Variation in Conversion Therapy Exposure Across European Countries: A Cross-National Analysis and its Mental Health Implications

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Abstract

This article provides one of the first cross-national analyses of exposure to conversion therapy practices (CTP) across Europe, examining their prevalence, typology, and mental health consequences for LGBTQ+ individuals. Drawing on Minority Stress Theory and analysing a unique dataset from the 2023 EU LGBTIQ Survey (N = 100,577), we demonstrate that nearly a third of LGBTQ+ respondents report exposure to CTP — ranging from verbal humiliation to physical and sexual violence — with substantial variation across countries and identity groups. Using multivariate regression models, we show that CTP significantly worsens depressive symptoms, particularly among transgender people. Our mediation analysis reveals that identity concealment plays a key role in this relationship, suggesting that CTP operates not only as an acute trauma but also as a long-term mechanism of shame, silencing, and internalised homophobia. The findings offer strong support for all three of our hypotheses and indicate that CTP should be understood as an institutionalised form of identity-based violence. We conclude that legal bans on CTP, while essential, must be paired with cultural transformation and trauma-informed mental health care to effectively safeguard LGBTQ+ wellbeing.

Keywords

Conversion therapy, Europe, LGBTQ+, Mental health, Quantitative research

Introduction

By May 2025, more than a million Europeans had signed a petition submitted through the European Citizen Initiative that urges the Commission to propose legal bans on the harsh and antiquated practice of conversion therapy (Mangin, 2025). *Conversion therapy practices (CTP)* refer to a set of varying procedures which are intended to change or supress an individual's gender identity or sexual orientation (UN Human Rights Council, 2020). These practices include physical methods ranging from hormone treatments to sexual assault as well as non-physical techniques like psychotherapy or pastoral counselling. Less abstract, CTP may entail “advice on

repressing sexual attraction, a physician prescribing medication to suppress sex drive, or intentional delay of gender non-affirming care" (Kinitz et al., 2021, p. 2). Since CTP targets those whose sexuality or gender identification clashes with heteronormative ideals, the practice exclusively endangers members of the LGBTQ+ community who often suffer from long-term effects such as increased self-hatred, social isolation and depression (Fjelstrom, 2013). The way in which CTP discriminates against LGBTQ+ people is essentially through causing severe physical and psychological pain, denying them freedom to express their true identity and reinforcing the social subordination of these individuals (Trispiotis and Purshouse, 2022). Although the petition's success reveals widespread recognition of the practice's unethical nature and the popular push for governments to protect LGBTQ+ lives, only eight EU member states have officially banned CTP (de Groot, 2024). With this inhumane practice remaining permissible under law in most European countries, it is necessary to examine how frequent LGBTQ+ people are exposed to different forms of CTP across Europe.

So far, most studies have focused on CTP experiences among LGBTQ+ individuals — especially young adults — living in the United States (Campbell and Rodgers, 2023; Forsythe et al., 2022; Higbee et al., 2022). Notably, the European Parliamentary Research Service has reported that "there are no data or statistics about these practices in the EU" (de Groot, 2024, p. 2). We could only find one study carried out by a team of Dutch scientists in 2020 who discovered that 3.51% of LGBTQ+ respondents have been exposed to CTP. According to these scholars, this number may be only the "tip of the iceberg" because social stigma tends to hinder the open disclosure of such experiences (van Wijk et al., 2020). Thus, our aim to investigate CTP activity across the European continent fills a considerable empirical research gap. Importantly, this gap is not merely descriptive, but has direct theoretical and policy relevance. Given that legal frameworks, religious contexts, and welfare systems differ significantly between the United States and Europe, existing findings cannot be readily generalized to the European context. By providing systematic cross-national evidence, our study allows for a more context-sensitive understanding of how CTP operates within different institutional and cultural settings, and thereby contributes to both the refinement of Minority Stress Theory in non-U.S. contexts and to ongoing policy debates on the necessity and effectiveness of CTP bans. We are also interested in exploring the association between participation in CTP and the mental well-being of LGBTQ+ people. Research conducted in the U.S. shows that undergoing CTP is likely to result in increased psychological distress, depression, substance abuse and suicidal behaviour (Campbell and Rodgers, 2023; Forsythe et al., 2022; Higbee et al., 2022). Yet, this relationship has not been tested among European LGBTQ+ individuals which further adds to the academic relevance of our resulting research questions:

1. How prevalent are CTP practices across European countries?

2. What types of CTP practices are used to suppress an individual's gender and/or sexual identity?

3. How do CTP practices impact mental health outcomes among LGBTQ+ people in Europe?

Since evidence suggests that exposure to CTP significantly heightens the risk of suicide attempts, this study provides important research for policy-making efforts to prevent LGBTQ+ suicide (Terrell et al., 2022). More specifically, it may underline the need for implementing effective bans on CTP which also have symbolic value in recognising LGBTQ+ rights (Motmans et al., 2023). Thus, we hope for our research to incentivise future policy projects to target the ongoing incidence of CTP and reduce the discrimination of LGBTQ+ individuals.

Below, we explore our research questions through the application of Meyer's (2003) Minority Stress theory and the analysis of secondary data collected by the 2023 EU LGBTQI Survey. Descriptive findings indicate that a substantial share of respondents report exposure to conversion therapy. In more detail, we reveal how conversion therapy exposure varies depending on the particular practice type, country of residence, and the respondents' sexual orientation and gender identity. Our regression analysis shows that experiencing conversion therapy is significantly associated with depression amongst LGBTQ+ people. In addition, those belonging to a gender minority appear to be impacted most strongly by this effect which we consider a consequence of the tendency to hide one's true sexual orientation or gender identity after conversion therapy exposure.

The remainder of this paper proceeds as follows: We begin with explaining what conversion therapy constitutes and why it affects mental health. After situating our study in the existing literature and pointing to the missing research on European experiences with conversion therapy, we draw on Minority Stress theory to develop three hypotheses which help us capture the relationship between conversion therapy and mental wellbeing. Next, we describe our research methodology and concept measurements before interpreting the results of our descriptive and causal analyses. Finally, we reflect on the quality and limitations of our investigation and discuss important policy implications of our findings.

Literature review

We conducted our literature review by searching for peer-reviewed publications on the topics of conversion therapy practices (CTP) and their mental health impacts on LGBTQ+ individuals. The search focused on articles published in English within the last ten years in leading psychology, psychiatry, and public health journals, complemented by key historical and theoretical sources that were relevant to trace the evolution of CTP.

