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Turning Queer Villages into Ghost Towns: A Community Perspective on Conversion Therapies

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relevant religious group. A broader answer is that such complicity is prima facie wrong because of the just mentioned harms, but also because there is a nonconsequentialist duty to not be complicit in such norms, where this duty holds quite apart from any harmful consequences that such complicity might cause. Which answer is correct?

The second issue concerns patient partialism. Insofar as these cases involve trade-offs between the well-being of the patient and the well-being of others who might be harmed by the relevant norms, is it morally permissible for the patient’s physician or therapist to favor the well-being of their patient over the well-being of other people? Could such partialism even be morally required? And if it is permissible (or required), what differences in the well-being of these two parties does it permit (or require)? For example, is it permissible to provide such a therapy for one’s patient even though doing so will prevent only half the harm that it will indirectly cause to others? Or is patient impartialism, the view that harm to one’s own patient is not to be weighted any more than harm to other people, the correct view here?

The third issue is whether patient contracts are permissible in these cases. They are an attractive option that can help to minimize some of the troubling outcomes. For example, if one of these conversion therapies includes an ongoing drug prescription, might it be permissible to renew this prescription only on the condition that the patient not misrepresent the physician or therapist as helping to “cure” people of homosexuality? Or are such contracts impermissible because of how they impinge on patient autonomy?

The final issue concerns uncertainty. In many of these cases, the outcomes of providing this kind of therapy, including the effects on the patient, the effects on the relevant homophobic social norms, and the effects on other parties (especially gay members of the relevant group), will be difficult to predict. We need moral guidance about how to act when our evidence about any of these three kinds of facts (or any other morally relevant facts) is sparse. The natural place to start is with simple default policies. In cases where the evidence about these matters is sparse, is offering the therapy morally required, optional, or forbidden?

By answering these four sets of questions, the authors can fill out their account. First, is complicity with homophobic social norms prima facie wrong solely because of its harmful consequences, or is it also wrong for nonconsequentialist reasons? Second, does a principle of patient partialism apply in these cases? If it does, what does the relevant partialist principle say? Third, are patient contracts permissible in these cases? If so, what kinds are permissible? And last, how should physicians and therapists proceed when there is insufficient evidence to make predictions about the effects of the envisioned therapy?

REFERENCES


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**Turning Queer Villages into Ghost Towns: A Community Perspective on Conversion Therapies**

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Science is rapidly deciphering the biological basis of human sexuality and desire. From this knowledge may emerge means to control these traits, and with it, one’s sexual identity. This issue’s target article by Earp and colleagues (Earp, Sandberg, and Savulescu 2014) highlights one ramification of concern from such biomedical innovations: Emerging capacities to suppress or “convert” same-sex attraction not only signify unprecedented control over one’s sexual orientation, they also threaten to diminish and disempower already vulnerable Queer communities. Cognizant of these potential harms, the authors rightfully claim that such biotech conversion “therapies”—or as coined here,
“anti-gay-love” drugs\(^1\)—must be regulated so that they are not forced upon others or administered to minors, though the authors concede that the use of such interventions may be justified on the basis of individual consent and respect for autonomy. Without question, upholding one’s choice to determine one’s sexual orientation based one’s higher order values is an important consideration. However, when justifying the use of anti-gay-love drugs, individual-level factors must be part of a much broader analysis that includes community-level considerations as well. We thus aim to support the authors’ conclusions that “there are a large number of possible ‘wider’ objections” and “other reasons why societies might justifiably seek to manage (or restrict access to) [conversion therapies]” (11), and provide definitive examples of such reasons.

Having the potential to “chip away” at small and already threatened minority groups with the result of transforming Queer villages into ghost towns, we argue that Queer communities have grounds to demand far greater protections and restrictions on access to anti-gay-love drugs. Previous attempts to hollow out Queer communities are indeed all too common in recent history, and the implementation of anti-gay-love drugs represents yet another means to advance such homophobic ends. We propose to apply principles of community consent and consultation to the specific historical experience of sexual minority groups. These population-level perspectives aim to contextualize and limit claims that the autonomous decisions of individuals are the primary ethical consideration in the introduction of anti-gay-love drugs in society.

TURNING QUEER VILLAGES INTO GHOST TOWNS: A SORDID HISTORY

The authors of this issue’s target article devote much discussion to anti-gay stigma. Despite mention of endemic hate for sexual minorities in society, this topic merits further depiction, framed especially within the authors’ arguments concerning the ethics of implementing biotech conversion therapies. Particularly noteworthy is their statement that “rather than take aim at the means it may be more productive to actually discuss the ends for which [new biotechnologies may be used]” (11, emphasis added) Here we highlight that numerous means and political decisions have stifled the existence of Queer communities; anti-gay-love drugs have the potential to continue this historical trend. The devastating effects of homophobia therefore suggest that rather than emphasize goals of autonomy, an ethical society should strive for more laudable “ends” focused on breaking the continuing cycle of assaults on Queer populations.

