the oldest 48. The average age is 23.64±4.67 years. 134 respondents are 18 years old or younger (8.25%), and 1491 respondents are 19 years old or older (90.20%). See Fig.2 for the respondents' age distribution:

Dividing the group with a cut-off point of 18 years old, the age distribution with gender information is shown in Table 1:

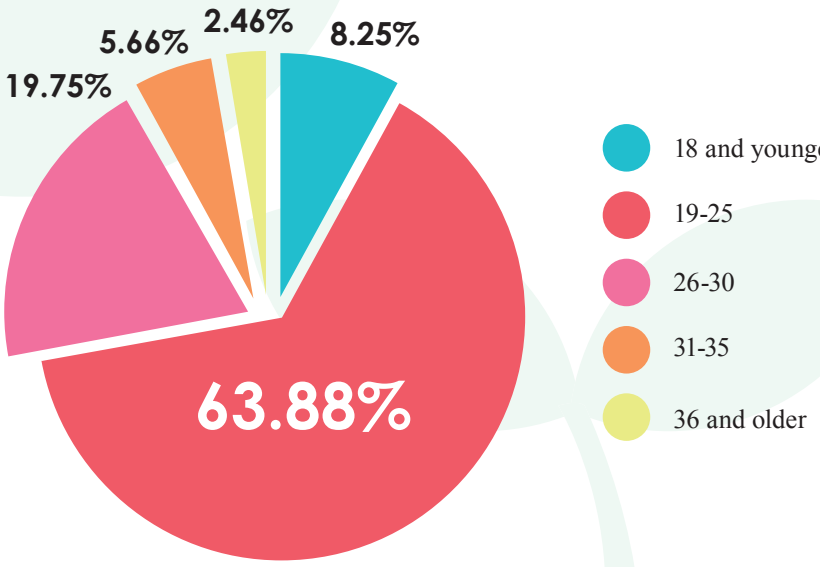

Fig.2 The respondents' age distribution

Table 1: The gender/age distribution

	Male	Female
18 years or younger	70	62
Adult	869	604
Unfilled	19	9

3. Education Background

Among 1,626 respondents who responded to the question of the highest degree earned, 320 have degrees below junior college; 445 with a junior college degree; 752 with a college degree and 109 with a MA degree or above. See Fig.3 for the respondents' academic degree distribution:

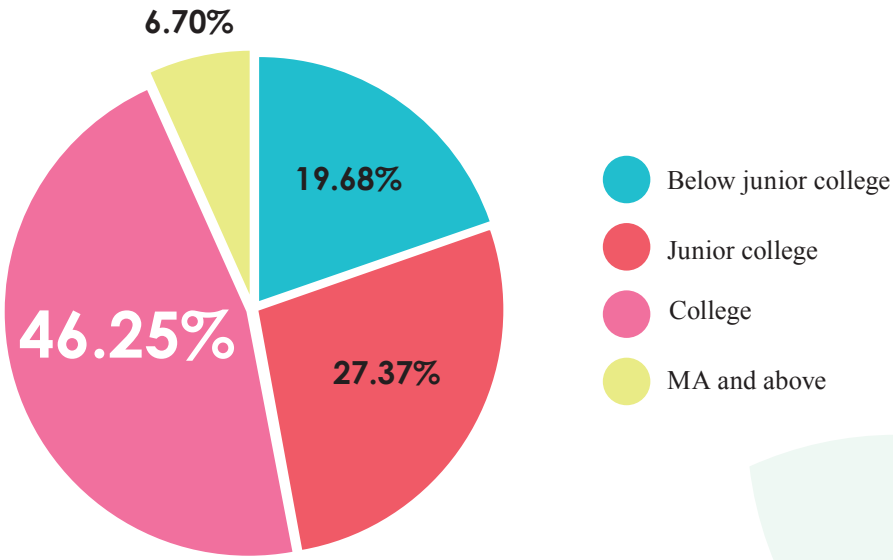

Fig.3 The respondents' academic degree distribution.

Table 2 The academic degree distribution by gender

	Male	Female
Below junior college	170	145
Junior college	274	167
College	424	319
MA and above	76	33

4. Employment Status

760 respondents were students at the time of the survey; 771 were employed and 122 unemployed. See Fig.4 for the respondents' employment status distribution, and Fig.5 for the distribution by gender.

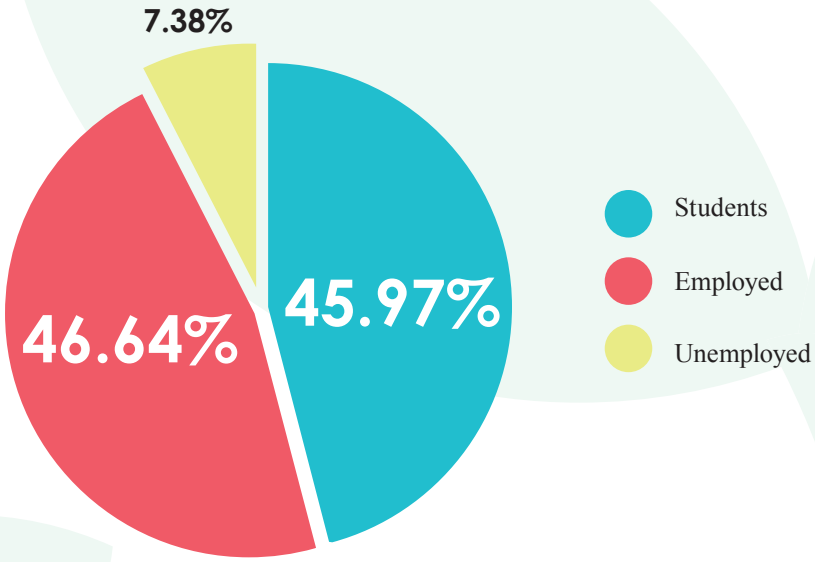

Fig.4 The respondents' employment status distribution

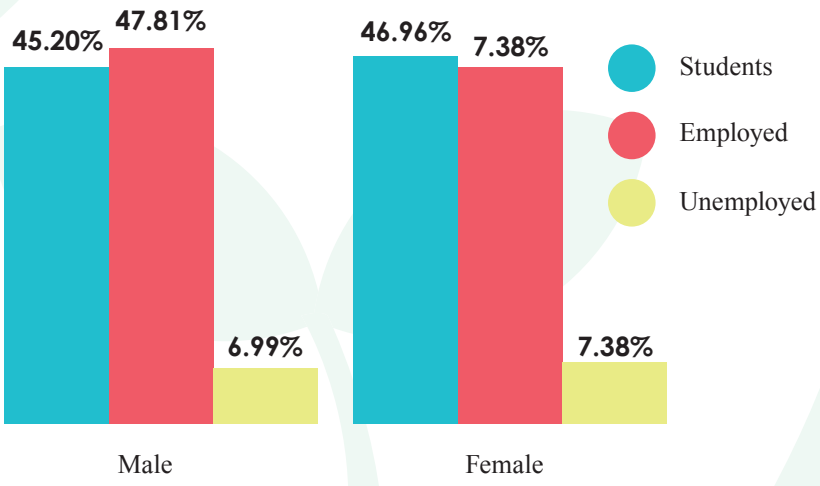

Fig.5 employment distribution by gender

5. Marriage status

1,597 respondents were unmarried (96.61%), 37 were married(2.24%), with 27 men and 10 women. 18 respondents were divorced(1.09%), with 11 men and 7 women. One female respondent was widowed(0.06%).

6. Regional distribution

This study covered 26 provinces, 4 municipalities, Hong Kong and Macau Special Administrative Regions in China. In addition, 19 respondents were from overseas (Fig.6; Table 3).

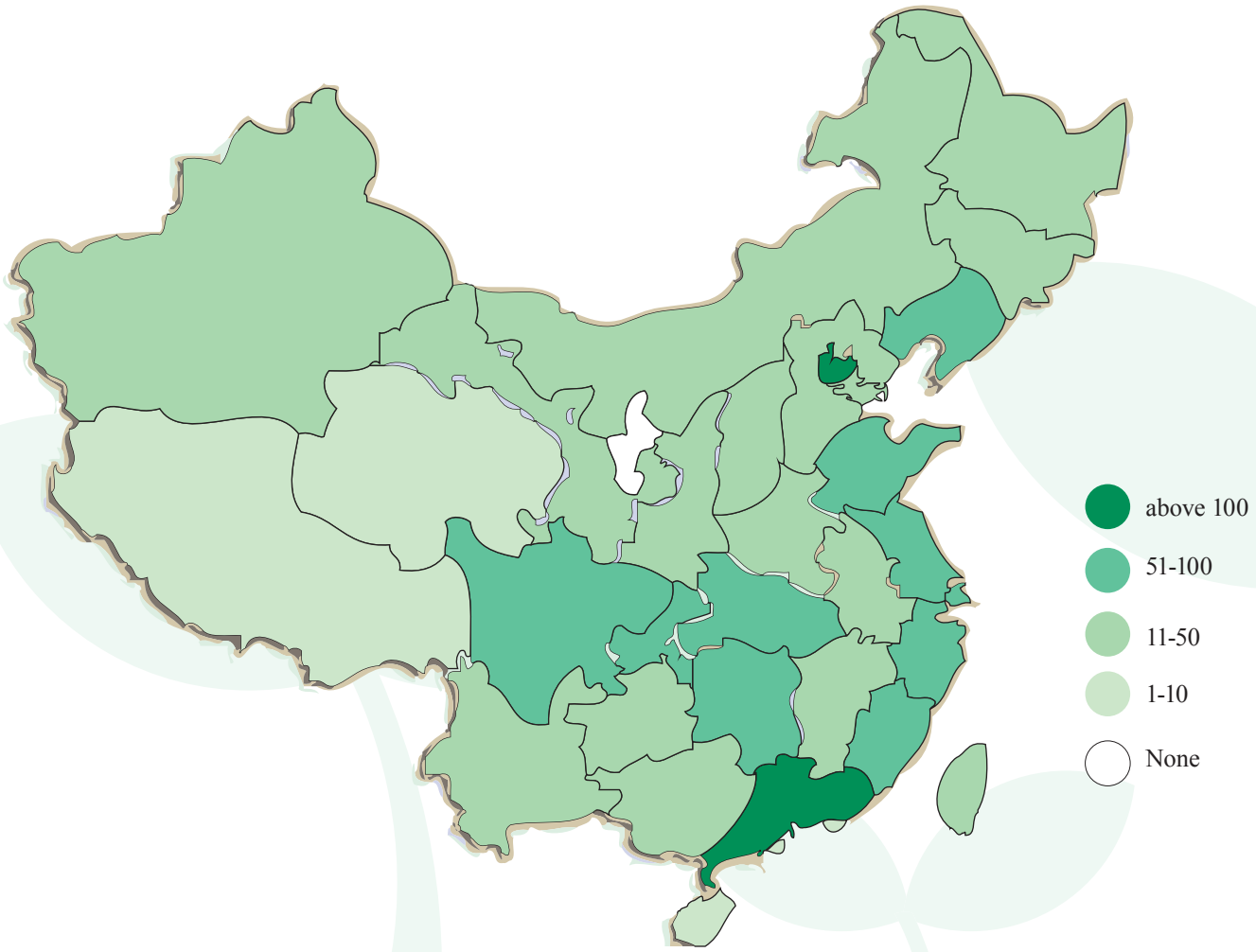

Fig.6 Region and respective number of people distribution

Table 3 The regional/individuals' distribution.

	Numbers	Percent (%)
Two residences	26	1.57
Anhui	31	1.88
Macau	5	0.30
Beijing	282	17.06
Fujian	57	3.45
Gansu	16	0.97
Guangdong	167	10.10
Guangxi Zhuang Autonomous Region	39	2.36
Guizhou	22	1.33
Hai'nan	8	0.48
Hebei	46	2.78
He'nan	48	2.90
Heilongjiang	25	1.51
Hubei	52	3.15
Hu'nan	53	3.21
Jilin	24	1.45
Jiangsu	82	4.96
Jiangxi	25	1.51
Liaoning	59	3.57
Inner Mongolia Autonomous Region	26	1.57
Other countries	19	1.15
Qinghai	2	0.12
Shandong	78	4.72
Shanxi	27	1.63
Shaanxi	50	3.02
Shanghai	83	5.02
Sichuan	83	5.02
Tianjin	26	1.57
Tibet Autonomous Region	6	0.36
Hong Kong	6	0.36
Xinjiang Uygur Autonomous Region	13	0.79
Yunnan	28	1.69
Zhejiang	79	4.78
Chongqing Municipality	60	3.63

The distribution of the respondents from overseas is as follows: The United States(4), Canada(2), Russia(2), Spain(2), Japan(2), Korea(2), The United Kingdom(1), France(1), Italy(1), Iceland(1), Malaysia(1).

(3) Assessment Tools

1. Sexual orientation, self-acceptance, and marriage status

We asked the respondents whether they had identified their sexual orientation, what their orientation was, whether they accepted their sexual orientation, and how they judged whether or not a person is homosexual.

Based on the Sexual Orientation Questionnaire (SOQ) (Baeck, Corthals & Borsel, 2011), we adapted a homosexual identification questionnaire comprising 5 questions: if the respondents have been attracted to people of same sex; if they have had same-sex intimate behaviors (such as embraces and kisses); if they have had homosexual behaviors and if they have had same-sex partners. This study's coefficient of internal consistency is 0.61.

Besides, the questionnaire also includes the following questions: if the respondents approve of same-sex marriage; if they have come out (revealed their homosexual orientation) and, if yes, the people they had come out to (multiple choice); if they have considered "cooperative marriage" (marriage between a gay man and lesbian woman), and if they have considered heterosexual (de facto) marriage.

2. Depression

The Center for Epidemiological Studies Depression Scale (CES-D) was created by Radloff from the American National Institute of Mental Health in 1977. Initially designed to study the relative factors in depressive symptoms and its developing pattern, it is widely used to screen the depressive symptoms in the general population, applicable to youths, adults and elderly people (Zhang Jie et al., 2010).

CES-D has a number of simplified versions such as ones with 8 or 10 questions. This study used the simplified Chinese version of CESD-9 (He Jin et al., 2013). It removed the questions on interpersonal dimension and a few other items after translation and adaption from the original version. CESD-9 includes 9 questions, of which 2 are reverse scoring questions, requesting the respondent to use 0-3 to assess the frequency of the symptoms during the past week. CESD-9's coefficient of internal consistency in this study is 0.89.

3. Self-efficacy

This study utilized the General Self-Efficacy Scale (GSES) to assess the LGBT people's self-efficacy. GSES is designed by Professor Ralf Schwarzer, a famous clinical and health psychologist together with his colleagues at Free University of Berlin, Germany. In the beginning it included 20 items, which later were expanded reduced to 10. The current scale has been translated into at least 25 languages and widely used around the world. The Chinese version of GSES was first used for the freshmen class in Hong Kong in 1995 by Zhang Jianxin and Schwarzer (Zhang & Schwarzer, 1995). In 2013, Chen Zhiyan translated a new Chinese version and used it in the Graduate School of Chinese Academy of Sciences. This study used the Chen Zhiyan version. The GSES's coefficient of internal consistency is 0.87.

4. The need for mental health services

The study of LGBT people's need for mental health services includes 6 questions:

(1) if they have received psychological counseling and psychotherapy or other psychological services ("psychological services") in the past 12 months;

(2) reasons for seeking psychological services;

(3) if they have considered receiving psychological services in the past 12 months;

(4) the kind of institution they would go for the psychological services;

(5) what kind of help they want to obtain;

(6) reasons for not considering psychological services.

5. Basic information

The basic information part includes 8 questions: the respondent's sex, age, ethnicity, place of residence, highest education degree, employment status, marriage status and the gender of their spouse.

III. RESULTS

(1) Sexual orientation, self-acceptance, and marriage status

1.1 Sexual orientation

Among 1,653 respondents, 1,291 are homosexual, 248 bisexual and 144 uncertain about their sexual orientation. See Fig.7 for the sexual orientation distribution:

See Table 4 for the sexual orientation distribution.