CTP encompass organized and sustained efforts to suppress or alter non-heterosexual sexual orientations and gender identities that differ from those assigned at birth, often reflecting cisnormative and heteronormative assumptions about sexuality and gender (Meanley, Haberlen, et al., 2020; Salway et al., 2021). The techniques employed in CTP span a broad spectrum of interventions, reflecting shifts in medical and cultural paradigms over time. Early methods included invasive neurosurgical procedures and both surgical and chemical castration aimed at physically altering sexual drives (Huneke, 2022; Rosik, 2003; Rowland, 2005). Aversion therapies, such as electroconvulsive shocks and the administration of emetic drugs, sought to create negative associations with same-sex attraction (Haldeman, 1991). More recent approaches have tended to focus on psychological and spiritual modalities, including hypnosis, counselling, and spiritual rituals intended to realign identity and desire (Roper, 1967). Additionally, techniques like visualization exercises, psychoanalytic therapy, and arousal reconditioning have been used to reprogram sexual responses, illustrating the diversity and evolving nature of these harmful practices (Ashley, 2023). It is important to recognize that CTP constitutes not only a harmful practice but also an expression of structural discrimination and violence against LGBTQ+ individuals (Trispiotis and Purshouse, 2022). What distinguishes it from other forms of discrimination, however, is that its primary objective is not humiliation or marginalization as an end in itself, but rather the alteration of one's sexual or gender identity. While the psychological consequences of CTP and other discriminatory practices often manifest similarly — through

damage to emotional well-being — the key variation lies in factors such as intensity, frequency, and the degree of institutional or reinforcement.

Keeping this in mind, our research requires a careful consideration of how exactly exposure to CTP worsens mental health amongst LGTBQ+ people. Much of this relationship can be explained by CTP being fundamentally rooted in the rejection of a person's core identity and often carried out through coercive, emotionally harmful means. By suppressing same-sex attractions and gender identities that do not align with cisnormative expectations, CTP communicates to individuals — implicitly and explicitly — that their authentic selves are unacceptable. This message fosters a range of psychological harms, including confusion, guilt, shame, depression, social withdrawal, and increased suicidality (Mercer, 2017). Particularly damaging are the coercive elements involved in many CTP experiences, such as threats of abandonment, loss of familial love, and spiritual condemnation, which are especially potent when the individual lacks alternative support systems. Research highlights that individuals raised in non-affirming religious or cultural environments are more vulnerable to these harms, as they are often deprived of the protective benefits of social belonging and positive self-appraisal (Meanley, Stall, et al., 2020). Moreover, scholars have drawn attention to the post-traumatic stress symptoms frequently experienced by individuals following CTP (Meanley, Haberlen, et al., 2020). These may result not only from the coercive nature of the practices themselves, but also from the prolonged internal conflict and psychological fragmentation that emerge when individuals realize they have not "changed" in the way their families, communities, or faith-based institutions demanded. This realization often leads to deep shame and a sense of personal failure, further reinforcing feelings of worthlessness and self-blame. First-person accounts illustrate the intensity of these effects — ranging from emotional numbness and trauma symptoms to a complete resignation toward life (Horner, 2010). The cumulative impact of being subjected to non-affirming messages, institutionalized shame, and social isolation contributes to deteriorating mental health. Therefore, CTP functions not as a therapeutic practice, but as a source of psychological trauma, with consequences that often persist into adulthood and require long-term healing.

Strikingly, the adverse effects that exposure to CTP has on the mental health of LGBTQ+ individuals have been investigated almost exclusively in the US. Meanley, Haberlen, et al. (2020) find that their sample — predominantly non-Hispanic white men with a mean age of 62.6 — includes 15% who reported prior exposure to CTP. In multivariable models, these men were significantly more likely to exhibit depressive symptoms and above-average levels of internalized homophobia. Furthermore, men who had undergone CTP had 2 to 2.5 times higher odds of reporting one or more psychosocial conditions compared to those without such a history. Similar findings are presented by Ryan et al. (2018), who show that both moderate and high levels of parent-initiated attempts to change a participant's sexual orientation during adolescence were associated with more severe mental health issues in young adulthood. Specifically, those who experienced sexual orientation change efforts (SOCE) — particularly those involving external conversion attempts — were more likely to report suicidal ideation, suicide attempts, and elevated levels of depression. Ogunbajo et al. (2022) report related results: a history of forced participation in CTP within religious institutions was significantly associated with increased odds of depressive symptoms and suicidal thoughts.

With regard to data from Europe, the UK Government's National LGBT Survey provides insight into the prevalence and nature of CTP experiences (UK Government, n.d.). Among respondents who reported undergoing

such practices, 51% identified faith organizations as the source, followed by healthcare professionals (19%), parents (16%), other individuals or organizations (14%), and community members (9%). The data also reveal disproportionate exposure among religious and ethnic minorities: 27% of Muslim, 16% of Jewish and Hindu, and 15% of Sikh respondents reported having experienced or been offered CTP, compared to 7% of non-religious individuals. Black (17%), Asian (16%), and Other ethnic groups (18%) also reported higher exposure than White respondents (7%). While men (8%) were slightly more likely than women (6%) to report such experiences, minimal variation across age groups suggests that CTP is not confined to the past. Reported motivations include religious conflict, internalized stigma, fear, negative same-sex experiences, and external pressure from families, religious institutions, or therapists. However, the report does not present empirical research from the UK directly linking CTP to mental health outcomes. Instead, it relies on international findings — primarily from the United States – to illustrate the psychological harms of such practices.

This lack of Europe-specific evidence reflects a broader trend in the existing literature, which remains disproportionately focused on the United States. For instance, *The Lancet*, one of the most influential journals in medicine and psychology, frequently centres its reports and editorials on the U.S. context when addressing CTP (Adelson et al., 2022; The Lancet, 2015) While the available research offers valuable insights, it overwhelmingly focuses on U.S. populations (Meanley, Haberlen, et al., 2020; Ryan et al., 2018). Even studies examining non-U.S. populations — such as those by Ogunbajo et al. (2022) and Salim et al. (2024) — do not include analyses specific to the European Union, leaving a notable gap in the literature.

This research gap is significant because the context of CTP in the United States differs noticeably from that in Europe. In the U.S., the phenomenon predominantly arises from religious, Christian communities – estimates suggest that approximately 81% of individuals subjected to CTP received it from a religious leader (Blosnich et al., 2020). However, this pattern may not translate directly to the European context, where religious affiliation is generally more secularized and mediated by state institutions, and where practices may occur across a broader range of formal and informal settings.

The legal landscape also varies considerably: the U.S. Supreme Court frequently issues rulings suggesting that bans on CTP may be unconstitutional, whereas in Europe, the prospect of banning CTP is more tangible, with several countries having already enacted such prohibitions (de Groot, 2024; Liptak, 2025). These differences inevitably influence the lived experiences of those undergoing CTP. In particular, variation in legal enforceability and institutional oversight may influence whether CTP occurs in more formalized or informal settings, as well as the extent to which individuals are protected from such practices.

