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Editor's Comments

The Alliance for Therapeutic Choice and Scientific Integrity is a multi-disciplinary educational, professional, and scientific organization dedicated to preserving the right of individuals to obtain the services of a therapist who honors their values, advocating for integrity and objectivity in social science research, and ensuring that competent licensed, professional assistance is available for persons who experience unwanted homosexual attractions. In 2009, the Alliance launched the *Journal of Human Sexuality (JHS)* to serve its mission and as a way of presenting, encouraging, and producing quality clinical and scientific scholarship on topics related to various aspects of sexual minority issues and on human sexuality in general.

In an era where opinion-based experts are dominating professional societies, influential conferences, and mental health publications, this monopoly of intellectual power centers by an ever-narrowing prospective must be challenged by evidence-based alternatives. The *Journal of Human Sexuality* aspires to provide a home for such scholarly options. We truly embrace our mission to champion scientific integrity.

Just as essential, the concept of therapeutic choice is foundational to the inherent dignity of the human person. For a civilization to thrive, social institutions must first recognize the importance of human agency and provide a community of understanding and trust. This fundamental concept of client self-determination must be rejuvenated in the mental health professions.

We express our sincere appreciation to Christopher Rosik, PhD, for his careful and dedicated stewardship as the Editor of Volume 12 of the *JHS*. This edition offers a lineup of papers, case studies, literature reviews, and book summaries. All of these reflect our commitment to the responsible conduct, dissemination, and use of science by professionals, public policymakers, legislators, and other non-mental health professionals involved in promoting medical and mental health on both a personal and public level.

Authors of *JHS* articles and reviews are held to the criteria; what is written needs to be based on a fair reading and the responsible reporting of scientific data and demonstrable professional experience. Authors interested in submitting papers for future volumes should contact the editor at 1-888-364-4744 or via e-mail at contactus@therapeuticchoice.com.

David Clarke Pruden, M.S.
Managing Editor, *Journal of Human Sexuality*

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Searching for Evidence of Harm: 79 Key Studies Do Not Demonstrate That Sexual Orientation Change Efforts (SOCE) Are More Harmful Than Other Counseling

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Critics of sexual orientation change efforts (SOCE), which is sometimes referred to as "conversion therapy," make two principal assertions—that such therapy is ineffective, and that it is harmful. This article addresses the latter assertion, evaluating the scientific evidence of SOCE harms. A recent book (Doyle, 2019) included an appendix labeled "Peer-Reviewed Journal Articles and Academic Books on 'Conversion Therapy' Outcomes that Include Measures of Harm." I undertook a literature review of the 79 sources cited in this document. Some of these studies do not contain *any* assertion or even discussion of the possibility of "harm" to individual clients resulting from SOCE. Others do assert or suggest that SOCE may be harmful but feature *no* study subjects. Only a minority of the sources include studies or case reports on individuals who have undertaken SOCE. Just six studies (reported on in 11 of the sources) involved sample sizes of 50 or more SOCE clients. These six are described in detail. Most of the studies suffer from significant methodological weaknesses. Several are explicitly "qualitative" rather than quantitative. The two strongest studies methodologically show the most positive outcomes and the fewest reports of harm. While these 79 studies do provide *anecdotal* evidence that *some* SOCE experiences were harmful to *some* clients, they do not demonstrate scientifically that SOCE is more harmful than other forms of therapy, more harmful than other courses of action for those with SSA, or more likely to be harmful than helpful for the average client.

Sexual orientation change efforts (SOCE) consist of therapy, counseling, and/or support groups designed to reduce same-sex sexual attractions, reduce or eliminate homosexual conduct, and/or increase opposite-sex attractions. Such efforts (sometimes referred to by critics as "conversion therapy"[2]) have been controversial for decades, ever since the

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[2] Those who engage in such efforts have, at various times, referred to them as "sexual reorientation therapy," "reparative therapy" (Nicolosi, 1997), "change therapy," and more recently, "Reintegrative Therapy®" (Nicolosi,

American Psychiatric Association's 1973 decision to remove homosexuality from its official list of mental disorders (Bayer, 1987). Yet despite the controversy and criticism, there has continued to be a demand for such assistance from people who experience their same-sex attractions as something unwanted.