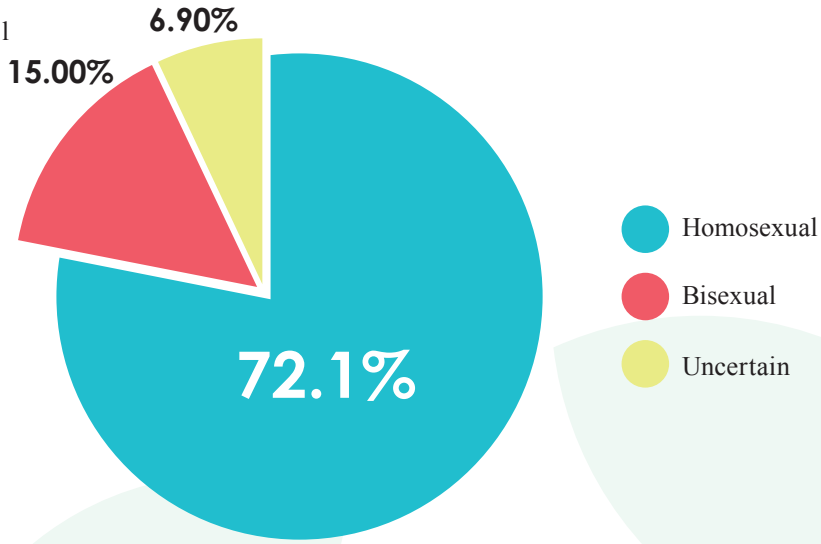

Fig.7 The sexual orientation distribution.

Table 4 The sexual orientations' distribution status by sex

	Male	Female	Intersex
Homosexual	768	507	16
Bisexual	127	117	4
Uncertain	63	51	/

1.2 Self-acceptance

The result shows that among the final respondents, 1,512 respondents(91.47%) accept their sexual orientations while 141 respondents(8.53%)do not. (Fig.8)

The proportion of acceptance among men is 90.29% and 92.89% among women. The proportions between men and women are similar and do not differ significantly.

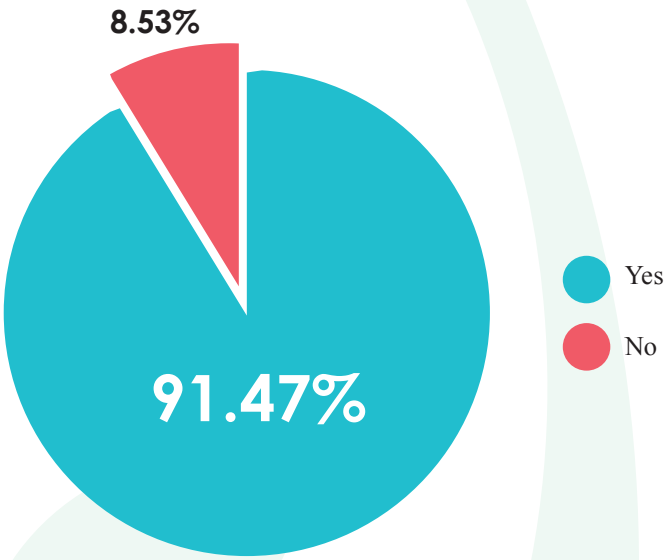

Fig.8 Acceptance of sexual orientations.

1.3 Disclosure status

As shown in Fig.9, among the respondents who accept their sexual orientation, 774(60.00%)have come out and 517(40.00%)have not.

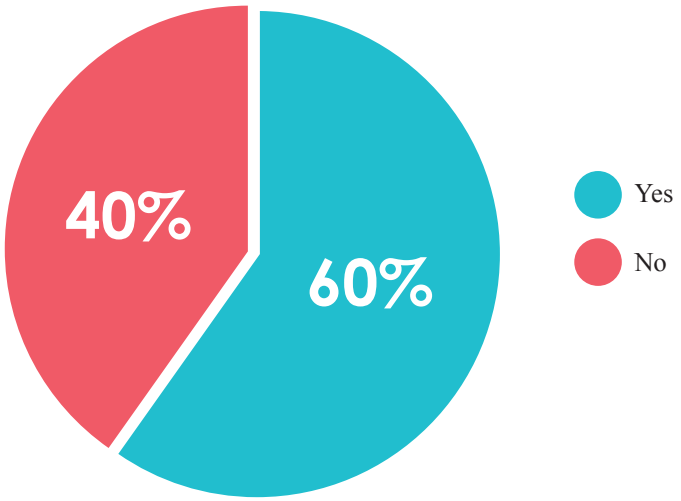

Fig.9 Disclosure status

There is no significant difference between men and women. See Fig.10 for the exact percentages.

Compared with the respondents who do not accept their sexual orientation, those who accept their sexual orientation have a higher percentage of coming out (Fig.11).

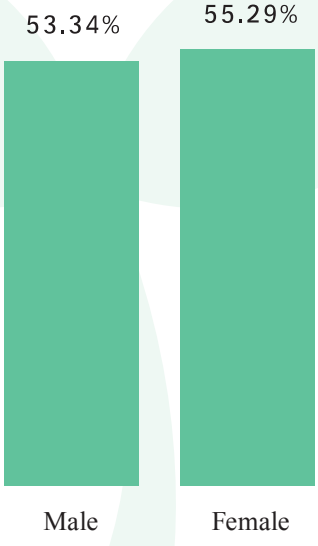

Fig.10
The “coming out” percentages of males and females.

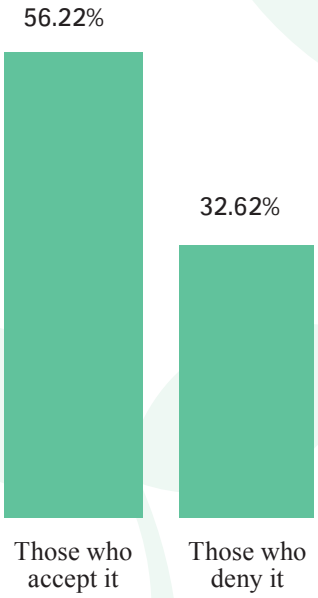

Fig.11
Acceptance of their sexual orientation and disclosure status.

We asked if the respondents chose to come out to their friends in the LGBT community, friends of the opposite sex, friends of the same sex, or relatives (a multiple choice question). The result shows that the friends in the LGBT community were chosen 586 times, friends of opposite sex 530 times, friends of the same sex 660 times and relatives 307 times. The respondents who came out to their relatives have the lowest percentage among the four groups. See Fig.12 for the percentages of the four choices.

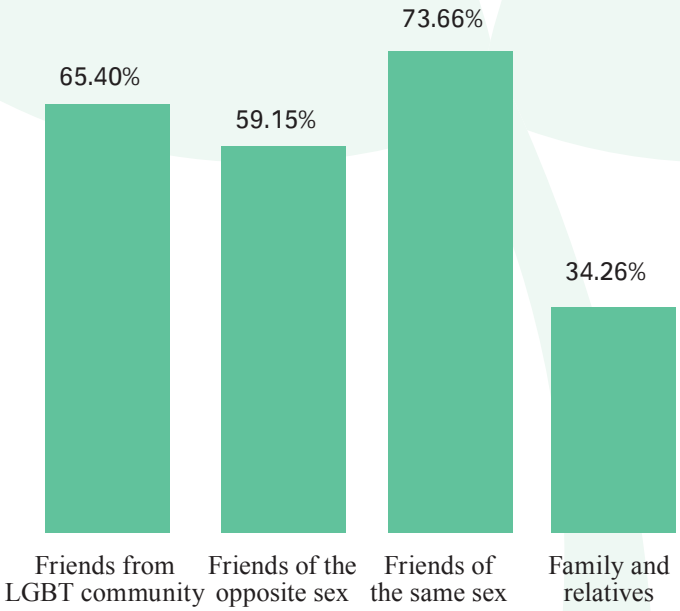

Fig.12 Whom they came out to

1.4 Same-sex partners and intimate behaviors

The result shows that 1,004 respondents (60.74%) have had same-sex partners (with committed relationship of longer than 6 months); 73.38% of the respondents have had same-sex sexual acts and 90.62% had same-sex intimate behaviors (such as embraces and kisses)(Fig.13).

Fig.13 Same-gender partners and intimate behaviors.

Chi-square test shows that a higher proportion of the female respondents have had same-sex partners than male respondents (χ^2=30.15,$p\leq$0.001), but the two genders do not differ significantly for their same-sex intimate behaviors. See Fig.14 for percentages of same-sex partners and same-sex intimate behaviors.

Chi-square test shows that compared with those who do not accept their sexual orientation, those who do are more likely to have same-sex intimate behaviors (χ^2=17.32,$p\leq$0.001), same-sex sexual behaviors (χ^2=9.50,$p\leq$0.01) and same-sex partners(χ^2=32.55,$p\leq$0.001).

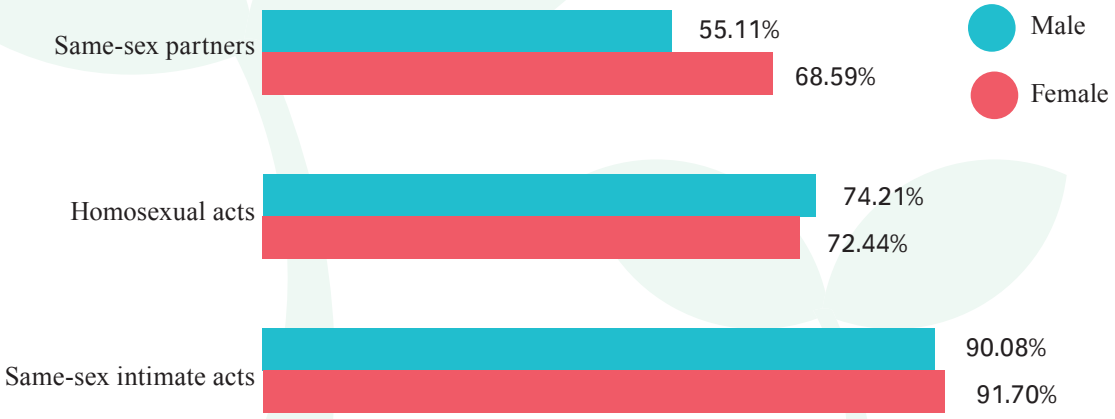

Fig.14 LGBT people's same-sex partners and intimate behaviors by sex.

1.5 Attitudes toward marriage

This study mainly aims to understand LGBT people's attitudes toward marriage by asking three questions: 1) if they accept same-sex marriage; 2) if they would consider cooperative marriage, and 3) if they would consider heterosexual marriage. The result shows that 1,623 respondents(98.22%)accepted same-sex marriage, 897 (54.27%) had considered cooperative marriage, and 636 (38.48%) had considered heterosexual marriage. See Fig.15, Fig.16 for the specific proportions.

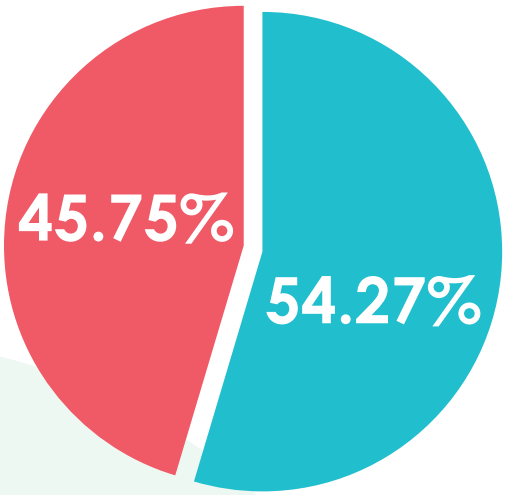

Fig.15 If the respondents have considered marriage of convenience.

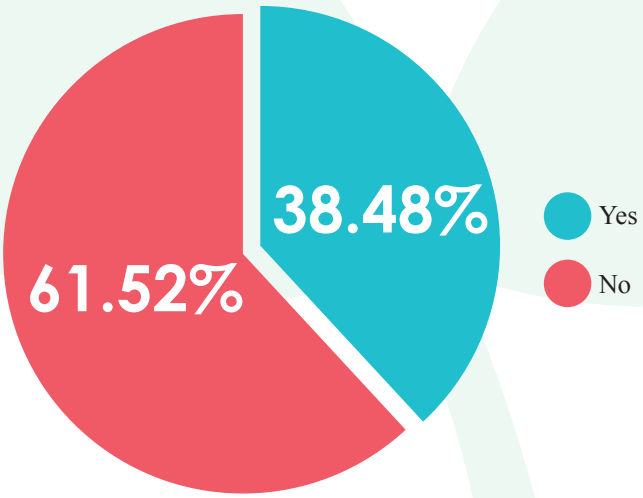

Fig.16 If the respondents have considered heterosexual marriage.

The result shows that a higher proportion of women ($\chi^2=9.88, p\leq 0.01$)accept same-sex marriage than men; and a higher proportion of men($\chi^2=9.99, p\leq 0.01$)have considered heterosexual marriage than women. See Fig.17 for the distribution of attitudes by gender.

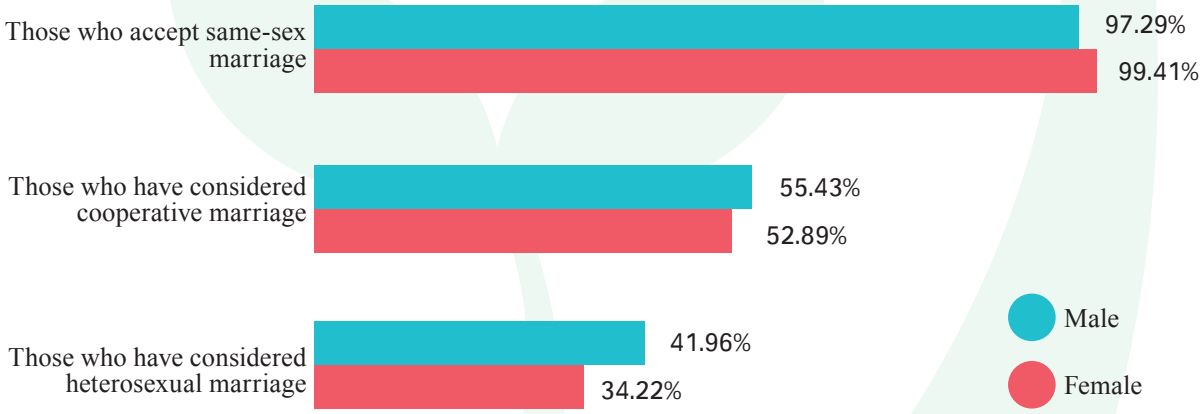

Fig.17 The attitude by gender of LGBT people.

(2) Depression

1. The overall status of CESD-9

The respondents' CESD-9 mean score is 10.41±6.43. CESD-9 sets the cut-off point of depressive tendency at 10 and the high risk of depression at 17 (He Jin et al., 2013). The result shows that 29.88% of the respondents have depressive tendency and 20.02% likely to have high risk of depression.

Setting 18 as the cut-off age, we regarded those who are 18 years old and younger as "youths" and respondents older than 18 as "adults". The result shows that LGBT youth's CESD-9 average score is 11.60±6.17 and LGBT adults score is 10.29±6.47. T test result shows that LGBT youth's CESD-9 score is significantly higher than LGBT adults(t=2.26,p<0.05).

CESD-9 scores do not differ significantly among LGBT men, women and intersex people; nor do they differ significantly between homosexual people(10.30±6.45)and bisexual people(9.93±5.96). The main difference is that the group who have not yet accepted their sexual orientation would have a significantly higher CESD-9 score than homosexual and bisexual people(F=8.524, p<0.001), that is, the people uncertain of their sexual orientation are more likely to be depressed. Further analysis has found that among 114 respondents who are uncertain of their sexual orientation, 35.08% have a high risk of depression. LGBT people who do not accept their sexual orientation(12.30±6.27)have a significantly higher CESD-9 score than those who accept their sexual orientation(t=-3.65, p<0.001), and the respondents who accept their sexual orientation have a mean CESD-9 score of 10.24±6.43.

From the perspective of whether or not they have come out, those who have not come out have a significantly higher mean CESD-9 score(10.84±6.62)than those who have come out(10.05±6.26), t=-2.60, p<0.05.

From the perspective of employment status, among the LGBT adults, the unemployed LGBT people have the highest score (12.91±6.49), higher than the students and the employed.