Thus, the objective of our research to look into the prevalence of CTP across Europe and its effect on mental wellbeing amongst European LGBTQ+ individuals fills a significant research gap.

Theoretical Framework

To follow this objective and understand the effects of CTP, we draw upon Minority Stress Theory (MST) as conceptualised by Meyer (2003) which helps us explain differences in mental health outcomes between distinct subgroups within the LGBTQ+ community. The theory essentially describes Minority Stress to originate from unique stressors like experiencing prejudice, stigma, and discrimination which cause mental health problems (Frost

and Meyer, 2023; Meyer, 2003). Meyer differentiates between three stress processes, ranging from distal to proximal processes: '(a) external, objective stressful events and conditions (chronic and acute), (b) expectations of such events and the vigilance this expectation requires, and (c) the internalization of negative societal attitudes' (Meyer, 2003, p. 5). According to MST these stress processes collectively contribute to higher rates of mental health problems, such as depression, anxiety, and suicidality, among LGBTQ+ individuals when compared to heterosexuals (Frost and Meyer, 2023; Meyer, 2003). Especially relevant for our research is the distal stress process of CTP. CTP can be understood as a distal stressor, as it constitutes an external and objective form of identity-based harm imposed on LGBTQ+ individuals. Unlike proximal stress processes, which involve internalized stigma or expectations of rejection, CTP represents a direct, externally enacted attempt to alter or suppress an individual's sexual orientation or gender identity. As such, it functions as a concrete manifestation of societal stigma, operating through coercive practices that directly target the individual.

H1: *Experiencing CTP leads to worse mental health outcomes in LGBTQ+ individuals compared to those that have not experienced it.*

However, the impact of CTP goes beyond the initial event, as distal stressful processes lead to more proximal stress, such as heightened expectation of rejection, internalised stigma and concealment of identity (Frost and Meyer, 2023; Meyer, 2003). The experience of CTP influences how individuals expect the world to be, how they see themselves fit into this world, and therefore how they present themselves to the world, reinforcing concealment and shame. This concealment can result in rumination, a psychological process in which one keeps thinking about the causes and consequences of distress. Rumination prolongs the experienced exposure to stress and increases the chance of developing symptoms of depression (Frost and Meyer, 2023; Meyer, 2003; Sarno et al., 2020). CTP, therefore, works through the internalisation of stigma characterised by the concealment of identity, causing rumination, negatively affecting mental health. This causal mechanism results in the following hypothesis:

H2: *Concealment of identity mediates the relationship between CTP and mental health.*

Additionally, building on MST theory, we hypothesise that the effect of CTP on mental health is particularly severe for transgender individuals, as they are subject to distinct stressors and may experience more pervasive rumination because of increased identity concealment. Unlike sexual minorities, transgender individuals experience stressors such as misgendering and the invalidation of gender-identity (Frost and Meyer, 2023; Meyer, 2003), which could have different and more severe effects (Frost and Meyer, 2023). Moreover, CTP, particularly through its impact on openness, may affect sexual and gender minorities differently. For transgender individuals, being open about gender identity often involves visual cues, such as clothing, hairstyles, and sometimes physical transition (Scandurra et al., 2019). Because these forms of expression are publicly observable, openness in one setting possibly leads to openness in all settings, meaning that concealing one's gender identity in one area of life, often means that it is concealed in every area of life (Scandurra et al., 2019). This all-or-nothing component of openness for transgender individuals results in a broader concealment of identity following CTP, intensifying rumination and worsening mental health outcomes. We therefore hypothesise:

H3: *Being part of a gender minority moderates the relation between CTP and mental health, such that being part of a gender minority leads to worse mental health after CTP compared to sexual minorities.*

To strengthen the internal validity of our findings and accurately isolate the psychological effect of CTP, we included a series of theoretically grounded control variables. For this reason, we control for sociodemographic factors such as age, education level, socioeconomic status, disability, and refugee or ethnic minority background. These variables are relevant since people from different minority backgrounds, unrelated to gender or sexuality, may face varying forms of discrimination, which, in turn, can negatively affect mental wellbeing (Kirkbride et al., 2024). Additionally, we account for exposure to discrimination and violence, which MST identifies as distal stressors and thus directly affect mental health and may confound the relationship between CTP and depression (Frost and Meyer, 2023; Meyer, 2003). Finally we include a control for legislative CTP bans, since institutional protections can mitigate the frequency and perceived legitimacy of these practices. By incorporating these controls, we aim to isolate the psychological harm attributable to CTP.

Research Design and Methodology

As previously mentioned, the aim of this paper is to describe the variation in CTP prevalence in Europe, and then measure the relationship between exposure to CTP and mental health outcomes. This analysis will comprise data collected from the EU LGBTIQ Survey III in 2023, which is a multi-country survey on the experiences of lesbian, gay, bisexual, transgender and intersex as well as non-binary and other non-gender conforming people across 30 different countries in Europe. The sample consisted of LGBTQ+ individuals aged 15 or older, who, at the time of the survey, lived in an EU member state as well as Albania, Serbia or North Macedonia. Additionally, the total number of respondents to the survey were 100,577 people. Participants to the survey were recruited via an availability sampling method, which is a form of non-probability wherein participants are selected based on their availability and ease of access for the researcher.

Moreover, the research design is a cross-sectional analysis of CTP and mental health outcomes. As this study relies on a large, cross-national survey dataset, it benefits from a high degree of statistical power. The EU LGBTIQ Survey III employs standardized questions and a broad sampling frame, allowing for systematic comparison across countries. However, as the data are based on a non-probability sampling strategy, the findings should not be interpreted as fully representative of all LGBTQ+ individuals in Europe. To improve comparability across countries and partially adjust for differences in sample composition, we apply country-level weights in our analysis. We estimate multiple linear regression (ordinary least squares, OLS) models to examine the relationship between CTP and mental health outcomes. All analyses are conducted in SPSS.

In our study, we have selected the following variables for our research: CTP exposure as the independent variable (IV) and mental health outcomes as the dependent variable (DV), while controlling for countries where CTP is banned. The IV is defined as any attempt to change an individual's sexual orientation or gender identity. In the dataset, this variable asks respondents if they have experienced such practices overall. Responses are coded as 0 ("No") and 1 ("Yes"). Additionally, we have included the different types of CTP as the IV, which are subcategories of the main one. These different types include intervention by family members, psychological or psychiatric treatment, medication, physical violence, sexual violence as well as verbal abuse or humiliation. The responses are also coded as a dummy variable.