During World War II, thousands of gay men were interned in concentration camps, tortured, murdered, and subjected to forced labor and inhumane “experiments” (many of which focused on conversion therapies); numerous others were forced into exile (Plant 1986). Systematic assaults upon Queer communities continued long after the war, where police routinely raided Queer establishments. In outrage, many communities rioted in opposition to oppression, resulting in events such as the Stonewall uprising in New York (Duberman 1994). Stemming from political inaction at the initial stages of the epidemic, HIV/AIDS decimated newly empowered Queer communities in the post-Stonewall era. Due to taboo and the advantage accrued from distancing oneself politically from Queer groups, health authorities dithered while ever-growing numbers of gay and bisexual men perished (Shilts 2007). To this day, policies in many jurisdictions inhibit Queer family building or force many into “reproductive exile” (Inhorn and Patrizio 2009), exemplified by regulations that bar assisted reproduction services to same-sex couples. Targeting populations of sexual minorities, such restrictions on reproductive freedom carry unsettling eugenic undertones.

For communities to flourish, members need a secure environment that enables their assembly, opportunities for friendship and family building, and the ability to establish a distinct culture. As demonstrated in the preceding, Queer communities continue to face numerous assaults on all these fronts, signifying that the least sexual minorities need—or should tolerate—is the introduction of clinically irrelevant, high-tech means to once again fragment their communities. As a result, Queer populations the world over will likely insist on far greater restrictions in access to anti-gay-love drugs than those proposed in the target article. Rather than placing the needs of individuals at the nexus of decision making, the appropriate conditions for the use of such drugs are arguably better defined through consultation with Queer communities themselves.

BEYOND THE INDIVIDUAL: COMMUNITY PERSPECTIVES IN BIOETHICS

Since its inception, cornerstone principles of bioethics have focused on the need to respect personal autonomy. Embracing an “atomistic view of the person,” early bioethics scholarship made “little or no reference to persons in relationship to others or as members of communities” (Levine 1988, 13). This has been particularly true in the areas of clinical ethics—to counter long-standing paternalistic values—and research ethics—in reaction to the atrocities of inhumane experimentation. More recently, however, bioethical discourse has begun to acknowledge the need to expand ethical considerations beyond those related to individuals.

First, recent studies demonstrate that even while protecting individual participants, research findings can pose harms to particular communities; the stigma resulting from studies that identified an increased prevalence of genetic

\(^1\) We choose this term to highlight that sexual orientation is not just about sexual desire: It is about the ability to love. Many—especially homophobic conservative groups—do not acknowledge this reality and distill homosexuality down to a primal sexual urge. The more profound significance of the term “love” aims to remind readers that sexual orientation is not reducible to carnal urges. It is a human condition that encompasses multiple aspects of the life of the individual and their place within a community possessing a distinct culture and identity. See the documentary film A Cure For Love: http://www.nfb.ca/film/cure_for_love
disease risk factors among Ashkenazi Jewish communities is one of many examples (Weijer 1999). Second, emerging global perspectives in bioethics bring to light that not all cultures adhere to respect for personal autonomy as a prime value (Weijer 1999). In recognition of the need to address community perspectives in the assessment of benefits and risks, notions emerged of community consent for participation in research and of community consultation in the design of research protocols. The additional principle of “respect for communities” now complements traditional principles of research ethics (McCarthy 1993).

As in the case of research that creates tensions between individual choice and the vested interests of communities as a whole, the use of anti-gay-love drugs may pose threats to Queer communities that should be considered alongside individual consent. Both Queer communities and bioethicists must reflect on the possible unfortunate consequence of the accumulative choices of individuals when setting limits on the justifications and appropriate use of conversion therapies. While the current discussion of anti-gay-love drugs does not focus on research contexts but rather on the future implementation of such drugs, notions of community consent and consultation still apply well to this discussion.

Some key questions remain open, such as how best to define “community” within the context of Queer identity, and what properties Queer populations possess that make them “eligible” for the use of this label. Though beyond the scope of this commentary, it is necessary to point out that such questions remain at the center of ongoing debate for many communities and cultures. It is important to recognize that despite such debates many Queer individuals acknowledge unique identities circumscribed by their minority status, and share a filial-like relationship with fellow sexual minority populations (Slagle 1995). In light of this fact alone, the notions related to community perspectives in the use of anti-gay-love drugs remain relevant and merit further analysis.

CONCLUSION

Given that attempts to hollow out Queer communities remain all too common, it is essential that analysis of anti-gay-love drugs expand beyond issues of individual autonomy to consider on par the foreseeable risks such drugs pose to minority groups as a whole. The inclusion of community perspectives thus enables a more robust evaluation and practical understanding of human sexuality. Many individuals experiment with their sexuality with opposite/same-sex partners—sometimes throughout their lives—and do not identify as “gay,” “straight,” or “bisexual” (Martucci 2010). Thus, drugs are not a requirement for a person to explore new dimensions of sexual identity; such explorations are common and will remain an integral part of human sexual development. We are thus left with the real-world context in which the choice of anti-gay-love drugs is made within an undeniable social context that casts a heavy shadow of influence over what may be indeed considered an autonomous choice.

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