In the last decade, the attacks upon SOCE by LGBT (lesbian, gay, bisexual, and transgender) activist groups and their political allies rose to a new level, with the first enactment of legal restrictions upon the practice of SOCE. In 2012, California became the first state to adopt such restrictions, banning sexual orientation change efforts with minors by licensed mental health providers (*Sexual Orientation Change Efforts*, 2012). At this writing, 23 states and over 90 localities have enacted or imposed restrictions upon SOCE (List of U.S. jurisdictions banning conversion therapy, 2021).

"No Illness, No Cure?"

Criticism of SOCE is sometimes rooted in the 1973 APA decision itself. These critics argue that since "there is no illness, there is no cure" (Schreier, 1998, p. 305). Indeed, some assert on this basis that SOCE is unethical. However, people often seek counselling or psychotherapy for reasons having nothing to do with the presence of a diagnosable mental illness (Rauch, 2015). For example, grief over the loss of a loved one and marital discord are among the most common reasons why people seek counselling—yet neither is a diagnosable "mental illness."

Why People Seek Change

Even if homosexuality is not, in and of itself, considered a "mental illness," there are still legitimate reasons why an individual might seek voluntarily to reduce same-sex attractions, increase opposite-sex attractions, and curtail homosexual conduct. For example, an individual may have experienced homosexual relationships and life in the "gay community" and become personally disillusioned with it. Homosexual conduct (especially among men) carries elevated health risks compared to heterosexual conduct (Winn, 2012; *The Health Hazards of Homosexuality*, 2017, pp. 91–377), which a client may legitimately seek to avoid.[3] An individual may aspire to form a family and may have a desire to do so by natural means, conceiving children through heterosexual intercourse and raising them in a home where both the natural mother and father participate in child-rearing. Some may be convinced that their same-sex attractions are not innate but are a result of developmental experiences or childhood trauma—such as child sexual abuse (Gallagher, 2016).

At this point, however, by far the most common reason why people seek change in their sexual attractions, behavior, or identity is religious conviction. Many people who are (for example) evangelical Protestants, conservative Catholics, Mormons, or orthodox Jews may consider their religious identities more fundamental to who they are than their sexual attractions are. Such individuals who experience same-sex attractions yet believe that the teachings of

2018) or "sexual attraction fluidity exploration in therapy," or "SAFE-T" (Rosik, 2016). For the most part, it is only critics of such efforts who use the term "conversion therapy." The term "sexual orientation change efforts" (or "SOCE" for short) is broad enough to include both professional therapy offered by licensed mental health providers and the more informal counseling and support offered by religious counselors and ministries, who may not be licensed and whose efforts are often not, strictly speaking, a form of "therapy."

[3] "Someone who wished to avoid the risk of death should be helped to avoid the activities that expose him to life-threatening disease; it is unethical for a therapist *not* to provide—or not to refer a client for—such help" (Phelan et al., 2009, p. 48).

Scripture or their faith forbid homosexual conduct may seek professional assistance in living their lives in a way that is compatible with the moral teachings of their faith.[4]

Arguments for Therapy Bans

While assertions that "homosexuality is not a mental illness" are one source of criticism of SOCE, they may not be sufficient to justify legal restrictions upon the practice, in light of the considerations noted above. Instead, there are two major claims that are used to argue in favor of what we will refer to as "therapy bans."[5] They are:

Claim: "This therapy is ineffective."

Critics claim that it is simply not possible to change someone's sexual orientation. Some suggest that an individual's sexual orientation is an innate biological or genetic characteristic which is inherently immutable. They assert that counseling can no more change a person's sexual orientation than it can change a person's eye color. This view is implicit in the scattered efforts which have been mounted to declare SOCE a form of "consumer fraud," the modern-day equivalent of selling snake oil (see, e.g., Complaint for Action to Stop False, Deceptive Advertising and Other Business Practices, 2016).