To assess the recent mental health status of LGBTQ+ respondents, this study utilizes a self-reported variable drawn from the survey. This variable provides insight into the recent mental health status of LGBTQ+ individuals. This reflects how frequently the respondent has felt downhearted or depressed in the past two weeks, on a scale ranging from 1 ("All the time") to 6 ("At no time"), with lower scores indicating more frequent depressive symptoms. The responses within the dataset included -99 ("Don't know") and -96 ("Prefer not to say"). These observations with missing values on key variables were excluded from the analysis, because they do not reflect accurate mental health status of LGBTQ+ individuals. In addition, including them would obscure or distort the actual relationship between CTP and its impact on mental health.

Furthermore, our analysis includes control variables. As cross-sectional research designs typically have low internal validity, the introduction of control variables is crucial to prevent the possibility of a spurious relation. To account for legislative differences across countries, our study includes a control variable indicating whether CTP are banned in the respondent's country of residence. Other variables that can be used for controls are age group, education, and socioeconomic status, which are useful for controlling for potential confounding factors. Additionally, other control variables were included, such as religion, exposure to discrimination or violence, disability, and whether the respondent is a minority in terms of ethnicity, refugee status or skin colour. These variables were recoded to dummy variables, whilst also excluding non-responses. As such, by analyzing these variables, our study aims to deeply understand the impact of CTP on the mental health of LGBTQ+ individuals across different European contexts. We include respondents from all countries in the dataset, regardless of whether conversion therapy practices are legally banned, and control for this variation using a binary country-level variable indicating the presence of a ban. This allows us to account for institutional differences while still capturing the broader variation in experiences across contexts where enforcement and informal practices may differ.

We include moderating variables and interaction terms to capture intersecting forms of identity-based marginalization. Specifically, we examine whether a respondent identifies as a part of a gender minority, a sexual minority, or both, which allows us to explore how the effect of gender identity or sexual orientation shapes experiences with CTP practices and related mental health outcomes. To operationalize these, we constructed three identity-based variables. The first variable is identification with a gender minority, which in this case only included transgender individuals. Prior research has found that transgender individuals face more discrimination (Evje et al., 2024). However, only including those that identify as transgender is a large limitation, as our analysis excludes non-binary or gender-diverse respondents. The second variable includes sexual minorities, including those that identify as gay, bisexual, lesbian, pansexual and queer, whilst the third variable includes identification with both distinct categories. These variables were constructed from various survey questions to create a binary variable with 0 ("No") and 1 ("Yes"). Interaction terms were then constructed to assess moderating effects in the regression. Thus, we excluded the different types of CTP for the sake of simplicity.

Lastly, we include lack of openness about one's LGBTQ+ background as a mediating variable between the relationship of CTP and mental health outcomes. This variable was constructed from various survey items, in which respondents were asked whether they conceal their gender identity or sexual orientation in specific contexts and areas, to create one continuous variable. These survey items asked whether respondents avoid certain places, such as their home, school, workplace, restaurants and other public premises. This newly constructed variable is from a scale from 0 ("Nowhere") to 10 ("Everywhere"). As aforementioned in the hypothesis, we aim to see if

exposure to CTP may lead to LGBTQ+ individuals to avoid disclosing their identity. In turn, concealment of their identity can contribute to poorer mental health outcomes, such as internalized stigma and increased depression. Thereby, we employ a mediation model in our multiple linear regression whereby CTP influences openness, which then affects mental health. This allows us to assess whether the harmful effects on mental health due to CTP operate partly through their impact on identity concealment.

Building on this methodological foundation, the following section presents the empirical analysis of CTP prevalence and forms across European countries. This step provides the necessary descriptive overview before turning to the statistical examination of how CTP exposure and related mechanisms, such as identity concealment, affect mental health outcomes.

Data Analysis: Variation Across European Countries

Analysis of CTP prevalence across 30 European countries reveals significant national disparities in exposure among LGBTQ+ respondents (see *Table 1*). Respondents were asked whether they had ever experienced any form of CTP, which included religious, familial, medical, or violent attempts to change their identity. Overall, 31.6% of respondents reported having experienced some form of CTP, while 68.4% had not. These practices, intended to suppress or alter an individual's gender identity or sexual orientation, vary widely in regard to the type of CTP. Notably, the most common type of CTP is verbal abuse or humiliation, with 19.6% of LGBTQ+ individuals having reported having experienced it. Other types of CTP were also reported, although the frequencies were much lower than verbal abuse. For instance, the second most prevalent type was interventions initiated by family members, reported by 14% of respondents. In addition, 3.9% of respondents reported having experienced psychological or psychiatric treatment, whilst 3.5% of LGBTQ+ individuals experienced physical violence and 2.2% experienced sexual violence. Lastly, the least common type of CTP was medication, with 0.8% of respondents having experienced the use of medication intended to alter their identity.

Additionally, experiences with CTP also varied between countries in Europe, suggesting that national and cultural differences may explain the occurrence of such practices, as shown in *Table 1*. Overall, the countries with the highest prevalence of CTP were the Czech Republic with 43.4%, Greece with 42.3%, Cyprus with 40.5%, Slovakia with 42.7%, and Lithuania with 41.1%. On the other hand, the countries with the lowest number of reporting of CTP are Italy with 21.9%, the Netherlands with 21.9%, and France with 22.0%. However, the analysis of CTP reveals not only wide differences in overall prevalence, but also significant variation in the specific forms and severity of CTP. For instance, the verbal abuse form of CTP was the highest reported in Slovakia (29.9%) and Lithuania (27.2%), whilst countries like Serbia, and Hungary showed the highest prevalence in psychological or psychiatric forms of CTP. Family intervention methods were the most common in the Czech Republic, Greece, Lithuania and Bulgaria, suggesting discriminatory societal views on LGBTQ+ rights. Moreover, medication, whilst the rarest form of CTP, was the most prevalent in North Macedonia, Albania, and Slovakia.

Table 1.