2. Comparisons with other demographic groups

In 2008, the Institute of Psychology of the Chinese Academy of Sciences conducted a national research study on psychological health, which based its sampling distribution on the distribution of region, gender, age and education from a national census. The research covered 39 cities of 21 provinces (autonomous regions, municipalities) and surveyed 16,636 people with 16,228 valid questionnaires. 49.0% of the respondents were male. The age range was from 11 to 100, with a mean age of 37.7±21.3 years old. We have chosen the 18-year-old and younger samples (N=3879) and adult samples (19-50 years old, N=5401) to compare with respective LGBT groups in this study. T-test shows that the LGBT youths have significantly higher (t=9.103,p<0.001=depression score (11.60±6.17) than the national youth samples(6.75±5.94), and the LGBT adult group have significantly higher(t=26.817,p<0.001) depression score(10.29±6.47) than the national adult samples (5.2±5.31).

From the perspective of the depression score distribution, Chi-square test shows that significantly higher proportions of LGBT youths have depression tendency and high risk of depression than the nation-wide youth samples(χ^2=91.91,$p\leq$0.001), and significantly higher proportions of LGBT adults have depression tendency and high risk of depression than the nation-wide adult samples(χ^2=1050.59,$p\leq$0.001). Apparently, the LGBT youth's high risk of depression proportion is 3 times that of the nation-wide youth (Fig.19)

and the LGBT adults' high risk of depression proportion is 4 times that of the nation-wide adults (Fig.20).

Here are the CESD-9 scores distribution comparisons between the LGBT youth and nation-wide youth, as well as the LGBT adults and nation-wide adults:

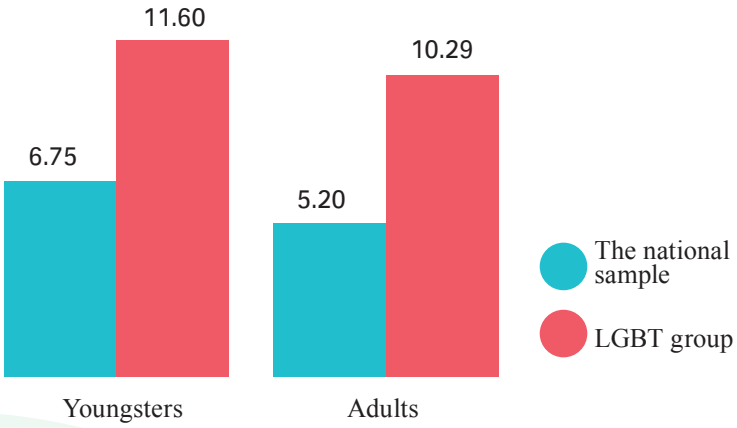

Fig.18 The CESD-9 score comparisons:
LGBT groups versus national samples.

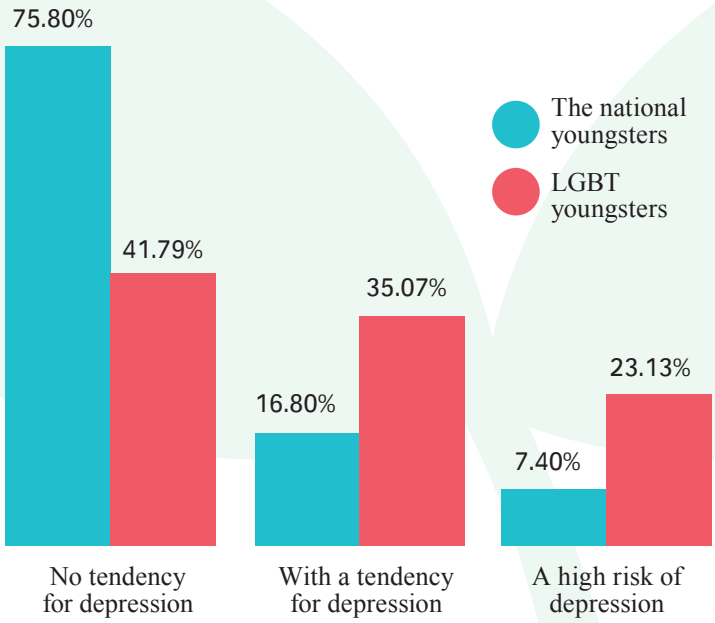

Fig.19 Comparison between
LGBT youths and nation-wide youth.

In conclusion, this study finds that LGBT group's depression level is significantly higher than the nation-wide samples, both for youth and adults. The proportion of LGBT group with depression tendency and a high risk of depression is significantly higher than that of nation-wide samples.

In the LGBT community itself, there are 5 sub-groups with a higher risk of depression: 1) minors (younger than 18), 2) those who are uncertain about their sexual orientation, 3) those who deny their sexual orientation, 4) those who have not come out, and 5) those who are unemployed.

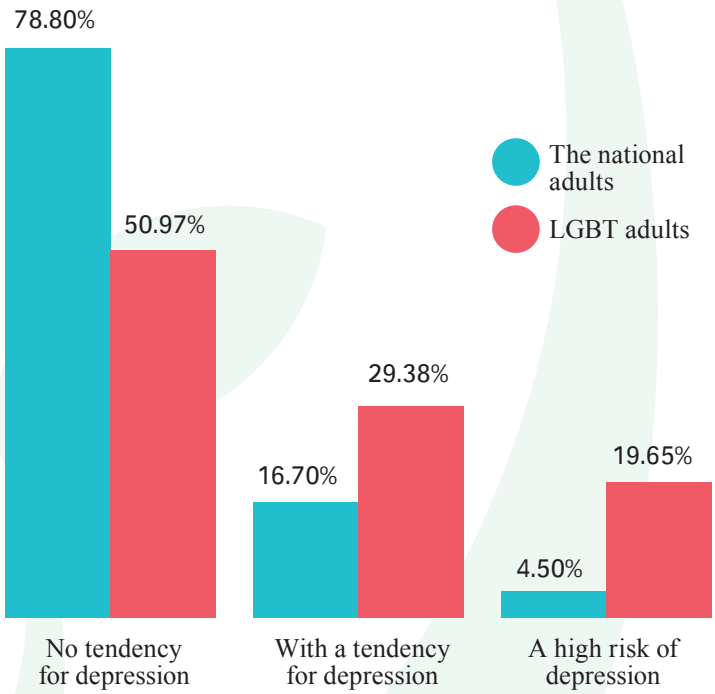

Fig.20 Comparison between
LGBT adults and nation-wide adults.

(3) Self-efficacy

A healthy self-efficacy level means that one has a positive view of oneself, and that this view of oneself matches the reality. A low level of self-efficacy inflicts one with self-blame and self-doubt, and such a person is likely to be troubled by depression and anxiety and to find it difficult to use their abilities. This study finds the respondents' average score on sense of self-efficacy is 27.26±5.29.

From the perspective of the LGBT groups, we have found that(1)different sexes do not differ significantly in their senses of self-efficacy(F=1.374,p>0.05); (2)The LGBT youth's sense of self-efficacy(24.59±5.18)is significantly lower than(t=-5.592,p<0.001)LGBT adults(27.52±5.24); (3)The respondents uncertain of their sexual orientation (25.65±5.36) have significantly lower sense of self-efficacy (F=5.730,p<0.01)than homosexual (27.37±5.31) and bisexual respondents(27.43±5.01),but the homosexual and bisexual people do not differ significantly; (4)Those who have not come out (26.97±5.12)have lower scores(t=2.08,p<0.05) than those who have come out(27.51±5.42); (5)Among LGBT adults, the unemployed (24.96±5.47)are significantly lower (F=9.428,p<0.001)than students(27.69±5.17)and the employed(26.99±5.17).

Among the adults, all the groups with different academic degrees differ significantly from each other in their sense of self-efficacy(F=37.768,p<0.001). The tendency is that the higher the degree, the higher the level self-efficacy. In 2013, The Institute of Psychology of the Chinese Academy of Sciences assessed 662 postgraduates from the Graduate School of Chinese Academy of Sciences for their sense of self-efficacy. The T-test shows that LGBT group with a MA degree or above had a significantly lower(t=-7.77,p<0.001) sense of self-efficacy (29.81±4.50) than the CAS postgraduate group(33.15±3.82).

Fig.21 The sense of self-efficacy status of groups with different academic degrees.

Similar to the CESD-9 result, this study finds that, generally, 5 sub-groups have a lower sense of self-efficacy:

1) the minors,

2) those who are uncertain of their sexual orientation,

3) those who deny their sexual orientation,

4) those who have not come out,

5) the unemployed.

The correlation analysis shows that the correlation coefficient is r=-0.542(p<0.001). Regression analysis also shows that as the gender, age and sexual orientation are controlled, the sense of self-efficacy level can predict the depression level, that is, the higher the sense of self-efficacy, the lower the depression level. This suggests that LGBT group's depression level may be mitigated if we can effectively improve their sense of self-efficacy.

(4) The need for psychological services

1. Overall demand for psychological services by LGBT people

This study finds that 116 respondents (7.02%)have received psychological counseling and psychotherapy or other psychological services ("psychological services"); 610 respondents(36.09%)have considered seeking psychological services in the past 12 months; 927 respondents(56.08%)have not considered psychological services(Fig.22).

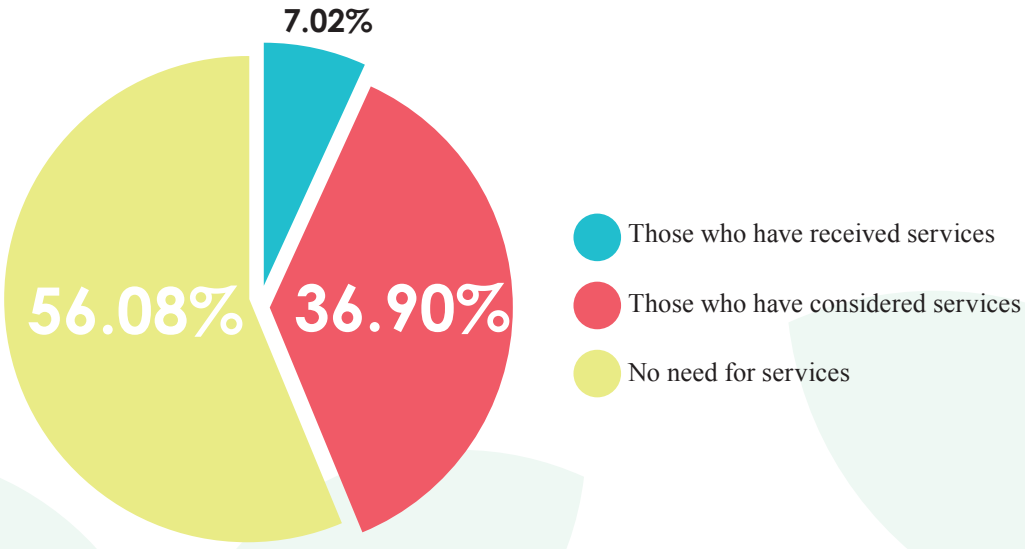

Fig.22 The overall demand of the psychological services

Chi-square test shows that, compared to women, a significantly larger number of men has received psychological services, and significantly more men have the need but have not sought psychological services(χ^2=6.68,p<0.05). See Fig.23 for the specific distribution by sex.

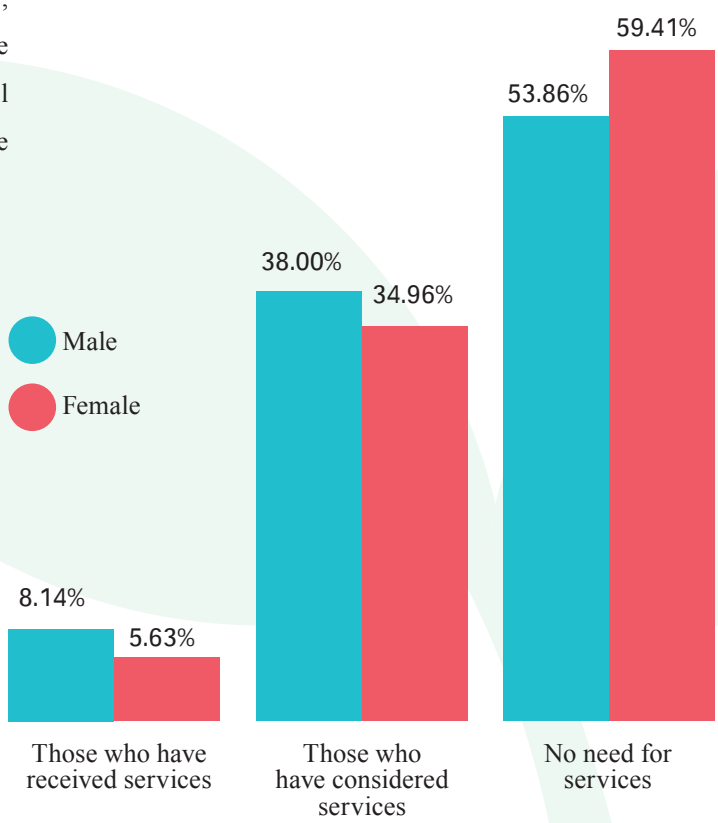

Fig.23 The need for psychological services: Men compared to women.

In 2013, the Institute of Psychology's research (N=662, mean age 25.73±2.24)had the same questions. The result shows that 13.53% of the postgraduate students have a need for psychological services. We chose this study's respondents with a MA or higher degree (N=102) for comparison. Chi-square test shows that significantly more respondents with a MA or higher degree in this study have the needs for psychological services(p<0.01) This suggests that with the same academic background, the LGBT group may have stronger needs for psychological services.

2. The reasons for psychological services needed

From 610 respondents who have considered psychological services, the most common problem they want to solve is to improve their emotional state, which was chosen by 60.61% of respondents. This is consistent with the relatively serious depression status of the LGBT group. Other common problems include “to solve the problems encountered in interpersonal relationships or romantic relationships”, “to improve self-confidence”, “to reduce the distress caused by poor self-acceptance”, “to look for the aim and meaning of one’s life” and “to have better communication with one’s family members” (Fig.24).

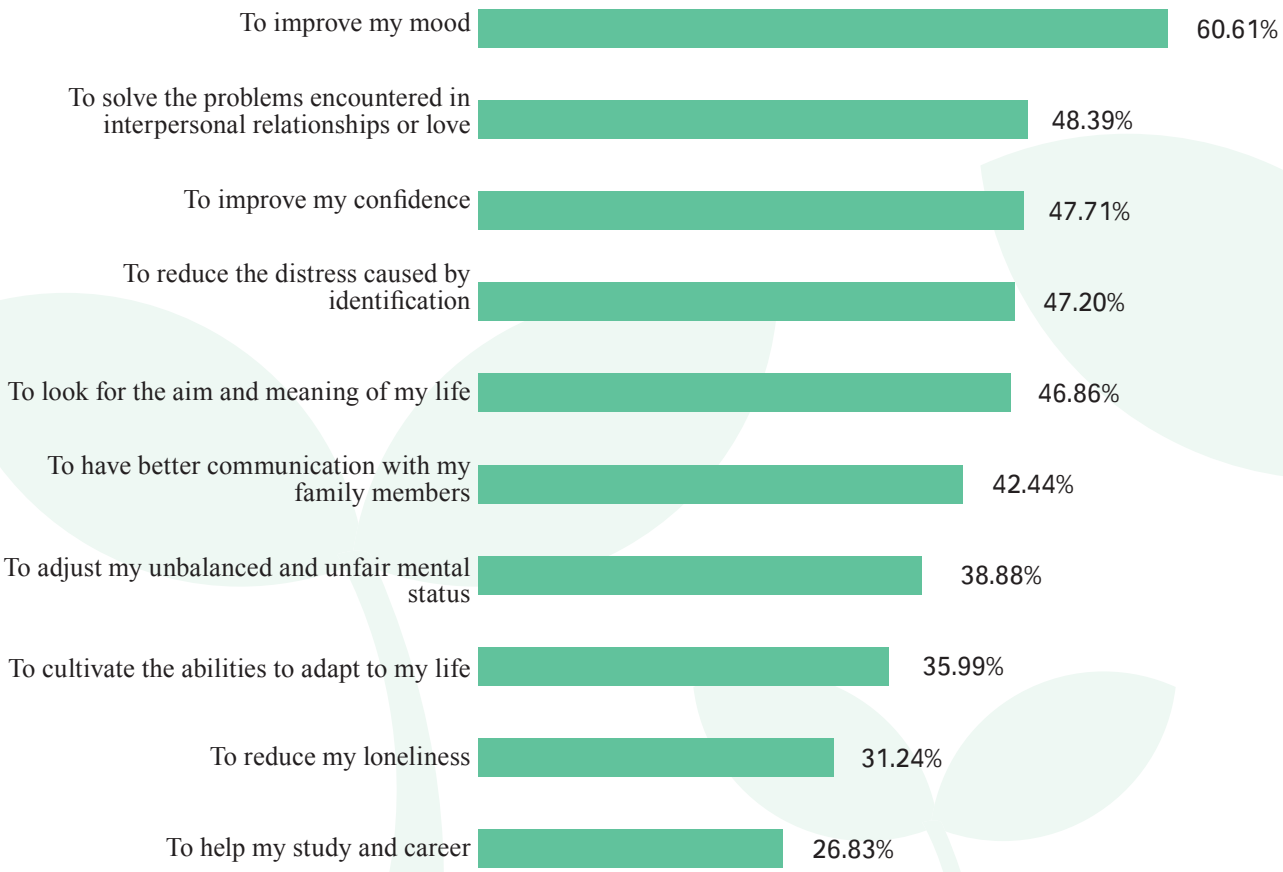

Fig.24 Psychological services needed by LGBT people

Among 116 respondents who have received psychological services in the last 12 months, 105 mentioned the reasons for doing so, which include, primarily, “to improve my mood and pressure”, followed by solving psychological problems (depression, anxiety etc). It is noteworthy that 18 respondents sought psychological counseling because of their parents. The specific reasons are summarized as follows (Table 5):

Table 5 The specific reasons for seeking psychological services.

Reasons to receive psychological services	Numbers	(male/female)
To improve my mood and pressure	21	(15/6)
To solve my psychological problems (depression, anxiety, etc.)	20 Note 1	(9/11)
To know about myself and my growth	14 Note 2	(12/2)
To seek consolation, understanding, support, a way out and help	13	(10/3)
Requested/forced by family members	8	(6/2)
Interpersonal relationship/communicative problems	4	(2/2)
For the sake of parents	4	(2/2)
Emotional issues	4 Note 3	(3/1)
Conversion Therapy (2 cases were forced by parents)	3 Note 4	(3/0)
So the psychologist can tell my parents that homosexuality is not an illness	3	(3/0)
To identify my sexual orientation	2	(1/1)
To have a HIV test	1	(1/0)
To accept the opposite sex, get married and have children	1	(1/0)
To solve the dilemma	1	(1/0)
To understand the counselor’s attitude towards homosexuality	1	(1/0)

Note 1: One case led to conversion therapy. This respondent filled out the conversion therapy questionnaire.
Note 2: One case led to conversion therapy during the consultation as the counselor tried to lead the client to change his/her sexual orientation. This respondent filled out the conversion therapy questionnaire.
Note 3: One case led to conversion therapy from their original purpose (to deal with the emotional issues). This respondent filled out the conversion therapy questionnaire.
Note 4: Two cases were forced by their parents. The 3 cases did not fill out the conversion therapy questionnaire.

3. The preferred institutions to receive psychological services

As shown in Fig.25, among the 7 kinds of psychological service agencies, the primary choice is LGBT institutions (chosen by almost 60% of the respondents), followed by psychological counseling companies, chosen by nearly 50%.

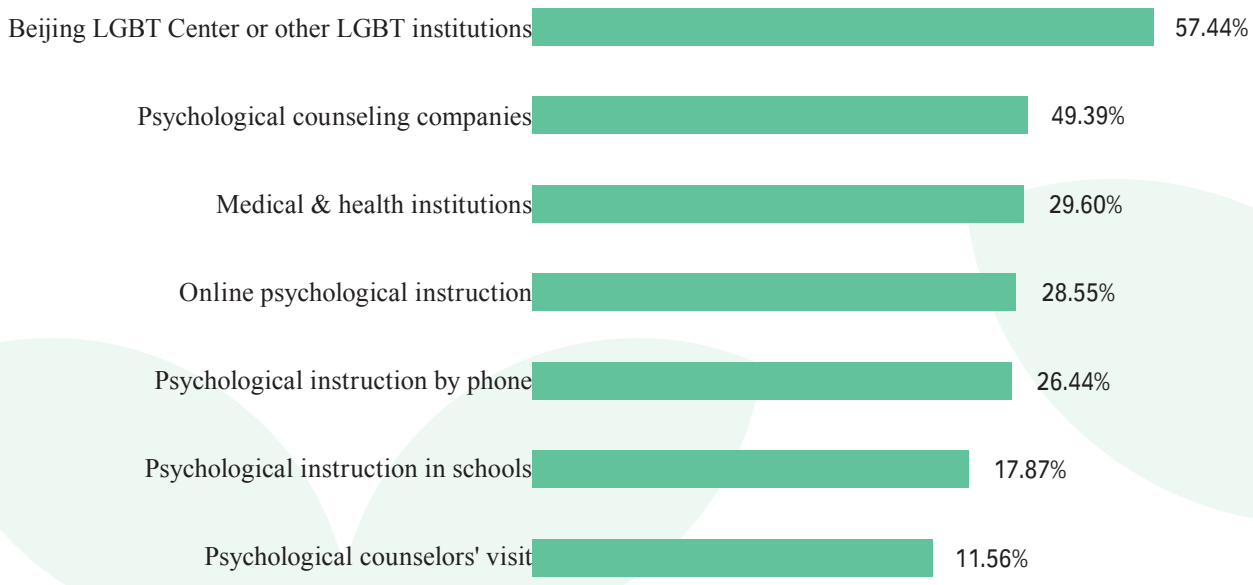

Fig.25 Channels to receive psychological services

4. Reasons preventing LGBT people from seeking psychological services

Among 610 respondents who have considered seeking psychological services, 336 say that they will not seek counseling services although they have the need to do so.

The primary concern is the cost, followed by concern about counselor's skills. Some respondents also claim that they worry that their sexual orientation may be revealed, or that they simply have no channels (Fig.26).

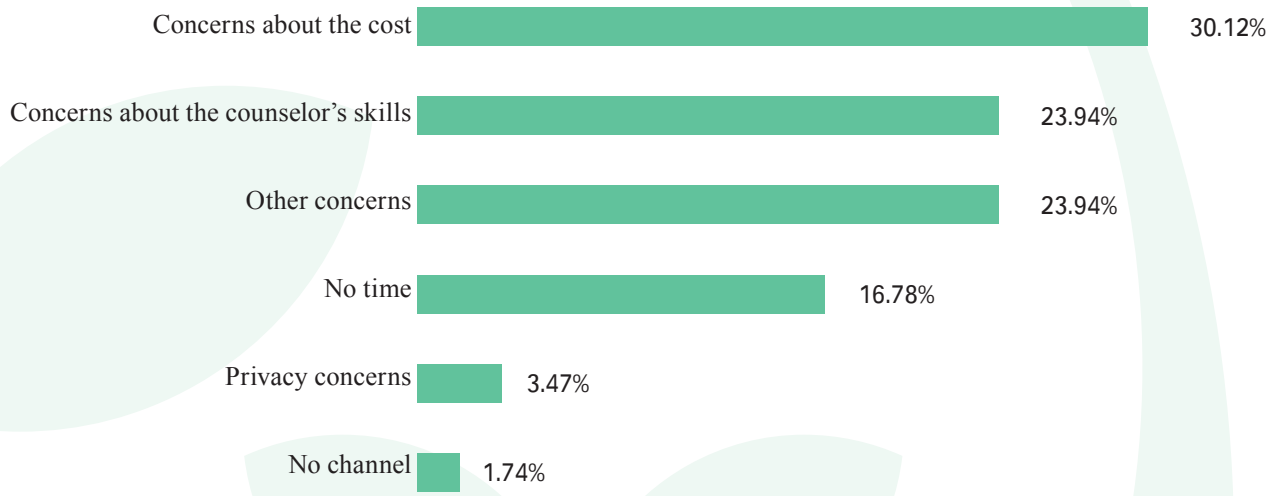

Fig.26 The reasons preventing LGBT people from seeking psychological services.

IV. DISCUSSION.

This study is the very first nation-wide research about LGBT people's psychological health conditions and their psychological service needs. Despite the existence of some previous psychological health studies, they are 1) restricted to certain regions without adequate sample sizes; and 2) lacking in inclusion of lesbians and bisexual people. This study thus serves as a supplement to those areas in earlier studies.

The study finds that LGBT group's depression level (both the youth and the adult groups) is significantly higher than their nation-wide counter-parts. From the perspective of the proportions of the people who have depression tendency and a high depression risk, the LGBT group is also higher than the national samples, a finding that is consistent with the earlier studies in other countries. Those studies also revealed relatively poor psychological health situation and high depression level among LGBT people.

Self-efficacy is predictive of depression level. Based on the finings about self-efficacy, we can see again that these 5 sub-groups have relatively low self-efficacy, which leads to self-accusation, self-doubt, depression and anxiety. As a result, people with love self-efficacy find it hard to function normally. The depression level among LGBT people may be effectively improved if the sense of self-efficacy can be improved.

116 respondents reported receiving psychological services in the last 12 months, reporting that the primary reason was "to improve their mood and to relieve pressure", followed by "solving psychological problems (depression, anxiety etc.)". 326 respondents considered psychological services, and their primary problem was to "improve their mood", followed by "to solve the problems encountered in interpersonal relationships or love", "to improve self-confidence", "to reduce the distress caused by identification", "to look for the aim and meaning of my life" and "to have better communication with my family members".

Although psychological services are in great demand by LGBT people, a considerable portion of them have never sought the services, due to concerns about the cost, the counselor's skills and other factors, as well as the fear of exposing their sexual orientation, or having no access to professional help. This situation may aggravate the risk of LGBT people's psychological health problems. From the information provided by the respondents who have received psychological services, these are valid concerns. For example, we found that 18 respondents received psychological counseling for the sake of their parents, 2 of whom were forced to receive conversion therapy. Three of them sought psychological services not because they had any problems with self-acceptance, but they were led by the counselor/therapist to accept heterosexuality during the consultation. Thus there is a pressing need to improve the counselors/therapists' understanding of the LGBT people, to eliminate their bias and to build their skills as LGBT affirming psychological counselors and psychotherapists.

In regards to the channels to receive psychological services, among the 7 common channels, the primary choice is the Beijing LGBT Center (or other LGBT organizations), chosen by nearly 60% of the respondents. This suggests that LGBT people prefer to receive services from the institutions that will accept their sexual orientation. However, currently only the Beijing LGBT Center and the Beijing Lesbian Center are providing these services. But in the future, LGBT organizations in other areas can provide training to counselors for LGBT communities based on the Beijing LGBT Center's model.

Part II:
Conversion Therapy and the LGBT Community

I.BACKGROUD

The CCMD-3 (Chinese Classification of Mental Disorders, Version 3), published in 2001, declassified homosexuality as a mental disorder; however, “sexual orientation disorders” were included, classified as “disorders stemming from sexual development and sexual orientations; not necessarily abnormal in sexual activity. However, the sexual development and sexual orientations of some people may trigger psychological disorders such as unwillingness, hesitation, anxiety, depression, and pain. Some may seek treatment in order to change their sexual orientation.” “Sexual orientation disorders” include homosexuality, bisexuality, and “other or unspecified sexual indirection disorders”.

Meanwhile, the public's views of gay people currently remain unshakeable. Studies on perceptions of homosexuality within the past decade in China, as well as LGBT people's personal experiences of societal pressure, both indicate low tolerance of gay people. Tolerance has been found to be positively correlated with emotional distance: tolerance levels are highest towards strangers, lower towards friends, and lowest towards family members. Discrimination from family members (especially parents) causes great pain to LGBT people. In semi-structured interviews conducted during the present study's first phase (September to November, 2013), 2 out of 4 gay men who had gone through conversion therapy stated that they had no sexual orientation/gender identity issues, yet had been forced by family members to receive conversion therapy.

Conversion therapy refers to psychological counseling or therapy aiming to alter a person's sexual orientation. This involves changing sexual behaviors and gender expression, or eliminating/decreasing sexual/emotional attachment and affection towards those of the same sex. However, conversion therapy is not counseling or therapy which:

1. Provides acceptance, support, or empathy for LGBT people, or helps them address issues, gain social support, or explore and develop self-identity;
2. Aims to prevent or address illegal/unsafe sexual activities, regardless of sexual orientation;
3. Does not attempt to change the person's sexual orientation.

In case studies on homosexuality conversion therapy published in China, counseling/therapy methods include psychoanalysis, self-examination (nei guan) therapy, cognitive insight therapy, problem-solving therapy, aversion therapy, hormonal therapy, medication, hypnosis, and electroconvulsive therapy (Chen, 2008). A Science & Technology Information article (2011) describes in detail the conversion therapy performed upon one gay man. During sessions #4 and #5, the therapist conducted role-playing in the counseling office. “The patient was rewarded for displaying masculine behavior; otherwise, he was punished with ammonia water as an aversion stimulus.” “When counseling ended, the patient was required to wear a rubber band around his wrist. He was instructed to snap it against his wrist repeatedly whenever he thinks of men, and only stop when the thoughts end.” Past literature on conversion therapy mainly reflected the perspective of the counselor/therapist; the results were also evaluated by therapists. Their general consensus is that their patients' sexual orientations have been success-

fully altered.

Based on information gathered through interviews, two goals for the current study are identified:

1. To understand LGBT community members' attitudes towards conversion therapy and reasons for undergoing conversion therapy. The current study shall study the LGBT community's views on conversion therapy. Focusing on LGBT people who receive conversion therapy, we shall analyze their commonalities and reasons for seeking conversion therapy. We shall also compare them with other LGBT people in terms of depression and self-efficacy.

2. To understand the procedure and methods of LGBT conversion therapy. We shall interview LGBT people who have received conversion therapy so as to understand their motivations for attempting conversion therapy; the procedure of conversion therapy; and the effects/influence of conversion therapy.

II.METHODOLOGY

1. Sampling Methods

The general public holds differing views on the complex subject of homosexuality, making personal privacy a significant concern in this study (Liu, 2000). In order to increase efficiency and reliability in surveys, this study's researchers cooperated with LGBT community NGOs to find survey participants. Social media networks (including Weibo, Douban, official websites, WeChat, Feizan, and QQ groups) and offline community events were used to publicize the study and recruit research subjects.

Meanwhile, LGBT NGO staff members contacted community members through social connections, inviting those who had received conversion therapy to participate in this study. Four methods of data collection (online surveys, online interviews, telephone interviews, and in-person interviews) were offered to participants.

2. Characteristics of Samples

2.1 Characteristics of Those Who Have Considered Conversion Therapy

In the current study, 865 participants (52.33%) are aware of conversion therapy, while 788 (47.67%) are not. Nearly one-tenth (151, 9.14%) of participants have considered attempting conversion therapy (Fig. 27, Fig. 28).