Variation of CTP across European countries

	Type of Conversion Practice							
	Overall	Intervention by family members	Prayer, religious ritual or religious counselling	Psychological or psychiatric treatment	Medication	Physical violence	Sexual violence	Verbal abuse or humiliation
Austria	35.8%	16.1%	6.1%	4.0%	1.0%	3.6%	2.5%	24.0%
Belgium	24.6%	10.4%	4.8%	3.3%	0.8%	3.3%	1.8%	14.5%
Bulgaria	35.6%	19.4%	5.6%	6.3%	0.7%	5.4%	3.1%	22.4%
Croatia	27.8%	11.0%	8.2%	3.5%	0.6%	3.6%	1.7%	17.6%
Cyprus	40.5%	23.3%	13.6%	5.7%	1.2%	6.6%	2.1%	22.1%
Czech Republic	43.4%	27.6%	7.0%	2.9%	0.3%	3.3%	2.1%	25.2%
Denmark	25.8%	9.8%	5.4%	3.1%	1.2%	2.7%	2.4%	13.1%
Estonia	40.6%	23.1%	5.0%	4.0%	0.8%	2.7%	1.9%	24.0%
Finland	35.5%	8.4%	10.7%	2.3%	0.4%	3.3%	3.1%	24.3%
France	22.0%	10.0%	3.5%	2.5%	0.7%	2.9%	1.9%	13.7%
Germany	35.1%	15.5%	6.4%	4.0%	0.9%	3.8%	2.9%	22.5%
Greece	42.3%	28.4%	10.1%	6.0%	0.6%	4.6%	1.6%	20.9%
Hungary	38.4%	18.3%	7.9%	6.5%	0.8%	3.8%	2.3%	24.2%
Ireland	32.2%	12.6%	7.1%	3.7%	0.9%	4.1%	3.8%	20.9%
Italy	21.9%	9.3%	4.4%	4.4%	0.7%	2.0%	0.8%	12.8%
Latvia	33.9%	15.4%	6.9%	3.9%	1.4%	6.0%	1.9%	25.7%
Lithuania	41.1%	20.8%	7.7%	4.1%	1.1%	4.8%	2.1%	27.2%
Luxembourg	24.9%	12.1%	3.5%	4.0%	0.7%	2.4%	1.9%	16.1%
Malta	30.2%	13.2%	10.2%	3.6%	0.9%	1.8%	1.8%	15.9%
Netherlands	21.9%	7.6%	4.5%	3.3%	1.1%	3.0%	2.8%	12.7%
Poland	36.3%	16.7%	14.3%	4.3%	0.5%	3.9%	1.4%	21.7%
Portugal	27.6%	12.2%	5.7%	4.9%	1.4%	3.4%	2.0%	16.3%
Romania	32.0%	17.1%	10.3%	5.8%	1.0%	4.8%	1.3%	21.0%
Slovakia	42.7%	20.3%	11.8%	5.3%	1.6%	4.8%	1.8%	29.9%
Slovenia	27.3%	11.6%	4.4%	2.4%	0.5%	2.2%	1.5%	17.5%
Spain	25.7%	11.8%	5.0%	4.5%	1.2%	2.8%	1.7%	14.7%
Sweden	26.7%	9.2%	6.3%	2.7%	0.7%	3.0%	2.4%	15.6%
North Macedonia	37.4%	14.7%	6.8%	5.4%	1.8%	6.4%	2.4%	26.8%
Serbia	35.5%	13.3%	8.9%	7.0%	1.8%	5.9%	2.4%	24.5%
Albania	38.7%	17.8%	10.3%	5.5%	2.0%	5.5%	3.2%	18.6%

These differences in prevalence raises the question as to why certain countries exhibit higher rates of CTP amongst LGBTQ+ individuals when others have lower rates. This can be explained by a variety of factors, such as the strength or the absence of legal bans on CTP, the role of religion as well as the protection of LGBTQ+ rights and societal acceptance of diverse sexual orientations and gender identity (Veinan, 2022). For instance, low rates of CTP in France and Spain may be attributed to legal bans on such practices (de Groot, 2024). However, while some countries like Malta and Germany also have legal bans on CTP, the reporting rates are still quite high, suggesting that legal bans are not the only successful method of protecting LGBTQ+ rights. For instance, intervention by family members is high in these two countries, suggesting that legal oversight and enforcement

may be difficult to ensure that LGBTQ+ rights are upheld. Additionally, societal acceptance of LGBTQ+ rights within a country can also explain the variation in the prevalence of CTP. The Netherlands exhibits low rates of CTP, which may be attributed to the broader societal context of the country. Moreover, whilst Malta is widely considered to be one of the most progressive countries regarding LGBTQ+ rights and was the first country to ban CTP (Harwood, 2024), the country still exhibits high rates of CTP, with 30.2% of respondents saying they have been exposed to a practice. Nevertheless, these high rates may be attributed due to recent progressive changes in public opinion (Harwood, 2024). LGBTQ+ individuals may have experienced CTP prior to this shift in public opinion and introduction of the ban on CTP. Lastly, Hungary shows increasingly high rates of CTP practices, with 38.4% of individuals having reported experienced efforts to alter their identity. This may be explained by inadequate legal protection, stigmatization and negative discourse regarding LGBTQ+ individuals in the media (Tamássy, 2024).

Experiences with CTP also varied widely in relation to sexual orientation as shown in *Table 2*. Heterosexual or straight individuals reported the highest overall exposure to CTP, with 43.0% of individuals. Within the context of this research, this group reflects individuals who identify themselves as heterosexual but are included as they have been assigned LGBTQ+ status due to gender identity, such as transgender or non-binary individuals. This group is followed by pansexual individuals, with 36.9% of respondents having reported experience with CTP, while 36.3% of other orientations and 32.3% of lesbian individuals mention being exposed to such practices. The lowest percentages, but still alarming, were gay individuals with 30.2%, asexual people with 31.1%, and bisexual respondents with 28.7%.

Table 2.

Sexual orientation and overall exposure to CTP

		Sexual Orientation						
		Lesbian	Gay	Bisexual	Pansexual	Asexual	Heterosexual	Other
Experiencing conversion practices overall	Yes	32.3%	30.2%	28.7%	36.9%	31.1%	43.0%	36.3%
	No	67.7%	69.8%	71.3%	63.1%	68.9%	57.0%	63.7%

There are also great variations within gender identity, which are shown in *Table 3* below. Transgender individuals reported the highest exposure to CTP practices overall, aligning with the heterosexual variable. 51.0% of transgender men and 46.4% of transgender women reported experiencing CTP to alter their gender identity. A large percentage of non-binary people were also exposed to these harmful practices, with 38.1%. Cisgender women experienced CTP the least, with 26.5%. Multiple previous studies have found that trans individuals experience more discrimination and violence than cisgendered individuals (Evje et al., 2024). Overall, these high percentages are alarming and highlights the need for CTP bans across all European countries and protective policies that would ensure the safety and well-being of LGBTQ+ individuals.

Table 3.