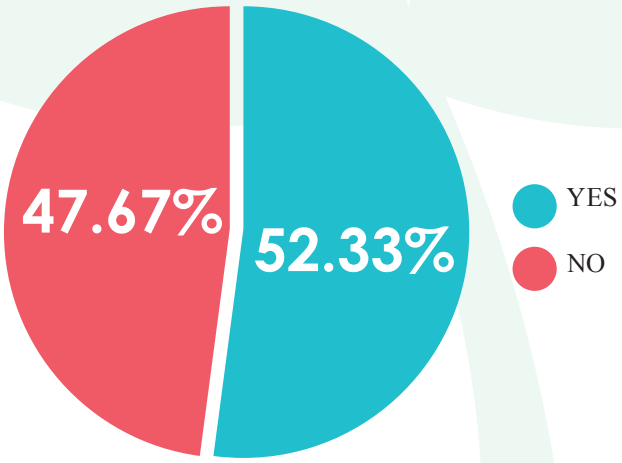

Fig.27 Whetehr they have heard of conversion therapy

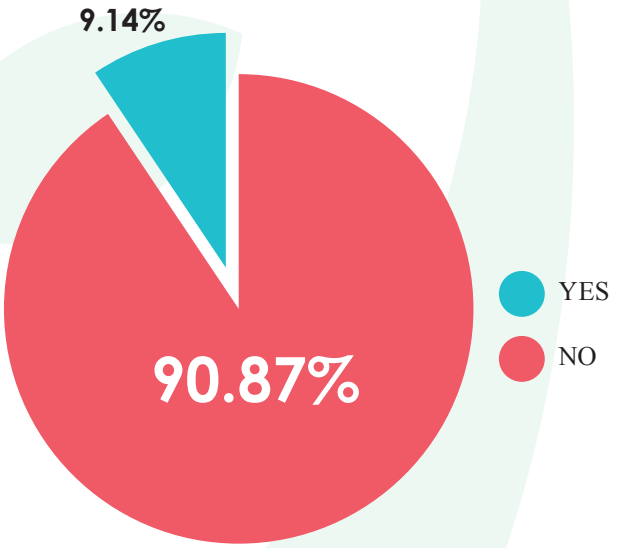

Fig.28 Whetehr they have considered conversion therapy

Among these 151 participants, 113 are male, 36 are female, and 2 are intersex. Men are significantly more likely to consider conversion therapy than women are (χ^2=19.94, p<0.001). In terms of age, 21 are youth or teenagers, 128 are adults, and 2 did not accurately state their age. Sex and age distributions are shown in Fig.29.

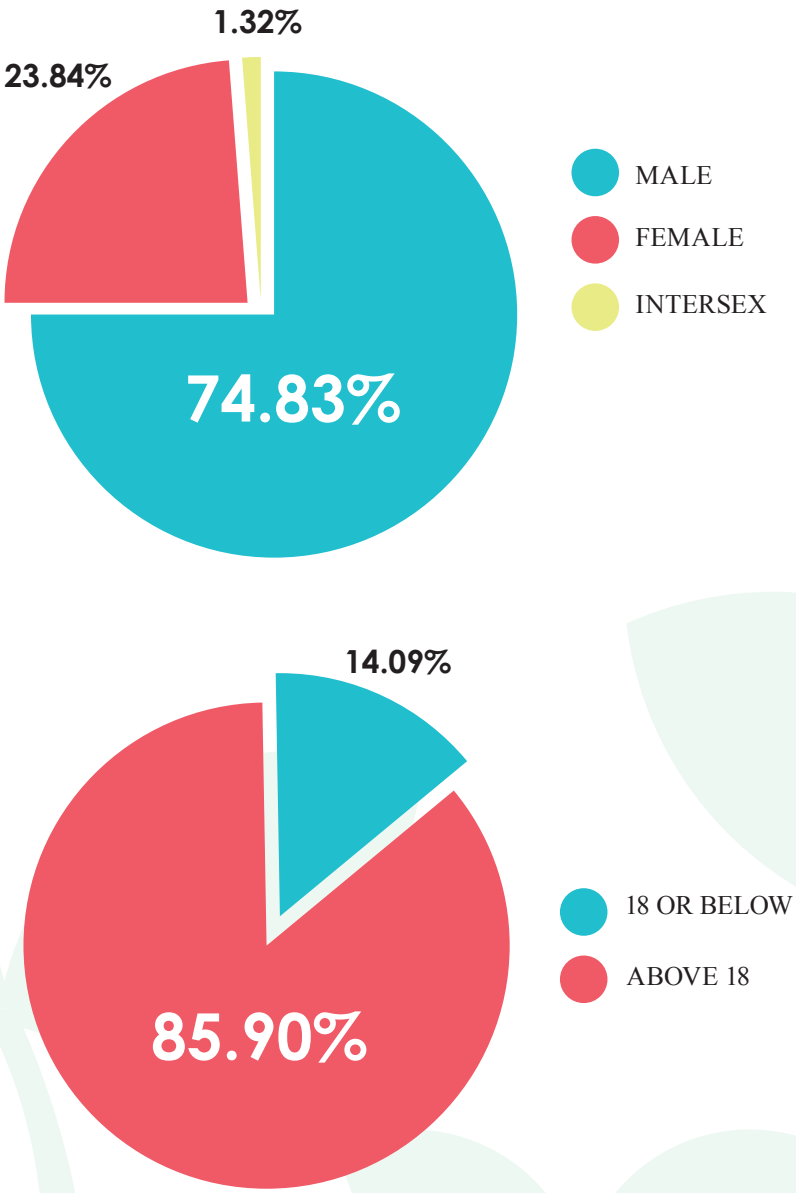

Fig.29 Age and sex distribution among people who have considered coversion therapy

Subjects were requested to state their highest level of education received. 31 received a secondary education or below; 52 a vocational training degree; 53 an undergraduate degree; and 11 received a master's degree or above. 4 participants did not accurately respond with their highest level of education. 74 participants are currently students; of the remaining participants, 63 are employed and 14 are currently unemployed. Highest level of education received and employment status distributions are shown in Fig.30.

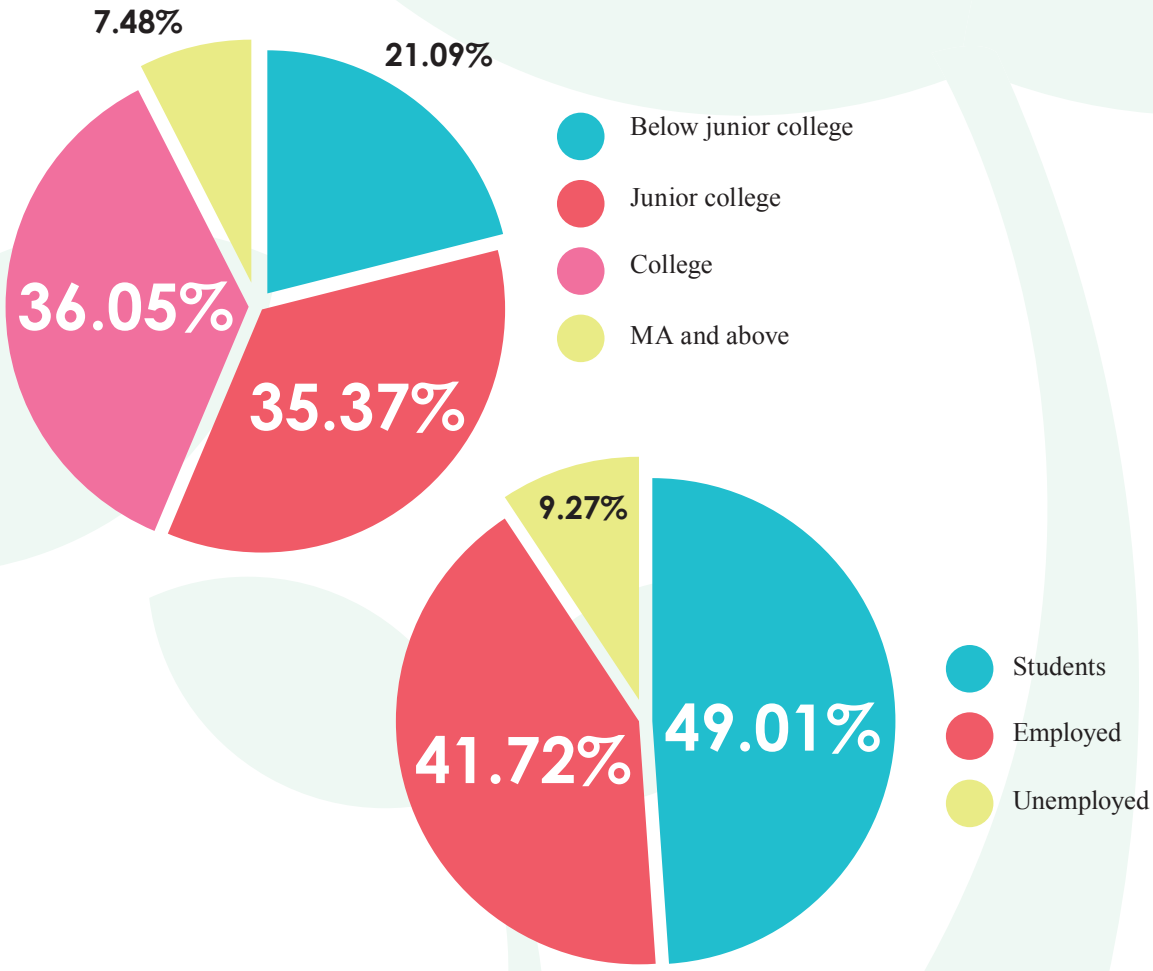

Fig.30 The respondents' academic degree and employment status distribution

144 are not married, 6 are currently married, and 1 has been divorced. Of the 7 who have been married, 4 are in marriages with opposite sex without disclosing their sexual orientation to their partners and 3 are in nominal marital relations of convenience. 56 have disclosed their sexual orientation (are “out”) while 95 have not. Those who have not disclosed are more likely to consider conversion therapy (χ^2=19.62,p＜0.001). Marriage status and disclosure status are shown in Fig.31.

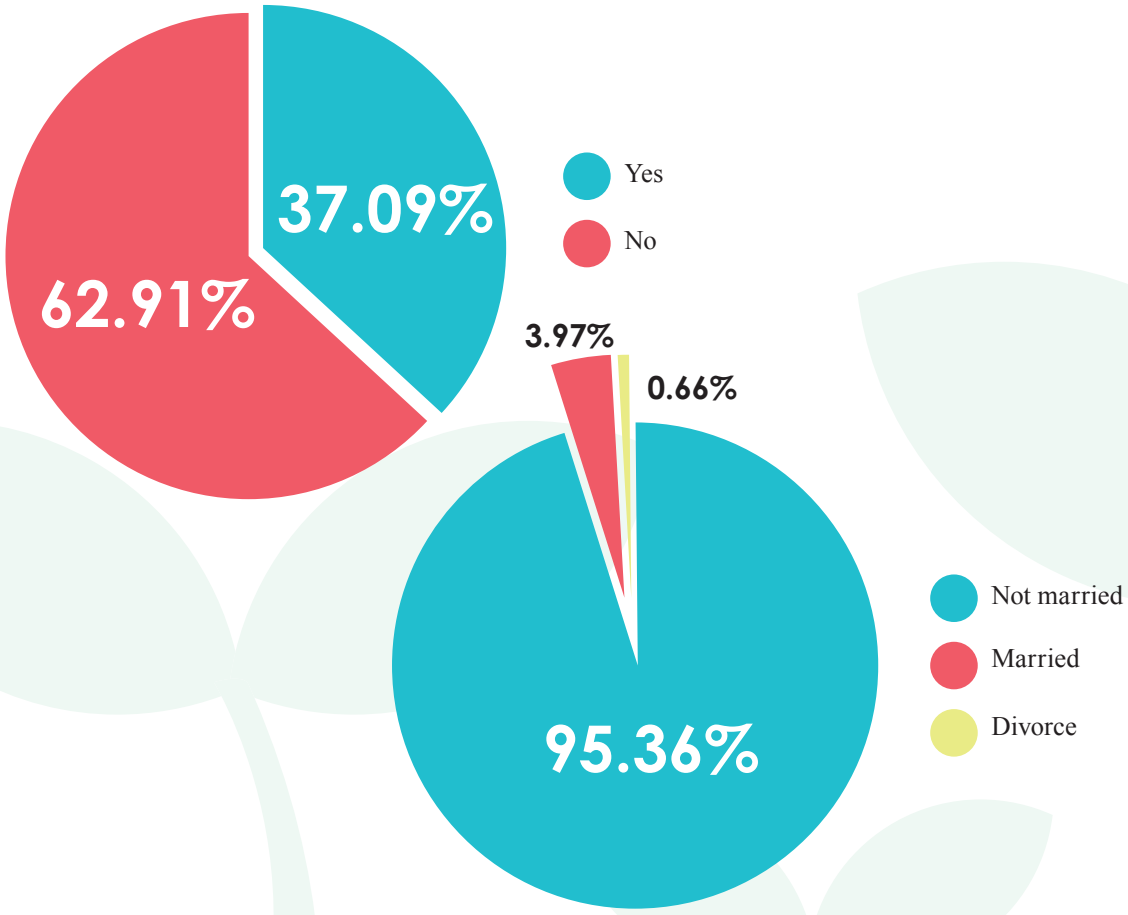

Fig.31 Disclosure and marital status

109 participants are homosexual, 22 bisexual, and 20 uncertain. 109 identify with their orientation (constituting 7.2% of total participants who identify with their orientation); 42 do not identify with their orientation (constituting 29.8% of total participants who do not identify). A chi-squared test indicates that the proportion of subjects who have considered conversion therapy is higher in subjects who do not identify with their orientation (χ^2=79.21, $p <$ 0.001). Distributions are shown in Fig.32:

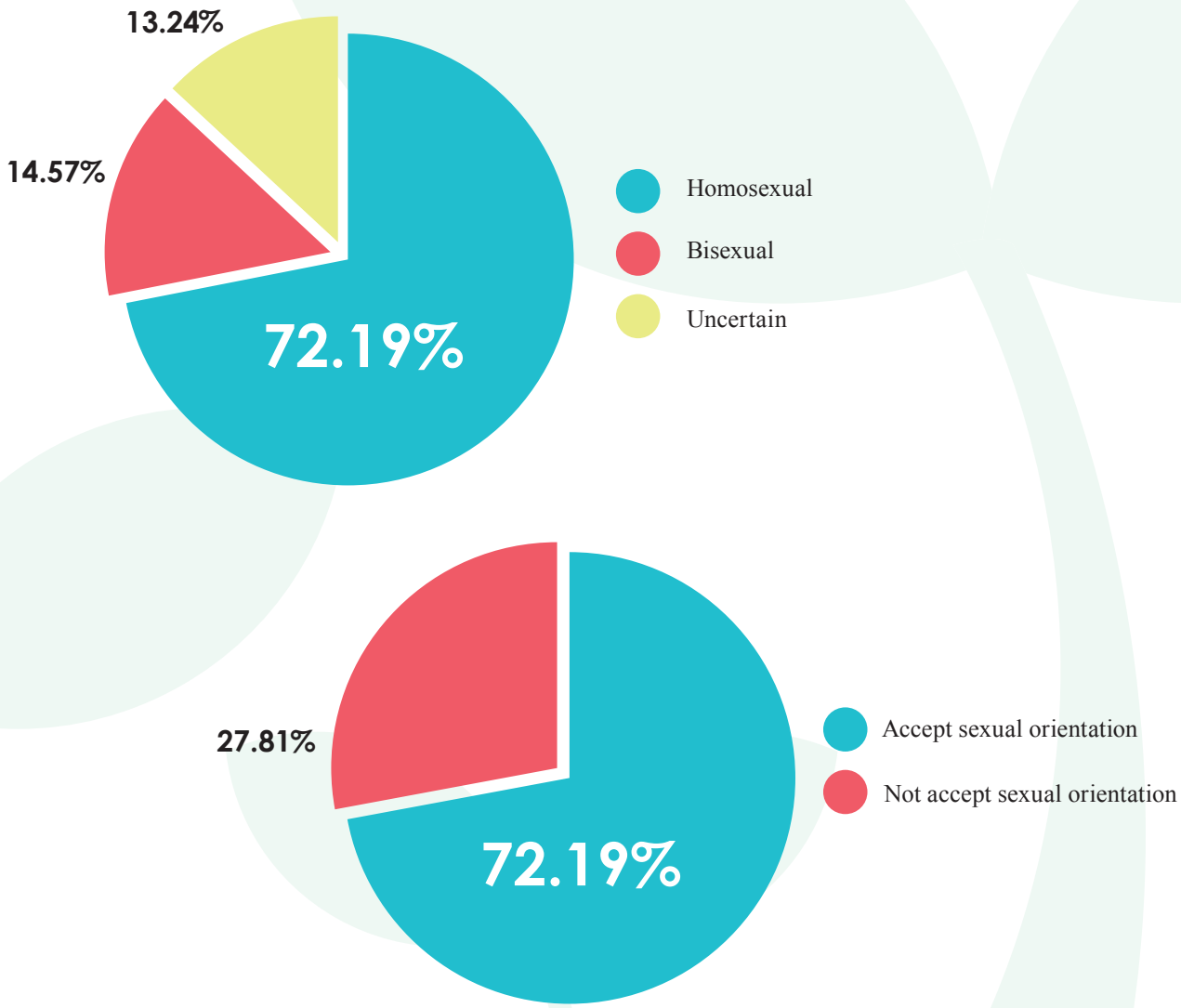

Fig.32 Sexual orientation distribution and acceptance of own sexual orientation

Of the 151 participants, 74 currently have had same-sex partners (here defined as having dated exclusively for over 6 months) and 77 have not. Those who have not had a same-sex partner are more likely to consider conversion therapy (χ^2=9.59, $p < 0.01$). 109 have had sex with a person of the same sex, while 42 have not (Fig. 33).

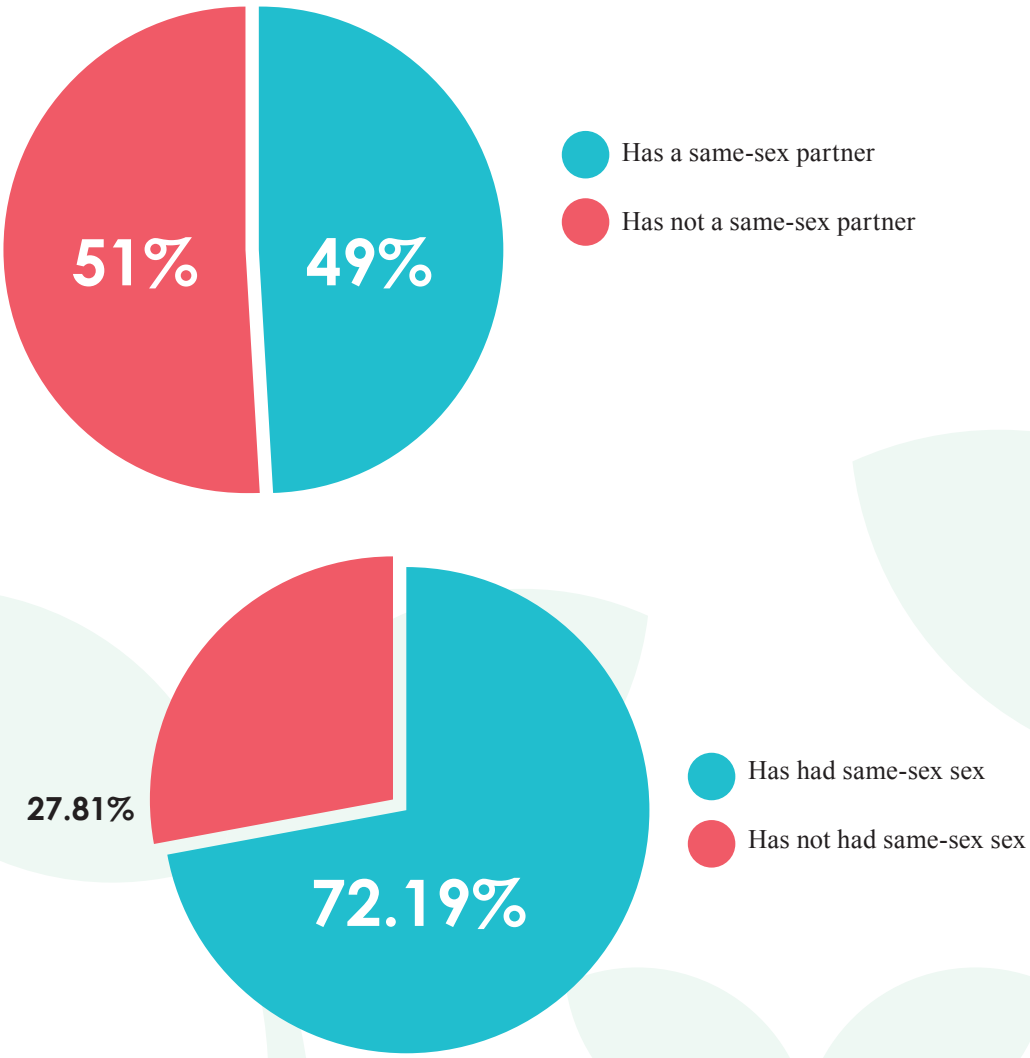

Fig.33 Same-sex relationship status and same-sex sexual history among respondants

2.2 Characteristics of Those Who Have Received Conversion Therapy

In this study, 9 participants who testified that they have received conversion therapy completed an online questionnaire. In addition, the Beijing LGBT Center's psychotherapists interviewed another 9 community members who had received conversion therapy. Hence a total of 18 people participated: 6 from Beijing, 3 Shanghai, 3 Fujian, 2 Zhejiang, 1 Guangdong, 1 Gansu, 1 Inner Mongolia, and 1 Chongqing. Sample characteristics are shown in Table 6.

Table 6 Characteristics of those who have taken conversion therapy

Sex		Sexual orientation		Age (at the time of therapy)	
Male	13	Homosexual	17	18 or below	4
Female	5	Bisexual	1	Above 18	14

Of the 116 participants who have been in therapy, 8 were required or coerced to do so by family members, but whether their therapy was conversion therapy or not is unclear. Three stated that they had received conversion therapy, but did not complete the conversion therapy survey. Therefore, these 11 cases were not included in this study's conversion therapy data analysis.

In the course of this study, researchers came into contact with 5 LGBT people who had undergone conversion therapy but, for various reasons, declined to participate. One told the researchers: “Sorry, but this is the one subject I never want to touch again.”

3. Research contents

In addition to the psychological health survey of the LGBT community in Part I, the study also consists of the following parts:

1) Attitudes towards Conversion Therapy

The study inquires whether the subjects have heard of conversion therapy, and whether they have considered conversion therapy or not and why.

2) Procedure of Conversion Therapy

Topics for participants who have received conversion therapy are designed to explore the procedure of conversion therapy. The same set of topics were used in both online questionnaires and in-person interviews. Topics include: 1. Whether or not the participant has been in conversion therapy; 2. The time and duration of the therapy; 3. The institution they visited for therapy; 4. The sex of the therapists; 5. Whether the therapists charged for therapy or not; 6. Reasons for undergoing therapy; 7. The number of sessions and length of each session; 8. The therapists' attitudes; 9. Conversion therapy methods used; 10. Whether their sexual orientation was altered or not; 11. How the therapy concluded; and 12. Life changes that the therapy has effected.

III. RESULTS

1. Attitudes towards Conversion Therapy

Participants received information on conversion therapy through 9 major outlets. The internet was the most popular (75.37%), while news media was second (15.19%). Only 2.42% became aware of conversion therapy through LGBT NGOs (see Fig. 34).

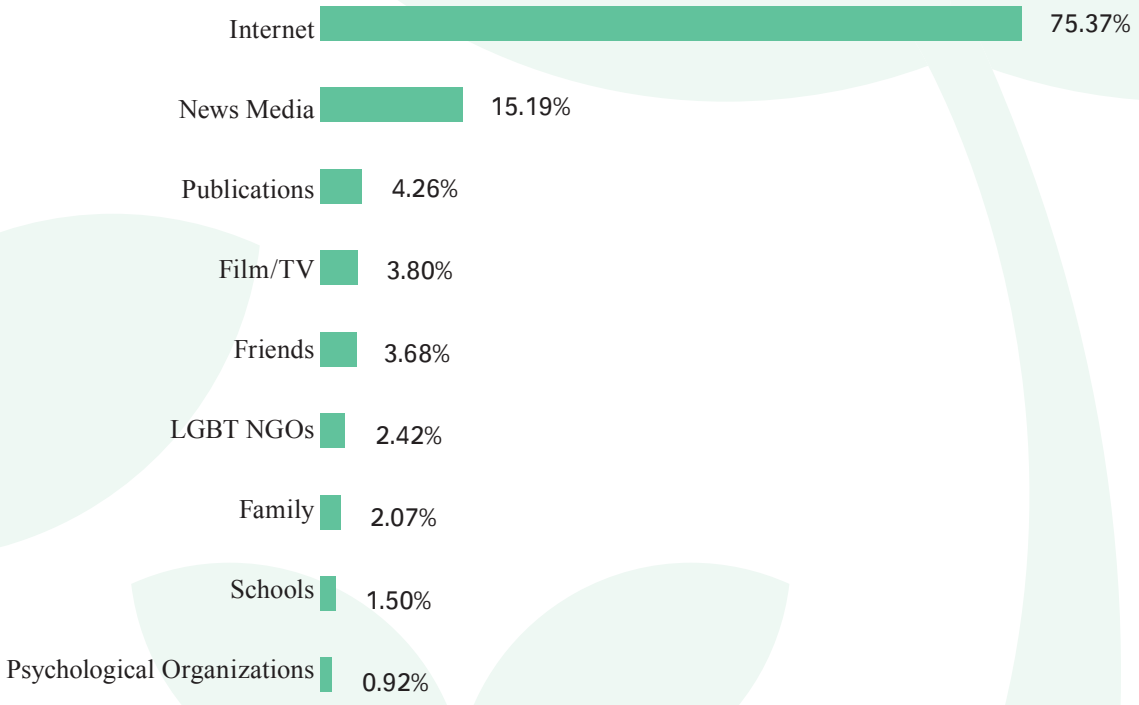

Fig.34 How participants became aware of conversion therapy

The 865 participants who have heard of conversion therapy yet declined undergoing it made their decision on following reasons: 1. Viewing conversion therapy unnecessary due to their positive self-identification (285 cases); 2. Taking homosexuality/bisexuality as normailty instead of a disease (207); 3. Believing that sexual orientations are unchangeable and that conversion therapy is unscientific/inhumane (223); Currently engaging in a romantic relationship (5); 5. Simply not wishing to change their orientations despite feeling that the life of a gay person is difficult (2) (Fig. 35).

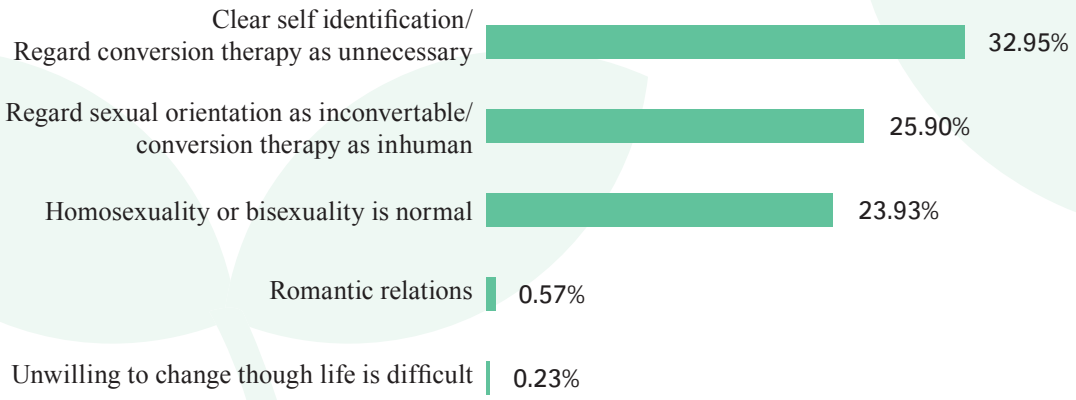

Fig.35 Reasons participants did not consider conversion therapy

2. Reasons LGBT People Seeking Conversion Therapy

Of particular importance, nearly one-tenth of participants were open to undergoing conversion therapy. When participants were asked for their reasons, 133 responded and 18 did not. 10 major motivations were identified, with "for parents or family members" as the foremost reason (30 participants), "to align with society and live normally" in the second place (29), and "stress/pain from living as an LGBT person" in the third (20). The percentages of these motivations are shown in Fig. 36.

Respondents' motivations for undergoing conversion therapy indicate that only 7.52% have taken it due to self-identity issues; pressure from family and society is the largest factor. A T-test demonstrates that participants who are willing to undergo conversion therapy and those who are not have no significant differences in scores on a sexual orientation scale (t=-1.874, $p > 0.05$). Furthermore, analysis suggests that sexual orientation scale scores have no significant correlation with willingness to undergo conversion therapy (t=0.046, $p > 0.05$). In conclusion, it is highly probable that those who consider attempting conversion therapy are not doing so due to sexual orientation identity issues.

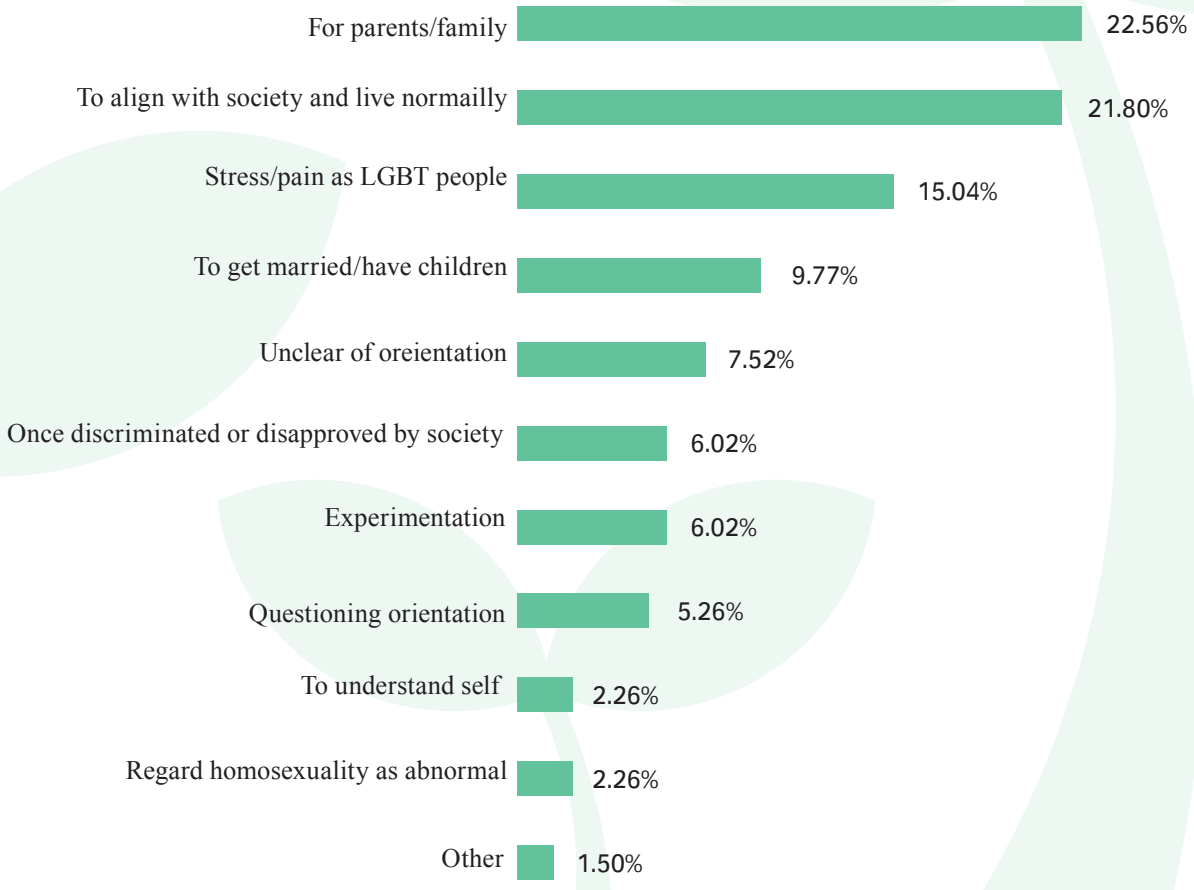

Fig.36 Reasons LGBT people seek conversion therapy

3. LGBT people willing to undergo conversion therapy are at higher risk for depression and have lower self-efficacy

3.1 Higher Risk of Depression

Research shows that participants inclined to conversion therapy have a mean depression score of 12.40±6.64, while participants averse to conversion therapy have a mean score of 10.21±6.38. A T-test shows that depression levels are significantly higher in participants willing to receive conversion therapy (t=3.992, $p < 0.001$). The distribution of depression scores (Fig.37) and a chi-squared test indicate that there is a significantly higher proportion of subjects at high risk of depression among those willing to receive conversion therapy than among those who are not (χ^2=13.817, $p < 0.001$).

3.2 Lower Self-Efficacy

Analysis shows that the mean self-efficacy score of participants who are inclined to undergo conversion therapy is 25.75±4.94, while that of participants who are not inclined to is 27.41±5.30. A T-test indicates that those who are willing have significantly lower self-efficacy (t=-3.683, $p < 0.001$).