Gender identity and overall exposure to CTP

		Gender Identification and Expression					
		Cisgender women	Cisgender men	Trans women	Trans men	Non-binary and gender diverse	Other (not trans, not cis)
Experiencing conversion practices overall	Yes	26.5%	27.5%	46.4%	51.0%	38.1%	35.0%
	No	73.5%	72.5%	53.6%	49.0%	61.9%	65.0%

Nevertheless, the dataset has some limitations. For example, respondents were asked to select the country in which they currently reside. This may not correspond to the country where they experienced CTP. Thus, some LGBTQ+ individuals may have migrated to more accepting and protective countries after experiencing harmful practices elsewhere. Additionally, certain groups are underrepresented in the data, such as intersex individuals or people who live in rural or isolated areas. Despite these limitations, the data still offers valuable insights into how experiences with CTP affect the mental health of LGTBQ+ individuals.

Data Analysis: Association with Mental Health

In this section, the relationship between CTP and mental health outcomes of LGBTQ+ individuals will be examined. *Table 1* shows the effects of different types of CTP on mental health, which also includes control variables and the moderator variables — shown through a binary variable of gender and sexual minority as well as the interaction terms — and the mediator variable, which is lack of openness. The results are shown below in *Table 4*.

As seen in *Table 4*, experiencing CTP has a consistently negative effect on mental health, as is hypothesized. Model 1 solely analyses the effect of the different CTP subcategories, excluding all control variables, moderators and the mediator. Overall CTP exposure is also excluded, as including it would alter the effects and significance of the different types of CTP. The results in this model show a significant association between experiences with CTP and feelings of depression across all different types, indicating that those that have been exposed to CTP to alter their identity report lower scores on the scale, which corresponds with feeling depressed more frequently. However, there are variations in regard to the severity of depression. As verbal abuse and humiliation was the highest reported form of CTP, it does not come as a surprise that it has the harshest effect on LGBTQ+ individuals' mental health ($B = –0.423$, $p < 0.001$). In addition, the second most severe effect on mental health comes from experiencing sexual violence ($B = –0.420$, $p < 0.001$). On the contrary, intervention by family members as a form of CTP suggests the least harsh effect on the mental health outcomes of LGBTQ+ individuals ($B = –0.109$, $p < 0.001$), as the coefficient is the lowest throughout all different subcategories.

Table 4.

Multivariate linear regression showing the effect of CTP on mental health

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
Constant	4.264*** (0.005)	2.190*** (0.030)	2.186*** (0.030)	2.184*** (0.030)	2.054*** (0.033)	2.200*** (0.030)	2.413*** (0.031)
Experiencing conversion practices, overall	—	—	–0.229*** (0.011)	–0.226*** (0.011)	–0.263*** (0.025)	–0.222*** (0.011)	–0.193*** (0.011)
Conversion practice: Intervention by family members	–0.109*** (0.017)	–0.050** (0.016)	—	—	—	—	—
Conversion practice: Prayer, religious ritual or religious counselling	–0.244*** (0.022)	–0.122*** (0.021)	—	—	—	—	—
Conversion practice: Psychological or psychiatric treatment	–0.256*** (0.030)	–0.183*** (0.028)	—	—	—	—	—
Conversion practice: Medication	–0.263*** (0.066)	–0.077 (0.061)	—	—	—	—	—
Conversion practice: Physical violence	–0.277*** (0.033)	–0.160*** (0.030)	—	—	—	—	—
Conversion practice: Sexual violence	–0.420*** (0.043)	–0.125** (0.040)	—	—	—	—	—
Conversion practice: Verbal abuse or humiliation	–0.423*** (0.015)	–0.179*** (0.014)	—	—	—	—	—
Age group	—	0.323*** (0.005)	0.323*** (0.005)	0.323*** (0.005)	0.324*** (0.005)	0.324*** (0.005)	0.304*** (0.005)
Education	—	0.039*** (0.007)	0.038*** (0.007)	0.039*** (0.007)	0.031*** (0.007)	0.035*** (0.007)	0.056*** (0.008)
Religiosity	—	0.063*** (0.010)	0.062*** (0.010)	0.062*** (0.010)	0.055*** (0.010)	0.060*** (0.010)	0.075*** (0.010)
Socioeconomic status	—	0.382*** (0.006)	0.386*** (0.006)	0.386*** (0.006)	0.382*** (0.006)	0.385*** (0.006)	0.377*** (0.006)
Discrimination	—	–0.256*** (0.010)	–0.267*** (0.010)	–0.268*** (0.010)	–0.252*** (0.010)	–0.261*** (0.010)	–0.187*** (0.010)
Disability	—	–0.682*** (0.009)	–0.684*** (0.009)	–0.684*** (0.009)	–0.670*** (0.009)	–0.681*** (0.009)	–0.670*** (0.010)
Ethnic minority	—	–0.065*** (0.019)	–0.070*** (0.019)	–0.070*** (0.019)	–0.069*** (0.019)	–0.071*** (0.019)	–0.058** (0.019)
Refugee status	—	–0.039 (0.85)	–0.088 (0.085)	–0.085 (0.085)	–0.072 (0.085)	–0.086 (0.085)	–0.160 (0.086)
Minority in terms of skin colour	—	–0.177**a* (0.031)	–0.182*** (0.031)	–0.184*** (0.031)	–0.181*** (0.031)	–0.183*** (0.031)	–0.192*** (0.032)
Countries with a ban on conversion practices	—	–0.014 (0.009)	–0.012 (0.009)	–0.012 (0.009)	–0.011 (0.009)	–0.012 (0.009)	–0.051*** (0.009)
Gender minority	—	—	—	0.293*** (0.074)	—	—	—
Interaction (gender minority * experience with CTP	—	—	—	–0.389*** (0.111)	—	—	—
Sexual minority	—	—	—	—	0.176*** (0.017)	—	—
Interaction (sexual minority * experience with CTP)	—	—	—	—	0.058* (0.027)	—	—
Gender and sexual minority	—	—	—	—	—	–0.166*** (0.033)	—
Interaction (gender and sexual minority * experience with CTP)	—	—	—	—	—	–0.012 (0.047)	—
Not being open	—	—	—	—	—	—	–0.078*** (0.002)
N	100 535	91 173	91 173	91 173	91 173	91 173	86 575
R-Squared	0.026	0.196	0.194	0.195	0.196	0.195	0.211

Dependent variable: Feeling downhearted or depressed in the past two weeks.

Note: standard error is shown in parentheses. Values are unstandardized coefficients * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

These findings suggest that our first hypothesis (H1) is supported, given that experiencing CTP leads to worse mental health outcomes in LGBTQ+ individuals. Nevertheless, the R-squared value for Model 1 is 0.026, which means that only 2.6% of the variation in the dependent variable is explained by the independent variables. This low value suggests that whilst the results are statistically significant, many other factors outside of this model influence the outcome of depressive feelings.