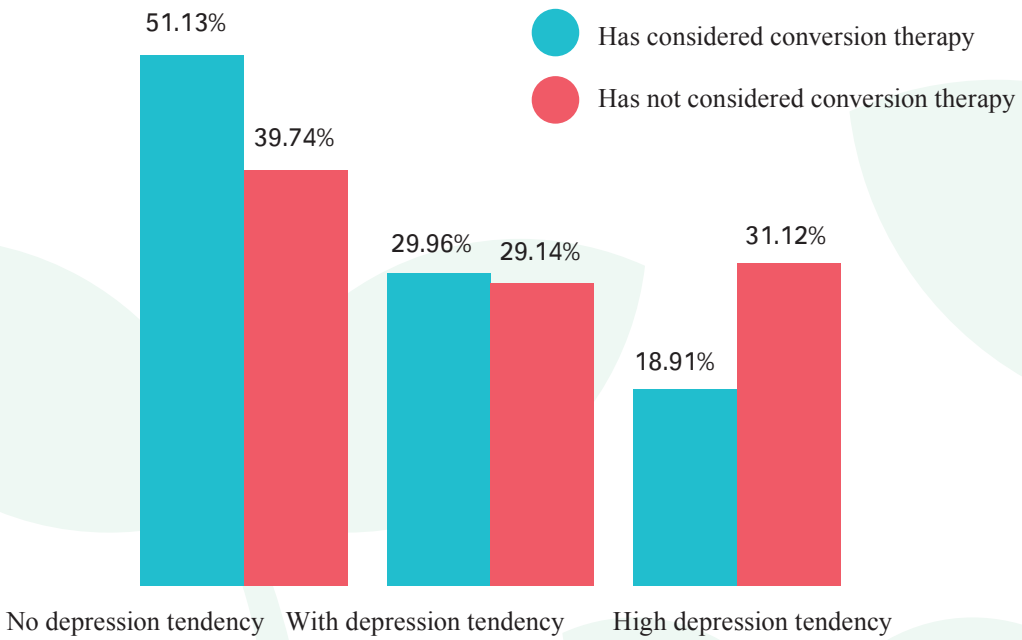

Fig.37 Comparison in depression tendency between those who have considered conversion therapy and those who have not

2. Procedure and Effects of Conversion Therapy

1) Reasons for Undergoing Conversion Therapy

The 18 participants stated the following reasons (Table 7):

Table 7 Reasons for undergoing conversion therapy

Reason	Number of cases
Coercion by parents	6
Failed relationships	5
Believing homosexuality to be abnormal	2
Psychological stress	1
Socializing difficulty	1
Enforced disclosure of sexual orientation	1
Fear of AIDS	1
Experimentation	1

As Table 7 demonstrates, “coercion from parents” is given as the most significant reason for receiving conversion therapy (6 cases). For instance, one participant said in an interview: “My mother threatened me by saying: if you don't go to therapy or turn straight, you'll never go abroad.” Another said “but they [parents] never accepted... they're against homosexuality.”

The second most cited reason was failed relationships. In interviews, participants stated: “When my first relationship ended, I felt that life in the [LGBT] circle was awful. I was very stressed.”; “All day it was like living underground.”; “There was too, too much pain and confusion in life being a gay person.”

2) Conversion Therapy Methods

Among the 18 research subjects' conversion therapy experiences, the longest ones lasted at least 1 year (3 cases) while the shortest lasted 1 session. The highest frequency was 3-5 sessions per week. Methods employed, similar to those in past conversion therapy case studies published in China, include (Table 8):

Table 8 Methods employed and number of cases

Method employed by counselor	Number of cases
Asking subject to think of the opposite sex's attractiveness; advising subject to date people of the opposite sex	6
Hypnosis	5
Aversion therapy and pain therapy	4[Note 1]
Oral medication	3[Note 2]
Sandbox	2
Suggesting isolation from same-sex groups or partners	2

Note 1: 2 cases of electroconvulsive therapy.
Note 2: 1 case of administering medication similar to male hormones.

Participants' responses identify the most common conversion therapy method as “asking subject to think of the opposite sex's attractiveness; advising subject to date people of the opposite sex”. Since this method appears harmless, it is easily overlooked or not recognized as a form of conversion therapy; however, it may intervene and impair the subject's self-identification. One participant said in an interview: “That therapist pushed all the responsibility on me. He told me that if I find a girlfriend, if I like women, if I become heterosexual, then all my family problems would be solved... The therapy sessions made me very uncomfortable. Each session ended with me doubting my previous thoughts, [such as] wondering if it was right for me to be gay.”

The most harmful and most easily recognizable methods are aversion therapy and pain therapy. Three participants stated that these methods were extremely painful. Two of these participants also received electroconvulsive therapy. This is a case of erroneously employing psychiatric therapy methods for a non-psychiatric psychological disorder. One participant who sought conversion therapy because of a failed romantic relationship described the electroconvulsive therapy he received. The therapist had used three methods (electroconvulsive, medical, and psychological therapy) on him once per week for 3 months. “Each week I received an electric shock and was given medicine to induce vomit.” During his treatment, guidance and electric shocks were administered simultaneously. “There was a TV in the room. He'd sit you on a chair that had wires and needles on it. And then he'd play videos for you, videos of men having sex, and when the video ended and you were feeling kind of excited he'd lightly shock you. If you were into it he'd shock you really hard. After the shock my head would feel kind of dizzy. Anyway, at first I'd immediately jump up and resist, fighting back really hard. Then he'd try talking you into it, telling you that it's therapy, you have to accept it, or the therapy will fail. Think about how smooth your life would go if you successfully turned back into a straight person. Things like that to make you go back. Later he said, if you really can't stand it, we can use leather straps to secure you. The shock will last for a few seconds, but don't worry, your life won't be in any danger.”

When participants in conversion therapy told their therapists about their sexual orientations, therapists/counselors (excluding the 2 therapists who used electroconvulsive therapy) displayed the following attitudes: appeared to accept the subject but guided them towards heterosexuality (6 cases); disgust (2); kind and willing to listen (2); neither supported nor opposed (1); and embarrassment (1).

3 Effects of Conversion Therapy

Effects of conversion therapy on sexual orientation: 5 participants said that their sexual orientations remained unchanged and 4 felt surer of their sexual orientations. None of the participants indicated that their sexual orientation was altered. In addition, out of 5 community members who had received conversion therapy and declined interviews, 4 stated that their sexual orientation was unchanged. A “successful conversion case” was found on an LGBT social website. Currently an active member on the website, this person wrote on her/his blog that she/he had begun to feel affection to the opposite sex first with help from a therapist and (later) through her/his own determination. The researchers contacted the person for details; the person agreed on further communication yet researchers were ultimately unsuccessful in interviewing her/him.

Effects on self-identification: 3 reported that conversion therapy disturbed their self-identification and induced inner conflicts with their sexual orientation; 2 reported that it caused self-hatred.

Effects on emotions and social adaptation: extreme pain (2 cases), increased depression (1), no improvement in anxiety (1), light masochistic tendencies (1), and 1 year off from school (1).

IV. DISCUSSION

1. Subjects Inclined towards Conversion Therapy

In this study, nearly one-tenth (151 participants, 9.14%) of participants have considered conversion therapy. Very few do so due to self-identity issues; the foremost reason is pressure from family or society. It is highly probable that LGBT people are not considering conversion therapy due to sexual orientation identity issues. Compared with LGBT people who do not wish to undergo conversion therapy, those who do so generally have higher levels of depression and lower self-efficacy.

Self-efficacy is defined as overall self-confidence when facing challenges in different environments or encountering new situations. It is a general evaluation of one's abilities to successfully cope with challenges. Individuals with high self-efficacy believe they are able to effectively control potential threats in their environment. They are more likely to face life events with active cognitive and behavior styles (e.g., optimism, seeking for help, and problem solving). They may experience more happiness and more life satisfaction as a result. Meanwhile, individuals with low self-efficacy often experience strong stress responses and anxiety, which leads to depression, a sense of pressure, and sadness. They are more likely to employ a passive attitude of avoidance. As societal discrimination against LGBT people is unlikely to change in a short period of time, LGBT people with low self-efficacy may find it more difficult to deal with bigotry and solve real-life problems under these circumstances.

If general self-efficacy in the LGBT community (especially among members inclined to conversion therapy) is raised, it may help them effectively protect against stress and seek positive problem-solving tactics. Extensive research by Bandura et al. has shown that self-efficacy is mainly formed through four routes: 1. Past experience: experiences of success help raise self-efficacy, while failure lowers it. 2. Modeling: if an individual observes a similar individual succeeding through hard work, they will believe that they too are able to succeed; conversely, observation of failures causes doubt in the observer's own abilities in similar activities. Furthermore, the more similar the observer perceives the model to be to themselves, the stronger the effect upon the observer's self-efficacy formation. 3. Social persuasion: an individual is more likely to persevere in an activity if they are persuaded that they have the ability to complete it. 4. Emotional states and physiological responses: emotions affect an individual's evaluation of their own abilities; positive emotional states may increase self-efficacy while negative ones decrease it. In conclusion, psychological healthcare service that improves LGBT people's emotional states and LGBT people acting as positive models may raise general self-efficacy in the LGBT community and reduce willingness to receive conversion therapy.

2. Procedure and Effects of Conversion Therapy

In this study, conversion therapy was shown to be highly ineffective at its goal of changing the subject's sexual orientations. In the 18 cases studied, none reported a change in their orientation; furthermore, conversion therapy has inflicted considerable harm and pain upon the participants, which may be attributed to the unscientific nature of conversion therapy. Homosexuality has been declassified as a disorder

in both the International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); however, this study has found no lack of cases in which treatments intended for psychiatric disorders were used on gay people. Another reason for conversion therapy's negative effects may be that psychotherapy/counseling should be, first and foremost, voluntary, while most LGBT people received it through coercion; they did not have severe self-identity disorders but were forced to undergo therapy by family members and society.

Psychological disorders among LGBT people are mainly caused by discrimination and bigotry from society. Therefore, it is even more crucial for psychotherapists to treat LGBT clients in a fair and equal manner. They need to clearly inform these visitors that homosexuality is not a disorder so as to eliminate feelings of shame. Therapy should employ affirmative psychological intervention and use direct methods to reduce symptoms; and protect, restore, or increase self-esteem, performance, and coping methods (Cao, Hu, and Huang 2012). Regrettably, feedback from participants who have received conversion therapy indicates that few therapists were truly accepting of the participants' sexual orientations when discussing them in therapy. The majority appeared tolerant but attempted to guide participants towards heterosexuality.

Research also shows that the majority of LGBT people received information on conversion therapy through the internet and news media; very few became aware through LGBT NGOs. This suggests that more educational programs are needed to introduce to the LGBT community the reality of conversion therapy.

V. INADEQUACY AND PROSPECTS

This research is inadequate in the following aspects:

1. Due to the concealment of the LGBT people, we could only look for those who had gone through conversion therapies through related LGBT communities and organizations for convenience of sampling, which might cause sampling deviations.

2. The number of people interviewed in the current project who have gone through conversion therapies is still not sufficient compared with their wide distribution; the insufficiency is also the result of these people's self-concealment and their reluctance to participate the interviews as conversion therapies have brought so much pain to them. On the other hand, it is likely that some LGBT people have had their sexual orientation "changed" and cut their contact with the community, hence not able to be contacted. We may use RDS driven sampling methods in the future to improve our research.

3. This research does not involve any counselors. In the future, we may cooperate with relevant institutions to implement stratified sampling method in order to survey the counselors and psychiatrists nationwide to find out their attitudes towards the counseling and treatment of the LGBT people.

Acknowledgments
References
Appendix

ACKNOWLEDGMENTS

We would like to thank the Ford Foundation and the Los Angeles LGBT Center for providing financial support for this study.

We would also like to thank Fang Gang[1], Guo Xiaofei[2], Nie Jing[3], Shen Dongyu[4] and other scholars and clinical psychologists for reviewing this report and for providing valuable comments and advice.

We want to thank the following individuals and organizations for their help and support in drafting and finalizing this report:

1.Fang Gang, Professor of Applied Psychology; Director of Research Institute of Gender and Sexuality at Beijing Forestry University; graduate student mentor/instructor

2.Guo Xiaofei, Ph. D Renmin University of China; Associate Professor of China University of Political Science and Law

3.Nie Jing, Lecturer and Counselor with Mental Health Education and Consultation Center of Peking University; Certified Psychologist of China Psychological Society of Clinical Psychology.

4.Shen Dongyu, renowned psychotherapist

REFERENCES

Baeck, H., Corthals, P.& Borsel, J. V. (2011). Pitch characteristics of homosexual males. *Journal of Voice, 25*(5), e211-e214.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review, 84*(2), 191.

Cochran, S. D., Sullivan, J. G.& Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of consulting and clinical psychology, 71*(1), 53.

Ireland, S. E.& Arthur, H. M. (2006). Integrating self-efficacy and aging theories to promote behavior change and reduce stroke risk. *Journal of Neuroscience Nursing, 38*(4), 300-308.

Mays, V. M.& Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91*(11), 1869-1876.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin, 129*(5), 674.

Tsang, S. K.& Hui, E. K. (2006). Self-efficacy as a positive youth development construct: conceptual bases and implications for curriculum development. *International journal of adolescent medicine and health, 18*(3), 441-450.

Zhang, J. X.& Schwarzer, R. (1995). Measuring optimistic self-beliefs: A Chinese adaptation of the General Self-Efficacy Scale. *Psychologia: An International Journal of Psychology in the Orient.*

Wang Caikang, Hu Zhongfeng and Liu Yong(2001). Evidences for Reliability and Validity of the Chinese Version of General Self-Efficacy Scale. *Chinese Journal of Applied Psychology. 7*(1), 37-40.

A short Chinese version of center for epidemiologic studies depression scale. *Chinese Journal of Behavioral Medicine and Brain Science, 22*(12), 1133-1136.

Guan Qinghua. (2010). Analysis on the Formation of College Students' Attitudes Towards Homosexuality: Taking Examples from Universities at Chong Qing. *Journal of Kunming University of Science and Technology (Social Sciences), 10*(6).

Cao Linfeng, Hu Youjun & Huang Jinwen. (2012). Pyschological Intervention of 26 Male Homosexual depression cases (self-translation). *Nursing and Rehabilitation Journal, 11*(8), 767-768.

Liang Bin & Kang Xudong. (2012). College Students in Chengdu about Their Knowledge and Attitude towards Homosexuality. *Chinese Journal of School Health, 33*(2), 211-212.

Zhang Jie, Wu Zhenyun, Fang Ge, Li Juan, Han Buxin & Chen Zhiyan. (2010). Development of the Chinese Age Norms of CES-D in Urban Area.*Chinese Mental Health Journal.*(2), 139-143.

Fu Xiaolong, Su Ning, Mu Qi'er & Liu Anqi. (2012). An Investigation of College Students' Cognition and Attitude to Homosexuality and Substantial Research. *The Chinese Journal of Human Sexuality, 21*(1), 22-28.

Liu Huaqing. (1998). Study of 75 Cases of Homosexual Psychological Status (self-translation). *Journal of Chinese Behavioral Medical Science, 7*(3), 212-213.

Liu Huaqing, Zhang Peiyan, Zou Yizhuang, Liu Jiqing, Li Xianyun, Guo Xufang, Yao Fuxin, Zhang Ximei, (2000).Psychology of homosexuals and contributing factors of homosexuality. *Chinese Sexological Science, 9*(1), 15-18.

Zhang Yan & Chen Fuguo. (2007). Progress in Study of Sense of Self-Efficacy and Its Relations with Psychological Health (self-translation). *Chinese Journal of Behavioral Medical Science, 16*(4), 377-378.

Chen Shaojun, Dai Xinmin, Li Shunlai & Ji Hong. (2008). A Survey on Public Attitude toward Homosexuality in Wuhan. *The Chinese Journal of Human Sexuality. 17*(8), 11-15.

Chen Xiuyuan. (2008). Homosexual study in China: Reviews and prospects——A Literature Review of 178 Academic Articles Published Between 1986 and 2006. *The Chinese Journal of Human Sexuality. 17*(11), 30-30.

Chen Xiuli & Feng Wei. (2003).Analysis of The Perceived Self-efficacy's Effect on Mental Health. *Health Psychology Journal. 11*(4), 270-271.

APPENDIX I: Organization Introduction

The Beijing LGBT Center

Founded on February 14th, 2008, Beijing LGBT Center is a non-profit, community-based organization that empowers the Beijing lesbian, gay, bisexual, transgender (LGBT) community through providing social services and organizing advocacy programs. Their work seeks to further the LGBT movement, eliminate discrimination and help the LGBT communities to have a healthy, independent life with dignity.

To achieve the missions above, Beijing LGBT Center has the following strategic goals:

1. To provide various resources for the discussion of LGBT issues and for the LGBT community development.
2. To provide professional psychological aid to the LGBT communities in Beijing and LGBT groups in other regions.
3. To build LGBT-friendly networks with experts, scholars and LGBT groups around China.

The Mental Health Department of Beijing LGBT Center was founded in 2010. Since then it has been providing professional psychological counseling services. Now it has a psychological counselor team of 14 certified members, offering individual and team counseling services. It has served more than 1,000 clients.

Since December 2012, Beijing LGBT Center has recognized the importance of gender diversity advocate education. It has held three LGBT-friendly psychological counseling training sessions for certified counselors in Beijing area and has recruited more than 80 counselors to the LGBT-friendly network. In June 2013, Beijing LGBT Center initiated a research on homosexuality conversion therapy, aiming to further promote gender diversity and gender equality education.

Chinese Academy of Sciences (CAS), The Institute of Psychology (IP)

The Institute of Psychology (IP) of the Chinese Academy of Sciences (CAS) was established in 1951 in Beijing. Its predecessor was the Institute of Psychology, Academia Sinica, which was founded in 1929.

The institute strives to understand the human mind by exploring both the biological and environmental factors underlying the mind and behavior. It also aims to become a world-renowned research center that promotes scientific innovation and socioeconomic development.

The institute comprises the Division of Mental Health and Behavior Genetics, the Division of Cognitive and Developmental Psychology and the Division of Social and Engineering Psychology. In addition, the institute is home to the CAS Key Laboratory of Mental Health and the Institutional Key Laboratory of Behavioral Science. IP's main research areas include early identification and intervention for mental disorders; social prediction and decision making; disaster and trauma psychology; cyber psychology and virtual behavior; and development, education, and the cultivation of creativity.

Appendix II: Two Interviews with the Persons Who had Gone through Conversion Therapies

I: Interviewee A

Male, born in 1996, student living in Beijing. He had several boyfriends but none of the relationships last long. He has had sex with males. He is eager to pluck himself out of the miseries he suffers as a gay man in China through going abroad.

All of his friends and classmates already knew his sexual orientation before he came out to his parents. He felt that his friends and classmates "thought it was normal. The only difference between me and them is sexual orientation and they never treated me differently because of this." He said."

During his second junior middle school year, his mother suspected that he was gay. She took him to a counselor at a counseling office for teenagers' mental health. The counseling lasted for two hours. As he said, he "did not have a concept for homosexuality" at that time. "I was still very young and I didn't want to admit it that early," he said. He discerned that the counselor was probing his sexual orientation and successfully convinced the counselor that he was heterosexual.

He came out to his mother after a quarrel with her this year. She could not understand it at all and mandated that he receive conversion therapies. After going to the conversion therapy for five or six times, he stopped because he had to prepare for the exams in order to study abroad. This June, his mother was diagnosed cancer and threatened him that she would not allow him to go abroad if he did not continue receiving the therapy and became heterosexual.

Receiving the Conversion Therapies under his Mother's Pressure

"I came out to my parents in last November." He had been getting along very well with his mother. But after he came out, she "could not understand" his being gay. "She often came to talk with me and often felt very disconsolate." His mother told his father about it and his father's attitude was neither supporting nor opposing, which "was better than I had imagined". "But my mother's reaction was that she could hardly comprehend and often ehhh... asked me a myriad of questions such as 'do you have a girlfriend' or 'why on earth is this happening' and still couldn't get it straight," he said.

"I never felt so big a difference between me and other people before I came out to my parents. But after I came out, my mother told me that anyway she felt this kind of thing was disgusting. I also think that my mother is quite sentimental in that sometimes;she'd rather I committed crime (rape) than be gay. That she was always saying so made me feel like being criminal for real."

"What she said would eventually affect me

though I didn't like them. Then I started thinking that it was indeed difficult for gay people to live a life in society nowadays because gay people don't have some basic rights such as marriage, procreation, etc., that many people have. So I was wondering if I had really ehhh... gone awry or ummm... had done something wrong. Then I had this interview with a counselor."

"I have been very unsettled for a while. I thought that if I was not gay, if I were straight, no matter whether man or woman, and if I could conform to the world and go with the mainstream of the society, then it would be much better and there would not be so much trouble for me and I would get along pretty well with my parents."

He decided to be separated from his mother for a while because his relationship with her had not been so well since he came out. He stayed by himself in one of his parents' apartments and his father in another, while his mother went to stay with some relative. After half a month, the family reunited because his father got ill. This time his mother told him that she had found a psychiatrist for him. "My mother feared that I wouldn't go and said the psychiatrist would mainly treat her and my father. But I know it was for me..."

This therapist A was somewhat famous and charged 3000RMB per hour. The interviewee A went there once a week and after five or six visits, he decided to stop.

This June, his mother was found to have cancer. "She got even more terrified because she always thought she would die soon, and then I can do whatever I want." Then his mother again contacted the same therapist. "But I really didn't want to talk to the therapist. It was expensive and I didn't want to receive therapy like this. The more he wanted to cure me, the more I would rebound, like rebellion." But his mother threatened him, "If you do not go to the therapy or become straight, then don't go abroad."

The Process of the Conversion Therapy

During the first interview the therapist A tried to find the reasons of the interviewee A's homosexuality. He investigated the interviewee's family background and his growing-up experiences. "As to the first talk, at the beginning he talked with my mother while my father and I were sitting outside. Then we together talked with him and actually he said that homosexuality was normal for a small group of people. He just said this was normal for a small group of people. Then he explained some possible reasons since he had known some situations of my family."

After the first talk the interviewee A started to go there alone "about once a week". "We didn't talk about my sexual orientation" in the second time (which was also the first time he went there alone) "because my mother and I just had a quarrel before the therapy and I just threw all my complaints to the therapist". "In the following two or three sessions he just tried to help solve well... our family conflicts. But I thought if he could solve the problem of my sexual orientation, lots of my problems would be solved automatically."

"It's maybe in the third or fourth session that we began discussing my sexual orientation. Well... Because I wanted to ease my mom a little I told her I was bisexual when I first came out. But actually I feel that I am mainly homosexual

and bisexuality is just a tiny bit for me.

"I had several boyfriends and we had sex in the past but we didn't last long. The therapist insisted that it is these experiences that turned me gay. He said I never experienced and thus didn't know what heterosexuality was like. So he told me to try. He said I was actually not homosexual but just had homosexual behaviors in this specific period of time.

"Just after a few talks, he began to try to switch our topic to heterosexuality, such as 'you'll never know if you haven't been with a girl' or 'it'll be much easier if you are with a girl in society nowadays'. Maybe he thought that at least I wasn't transsexual and that I hadn't imagined myself as a girl. So he thought it was probable for me to become heterosexual and kept talking with me on this."

The interviewee A mentioned that he had received some hypnosis in the process of the therapy but did not provide further details.

After five or six treatments, the interviewee A decided to stop it. He pretended that he already accepted the possibilities of being heterosexual and told the therapist A "oh, I think it's possible for me to accept a woman". "I didn't want to find trouble for myself anymore." The interviewee then cut the therapy short because he had to prepare for the exams in May and June for studying abroad.

One of the reasons that interviewee A stopped the therapy is that he had strong antipathy towards it. Since the third or fourth interview, the therapist A tried to drag him onto heterosexuality and thought it was probable for the interviewee A to become heterosexual. The therapist A constantly dropped this hint and advised him to "try more", "try seeking the feeling of having a girlfriend". The interviewee A said "the more he said the more I disliked it". "After having experienced all of these I... well, I became more convinced, I mean I will be going all the way (to be gay) to the end."

"I had a feeling I was gay when I was very little and I started having crushes on guys. So I thought this kind of thing was born this way. So I don't want to change anymore."

Another reason is that he read reports that some laws and regulations supporting homosexuality were promulgated in foreign countries during this period of time and he wanted to improve his living conditions through going abroad. "Since I read so many reports, and there were indeed many, that recently in a lot of countries like the UK and the US many rights of gay people got recognized legally, like the same-sex marriage bill in Britain and some bills in America... so I thought this kind of thing was being accepted worldwide." "I don't think I need to make changes anymore."

The Results and Impacts of the Conversion Therapy

As for the conversion therapy the interviewee A had received, he thought, "I couldn't get the help I wanted through this therapy my parents threw on me. In Beijing, especially where we lived, I couldn't find help and I don't know whom I could turn to in order to find answers to my questions. During that half year, I just went to whichever institute my parents wanted me to go. I knew this kind of therapies was a tremendous harm to my body and mind, but I couldn't

find other aid, because there was not some famous or concrete system to help these people to get psychological support or something like that."

"As for what I think about the therapist, he didn't give much help to my family. He just threw all the blame on me and told me to get a girlfriend and like females and become heterosexual, and after that my family problems could be solved. He should have told my parents that to be gay was normal and they should understand. But not a single word like that... I think actually the main problem lies in my parents. I had thought that he would talk a lot with my parents but I didn't expect that instead he just talked with me, on my sexual orientation, etc. which made me really miserable. I felt that this guy is totally useless."

Every session of the treatment was a challenge to the self-identification of the interviewee A, after which he had to struggle to regain his self-recognition and self-esteem. "From my coming out to our separation (between A and his mother), then to the counseling...I always went to see this therapist after school. Every time I went to see him, I would feel miserable for the whole day. I became uncertain about the things I had believed in, such as 'is it right to be a gay?' But anyway I thought I was right and I had to be true to myself. Another week passed and another session came and the same feelings arose like a cycle during that period of time."

II: Interviewee B

male, born in 1984, undergraduate, working and living in Shenzhen

"I seem to care more about boys since I was a child. I may like girls but I feel they won't turn me on. If I am held in a boy's arms, I will be turned on." He determined his sexual orientation at the age of 22. "If I am heterosexual, I should be involved physiologically and psychologically. But I seem to like girls just psychologically and I don't have feelings for girls physiologically. But I seem to like guys both physiologically and psychologically. So I think I am gay."

Seek Conversion Therapy because of Setbacks in Emotional Life and Pressures of Being Gay

In 2011, the interviewee B received conversion therapy. "Because that was the end of my first relationship. I felt that gay people's lives were terrible and I felt great pressure. I felt like living underground. And I was perplexed at that time and didn't know how to continue my life."

"I suffered a lot after the breaking up because it was my first love anyway. But after that I thought about this carefully. I might have had some feelings for girls in the past... In my college years I loved a girl secretly, who was cute in my eyes. I might have a crush on her, but I didn't know if it was love derived from the crush. I was confused. I was wondering if I was a pure gay man or if I had a chance to change. Because living as a gay man is painful. I was confused."

The interviewee B said, "Why did I take the therapy? One of the reasons is that I wanted to have a better life. But more importantly it was for my parents and my family so that they wouldn't suffer because of me. That was the main purpose."

"I just surfed and searched online and found

a cheap one to go for further information."

The Process of the Conversion Therapy

The interviewee B received conversion therapies once a week for a total of three months. The therapist used three methods including electric shock, medication and psychotherapy. "Every week I had an electric shock and took emetic drugs. He also gave some medicine for daily uses and he said these pills would help me sleep well."

Before the therapy, the interviewee B took a psychological test to determine his sexual orientation. "He gives you some forms that look like psychological tests to judge whether you are absolutely homosexual or bisexual or whatever it is." "It seemed that the test showed that I was bisexual and he said there was a chance for me to turn back to be heterosexual. Then he introduced to me the similar cases he handled before, including the treatment procedure and the current status of the few gay men he had cured. I believed him at that time."

During the therapy, electrical shock and induction were carried out simultaneously. "He (the therapist B) would give you some instructions on thinking. Then he just asked you to relax and after you fell into certain state of mind, he would start showing some porn videos. He would keep playing both male-female porn and gay porn in turn. If you responded to the gay porn, he would shock you using electricity and said something to you, but if you had an erection during male-female porn, he also spoke but didn't give electric shock."

The electric shock therapy that the interviewee B had received was like this. "In the room there was a TV set and he would let you sit on a chair on which there were some wires and needles. Then he would play porn videos for you and it was gay sex. After you watched it, he would give you a mild shock when you felt turned on. Then when you were excited, he would give you stronger shocks and you would feel a little dizzy then. At first I jumped up immediately once I got shocked and refused it and became really rebellious. Then he tried to persuade you that this was the process of the therapy and you had to accept it or it fails. 'Just think that your life will be a lot easier if you get back to be heterosexual successfully.' He would say things like this and got you back in the chair. Afterwards he said that if you really could not bear it he could use a belt to tie you up. He said the shock would last for a few seconds but you need not worry. There would be no real danger for your life."

About a month later, the interviewee B "already had no reactions" when he saw gay porn. Then the therapist B told him, "'now you are at a state of recovery. You are starting to turn to be heterosexual.'" "That was roughly what he said," our interviewee recalls. "He (the therapist B) said it was a good sign, gradually 'you can start to appreciate the organs of females and the beauty of women and imagine that you are with them and you would have that feeling.' Actually because I felt that I could have sex with both male and female I mean I could do it with girls. So when I imagined as he constructed, I indeed had erections. So as he said this was a change

that testified that I was being cured. That meant that the process of converting to be heterosexual had gradually begun. But I thought this was kind of stupid when he gave you thinking instructions by your side and inducted you to see those parts of women bodies and got an erection. But if you saw males and had similar responses you would get shocked or emetic drugs. In fact for a certain period after that, I may feel uncomfortable when I saw male nudity."

The Impacts of the Conversion Therapy

According to the interviewee B, the whole process was a torment to him. "When there was still one week to go, I felt I could hardly hold on anymore. I felt very pessimistic about my life. I wanted to find someone I could confide in but I could find none. At that time I liked to walk on some dark roads, and in the dark I cried, and I cried without knowing whom I could turn to for help. I dare not make a phone call and I just felt desperate."

"The reason of my being pessimistic is that I didn't get the good results that I had expected despite the fact that I have spent so much money and suffered so much. I quit my job to take the therapy as I just couldn't work normally at that time. I just felt that I was useless for society and it was meaningless for me to live. People like me would bring lots of difficulties to the family and wouldn't be successful in career as others because people like me are frowned upon in society. I got very desperate, really desperate since I could change nothing."

The interviewee B thought of suicide but "the desire for life and the responsibilities for the family" made him abandon this idea. "Committing suicide is selfish. I couldn't do that to my family, so I stopped thinking about it."

Though having undergone such painful therapy and having lost interest in gay porn during the process, he thought "the so-called conversion therapy didn't have any effect but making me suffer." In addition, "One of the keen feelings I had about it was that I had lost interest in both boys and girls. Every day I was absent-minded and in low spirit and I felt extremely uncomfortable and I refused to go to the therapy."

"About two or three months after the end of the therapy, I felt that my interest in boys gradually came back. Then I thought it was not possible to be changed. I felt the therapy hadn't worked and I was determined that I am a gay man. I should do just what gay people should do, honestly and firmly. Then I came out to my parents, then my uncles and my younger cousin."

北京同志中心
BEIJING LGBT CENTER

Address: Bldg B, Rm2606, XinTianDiPlaza,
XiBaHe Nan LuJia No.1, Chaoyang District, Beijing

Tel: 010-64466970
Email: bjlgbt@gmail.com
Fetion: 18810132334
Website : http://bjlgbtcenter.org
Weibo:http://t.sina.com.cn/bjlgbtcenter
Douban Site: http://www.douban.com/host/bjlgbtcenter
Feizan: http://www.feizan.com/space-659.html
Mailing List: http://t.cn/zYGyfe6
Facebook: http://www.facebook.com/bjlgbtcenter

Design: Su Wen Shao