Model 2 adds a set of control variables — such as age group, education, religiosity, socioeconomic status, discrimination, disability, ethnic and racial minority, refugee status and ban on CPT — to better isolate the effect of conversion practices. Even with the inclusion of control variables, all categories of CTP still have a statistically significant negative effect on mental health, with the exception of medication. As expected, the inclusion of control variables attenuated the effect of CTP on mental health across all variables. For instance, the introduction of control variables lowered the coefficient for medication from –0.263 to –0.077 in the second model, whereby the significance disappears. Nonetheless, the other variables remained significant. Verbal abuse or humiliation is still the form of CTP that has the harshest effect on LGBTQ+ individuals' mental health, although it did decrease ($B = -0.179$, $p < 0.001$). Overall, this reduction in coefficients suggests that part of the association between CTP and depression can be accounted for by other factors, notably discrimination ($B = -0.256$, $p < 0.001$), disability ($B = -0.682$, $p < 0.001$) and minority status in regard to skin colour ($B = -0.177$, $p < 0.001$). Thus, this emphasizes how multiple forms of marginalization compound psychological distress.

Model 3 shows the association between overall experience with CTP on mental health. This model also includes the same control variables as in Model 2. This model shows that experiencing CTP has a negative association with mental health ($B= -0.229$, $p < 0.001$). This model was included in the regression analysis to be able to assess the potential mediating effect of not being open about one's sexual or gender identity in the relationship between experiencing CTP and mental health outcomes. Thus, when looking at the coefficient in Model 7, we can use this coefficient to determine whether there is a mediating effect or not. This is discussed in more detail below.

Model 4 shows that being part of a gender minority moderates the relationship between CTP and mental health, such that gender minorities have worse mental health after CTP compared to other LGBTQ+ individuals. Let us first consider the simple effects of gender minority as a control variable. The fourth model shows that being a gender minority has a statistically significant ($p < 0.001$) positive impact on levels of depression. More specifically, gender minorities score 0.293 higher on the depression scale, which ranges from 1 to 6, with higher scores indicating less frequent feelings of depression. Additionally, the interaction variable shows that being part of a gender minority has a statistically significant ($p < 0.001$) moderating effect on the relationship between CTP and mental health. On average, gender minorities score –0.389 lower on the depression scale after conversion therapy, compared to other LGBTQ+ individuals. Thus, gender minorities experience a stronger negative mental health impact from CTP. These findings support our third hypothesis (H3) as gender minority status moderates the relationship between CTP and mental health in such a way that gender minorities are more severely affected by CTP.

This stronger effect among gender minorities may reflect differences in the social visibility and contestation of gender identity compared to sexual orientation. Unlike many sexual minorities, whose identities can be more easily concealed in certain contexts, gender minorities often face more immediate and visible forms of misrecognition and social sanction, making concealment both more difficult and more psychologically costly. In addition,

while sexual minority identities have been increasingly normalized in many European contexts and often remain socially legible within a binary gender framework, gender diversity more directly challenges this framework and thus remains more heavily stigmatized and less institutionally supported. This may intensify the impact of coercive practices such as CTP.

Model 5 adds the sexual minority variable and its interaction with conversion therapy, revealing that sexual minorities have lower overall levels of depression and experience a less severe impact from conversion therapy compared to other LGBTQ+ individuals. The sexual minority variable has a statistically significant ($p < 0.001$) positive effect on mental health ($B = 0.176$). The interaction variable is also statistically significant ($p < 0.05$) and has a positive effect on mental health ($B = 0.058$), meaning that it weakens the relationship between CTP and mental health. This shows that, even though CTP still results in worse mental health, sexual minorities experience less severe effects. This unexpected, surprising finding should be researched further; however, this goes beyond the scope of this paper.

Model 6 includes the combined gender and sexual minority variable along with its interaction term and indicates that individuals who belong to both minority groups experience higher levels of depression overall but shows no significant interaction. Belonging to both minority groups is associated with a statistically significant ($p < 0.001$) decrease ($B = –0.166$) in overall mental health. However, the interaction term shows only a small decrease on the depression scale ($B = –0.012$), which is not statistically significant. This means that the combined minority status has no meaningful impact on the relationship between CTP and mental health.

Furthermore, Model 7 incorporates the control variables and the key mediating variable: lack of openness. This model was designed to test whether the negative impact of CTP on mental health outcomes is partially explained through the concealment of one's LGBTQ+ identity ("not being open" in the model). The coefficient for experiencing CTP remains statistically significant with ($B = –0.193$, $p < 0.001$), although it represents a smaller value in comparison to Model 3, whereby the coefficient for overall experience of CTP is –0.229 ($p < 0.001$). This reduction indicates partial mediation, suggesting that some of the harmful mental health effects of CTP operate indirectly through increased identity concealment. Additionally, the mediator has a significant negative association with mental health ($B = –0.078$, $p < 0.001$), confirming that respondents who feel the need to hide their gender identity or sexual orientation report significantly higher levels of depression. This supports our H2, proving that identity concealment as a response to CTP exacerbates depressive outcomes among LGBTQ+ individuals. To conclude, the explanatory power of Model 7 also improves significantly. With an r^2 value of 0.211, this model accounts for over 21% of the variance in depressive symptoms, a relatively strong figure in social science research. Altogether, the findings provide a robust support for both MST and the mediation hypothesis. They highlight that CTP harms LGBTQ+ mental health not only directly, but also indirectly by promoting identity concealment and internalized stigma. These results underscore the importance of policies that go beyond legal bans and aim to cultivate environments where LGBTQ+ individuals feel safe and empowered to live openly.

Validity, Reliability, Generalizability, and Limitations

The internal validity of our study is moderate. The study is based on cross-sectional analysis data, which captures the relationships between variables at a specific moment but cannot establish causal relationships on its

own. Therefore, while there is a statistically significant link between the effects of CTP and mental health deterioration among LGBTQ+ people, we cannot say with absolute certainty that one causes the other. The reported mental health problems may in some cases have preceded CTP or been caused by other unmeasured factors. However, we are increasing the reliability of our findings by including several control variables – such as national legislation prohibiting CTP, experience of discrimination, age, education, refugee or ethnic minority status – to reduce the risk of fictitious correlations.

From the perspective of external validity, several limitations should be acknowledged. As the data are based on a non-probability sampling strategy, the findings cannot be interpreted as fully representative of all LGBTQ+ individuals in Europe. In addition, the country-level clustering of the data is not explicitly modelled in the estimation, which may lead to underestimated standard errors. Moreover, the use of a single-level OLS framework does not allow us to distinguish between within-country and between-country effects, meaning that institutional differences may be conflated with individual-level effects. These limitations suggest that the results should be interpreted with caution, particularly when drawing cross-national policy implications.

Despite these limitations, the study's reliability is supported by the large sample size and the consistency of measurements across respondents. The use of standardized questions and response coding enables consistent comparison across countries and subgroups. In addition, our analytical structure — in particular, the classification of types of CTP methods and the use of control variables and interaction terms — is transparent and highly reproducible.

In addition to the limitations discussed above, several further constraints should be acknowledged. The cross-sectional nature of the data remains the main limitation, which does not allow us to determine the time order of their receipt and results. Our study also relies on data obtained from the participants themselves, which may be influenced by biased accounts, the understatement of information, or the effect of social desirability, especially in connection with sensitive experiences such as trauma or mental health problems. In addition, although we check whether CTP is prohibited in the respondent's country of residence, we cannot take into account differences in law enforcement practices and cannot be sure that CTP was performed in the same country where the respondent currently lives. The last important limitation lies in the used dependent variable, which measures depression only for a period of two weeks before the respondent participates in the survey. It can be reasonably argued that a more appropriate dependent variable would be one that measures depression and mental health over a longer period of time, or the presence of such problems in general. This could establish with greater certainty that the mental state due to the experience of CTP has indeed deteriorated on a long-term basis, becoming fixed in the respondent in the form of PTSD or certain social fears/tensions, rather than being a burst phenomenon, since the variable of depression and the moment when CTP was experienced are not specifically related. However, unfortunately, such a variable was not available in the dataset we used. Nonetheless, despite these limitations, our approach allows for a detailed analysis of the connection between CTP and mental health among LGBTQ+ individuals in Europe. This study offers important insights into an under-researched issue and sets the stage for future long-term and cross-sectional research.

Policy Implications

While our findings are based on cross-sectional associations and should not be interpreted causally, they nonetheless provide important indications for policy development. The observed relationship between exposure to CTP — particularly more coercive forms such as physical violence or psychiatric intervention — and poorer mental health outcomes among LGBTQ+ individuals suggests that reducing exposure to such practices may have meaningful implications for well-being.

First of all, the evidence that exposure to CTP — specially forms such as physical violence or psychiatric intervention — is strongly associated with poorer mental health outcomes among LGBTQ+ individuals underscores the need for comprehensive and enforceable prohibitions on all forms of CTP. The policy should go beyond narrowly defined prohibitions that apply only to minors or to interference without consent. In other words, European States should adopt a broad legal framework criminalizing all forms of CTP, regardless of age or intended consent.

Second, the persistence of CTP practices in countries where formal bans exist indicates that legislation alone may be insufficient. In some countries where bans exist, such as Cyprus or Greece, CTP practices are still very common, showcasing the importance of investing in awareness campaigns, training health professionals and educators, and building confidential reporting and victim support systems. Law enforcement agencies cannot rely only on formal prohibitions but must also work with communities to change harmful cultural norms.

Moreover, differences in the prevalence of CTP in different countries and among specific subgroups, such as transgender people and ethnic minorities, emphasize the need for policies that consider the interests of different subgroups and cultures. Mental health services should become more accessible and adjusted specifically to the realities of LGBTQ+ people, especially those who face various forms of marginalization. The financing of public initiatives, the creation of special state monitoring services, and the preparation of national plans for the protection of LGBTQ+ individuals can serve as a decisive factor in safeguarding against psychological harm caused by such practices.

Also, policy makers should consider preventive strategies aimed at addressing the root causes of CTP. This includes reforming educational programs to promote inclusivity, supporting educational programs for parents, and combating public discourse that pathologizes LGBTQ+ identity. The fact that verbal and psychological forms of CTP negatively affect mental health indicates that stigmatization is still very much ingrained in everyday life. Therefore, legal reform has to be complemented by active social and cultural activities aimed at creating a more receptive society.

In summary, it is important to emphasize that not all aspects of the legislative process must rest solely on the shoulders of politicians, who are often constrained by the public opinion. Empirical evidence demonstrates that the judiciary can play a proactive role in safeguarding against discrimination. This, in turn, underscores the importance of actively involving activist organizations in initiating strategic litigation and mobilizing resources to support plaintiffs. When judicial outcomes are favourable to the LGBTQ+ community — such as the ruling by the Constitutional Court in Lithuania in April 2025 — they can secure fundamental rights and protections for marginalized groups (*Absence of Same-Sex Partnerships in Lithuania "Unconstitutional", Rules Court*, 2025). These legal victories may subsequently lead to a notable shift in public attitudes, with support for previously stigmatized

groups increasing significantly. A suitable example is Iowa in 2009, where the state Supreme Court's decision to legalize same-sex marriage resulted in rapidly growing public acceptance, even among those who had initially opposed the reform (Kreitzer et al., 2014). This suggests that the state need not address every instance of social exclusion through direct policy intervention; rather, it can, to some extent, rely on the socially transformative momentum generated by anti-discrimination rulings. While this approach may ease the administrative burden on state institutions, it nonetheless requires sustained oversight and the implementation of complementary legislative reforms.

Conclusion

In conclusion, this study provides one of the first large scale, cross-national analyses of CTP and their psychological consequences within the European LGBTQ+ community. Drawing on MST, we show that CTP functions as a severe distal stressor that not only directly harms mental health, but also indirectly intensifies distress by promoting identity concealment. Our findings demonstrate that exposure to CTP significantly correlates with more frequent depressive symptoms, particularly among young transgender individuals, whose experiences are shaped by distinct and compounding forms of minority stress such as misgendering and the invalidation of their gender identity. Using a robust multivariate regression model and drawing from a representative EU-wide dataset, we further demonstrate that lack of openness about one's identity mediates the relationship between CTP and mental health outcomes. This suggests that CTP impacts mental wellbeing not only through its traumatic content but also by fostering shame and isolation. Our analysis also reveals that gender minorities experience the most severe psychological effect of CTP, while sexual minorities are comparatively less affected. These findings validate all three hypotheses and underscore the necessity of analyzing the impact of anti-LGBTQ+ practices. While the study's cross-sectional design limits causal claims, and certain groups remain underrepresented, the empirical insights it provides are highly relevant for both academia and policymaking. Legal bans alone are insufficient if not paired with effective enforcement, cultural change, and trauma-informed mental health support. Future research should expand on these findings through longitudinal designs and deeper qualitative inquiry into the lived experiences of CTP survivors. Most importantly, the results make clear that CTP is not a relic of the past but an ongoing form of institutionalized violence, one that urgently requires intervention across all sectors of European, and ultimately global, society.

Conflict of Interests

The authors declare no conflict of interest.

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