However, scientists have failed to uncover the long-sought "gay gene" which was theorized to determine a person's sexual orientation (Ganna et al., 2019; analyzed in Sprigg, 2019b), and the best modern science has debunked the idea that sexual orientation is absolutely immutable (Dickson et al., 2013; Mock & Eibach, 2012; Ott et al., 2011; Savin-Williams & Ream, 2007; analyzed in Diamond & Rosky, 2016; Sprigg, 2019a). Those with a somewhat more nuanced view, therefore, may acknowledge that change in some of the elements of sexual orientation (attractions, behavior, and self-identification) does occur over time in some people—but still claim that it is futile to try to deliberately effect such change through therapeutic interventions (Diamond & Rosky, 2016, p. 368). They may charge that SOCE practitioners guarantee total transformation from 100% homosexual to 100% heterosexual on all the elements of sexual orientation, and that merely incremental change in one or more elements of sexual orientation constitutes a "failure" of therapy to achieve such dramatic transformation. This is a straw man argument, because most SOCE practitioners do not "guarantee" success, and many SOCE clients would

[4] Phelan et al. explain, "For many, the desire to diminish homosexuality and to develop heterosexual potential is intrinsic to their value system. This may include a religious background that values gender complementarity and traditional understandings of family and sexuality," and "failure to offer therapeutic help to persons who are 'dissatisfied' with their homosexuality on religious grounds would be violating their rights not only to autonomy and self-determination, but also to religious freedom" (Phelan et al., 2009, p. 48). SOCE critic Douglas Haldeman appeared to agree in a 2002 article not included on the "Measures of Harm" list, saying, "In some circumstances, it is more conceivable, and less emotionally disruptive, for an individual to contemplate changing sexual orientation than to disengage from a religious way of life that is seen as completely central to the individual's sense of self and purpose. . . . [W]e must respect the choices of all who seek to live life in accordance with their own identities; and if there are those who seek to resolve the conflict between sexual orientation and spirituality with conversion therapy, they must not be discouraged" (Haldeman, 2002, pp. 262–263).

[5] Legislative restrictions upon SOCE that have been proposed or enacted vary in two key respects. Most apply only to licensed mental health practitioners; however, some apply to all sexual orientation change efforts, regardless of who the provider is. Most thus far have applied only to SOCE with minors, but there has been a growing effort to apply them to adults as well. I will refer to all these variations as "therapy bans" or "SOCE bans" interchangeably.

consider such incremental change to be a success, not a failure.[6]

Critics of SOCE claim there is no evidence of its effectiveness. This is untrue, as I have reported elsewhere (see Sprigg, 2018c; analyzing Black, 2017; Jones & Yarhouse, 2011; Karten & Wade, 2010; Nicolosi et al., 2000; Santero et al., 2018; and Spitzer, 2003). There is abundant anecdotal evidence in the form of personal testimonies of people who recount having experienced change in their sexual orientation. However, there is also scientific evidence, some of which has been published in peer-reviewed academic journals (see Phelan et al, 2009, p. 1, for a summary). What is true is that the quality of studies that have been done is limited by sampling challenges and methodological weaknesses, so one could perhaps say there is not definitive scientific *proof* of the effectiveness of SOCE, nor of which techniques may be the most effective.

Claim: "This therapy is harmful."

Assertions that SOCE is unethical because it treats a non-existent "illness," or that it is ineffective because it is impossible to totally reverse a person's sexual orientation, are used in support of therapy bans (despite the weaknesses of these arguments, as noted above). However, it is difficult for these arguments to overcome the presumptions in favor of client autonomy and of religious liberty which protect the right of clients to seek the life change they desire[7] and the right of therapists and counselors to assist them.[8]

The draconian step of legislators or regulators imposing an outright legal ban on such therapies or counseling, complete with government-enforced sanctions to punish violators—merely on the basis of the client-chosen goal being pursued—is something completely unprecedented in the mental health field. Under these circumstances, such legislators or regulators have a right—and a duty[9]—to demonstrate that SOCE is actually

[6] The leading national organization for professional therapists who engage in SOCE, the National Association for Research and Therapy of Homosexuality, or NARTH (now known as the Alliance for Therapeutic Choice and Scientific Integrity), wrote in 2009: "We acknowledge that change in sexual orientation may be difficult to attain. As with other deeply ingrained psychological conditions and behavioral patterns . . . change through therapy does not come easily, and there is a substantial therapeutic failure rate. . . . But even when clients have failed to change sexual orientation, other benefits commonly have resulted from their attempts" (Phelan et al., 2009, p. 39).

[7] The American Counseling Association states that one of the "fundamental principles of professional ethical behavior" is "*autonomy*, or fostering the right to control the direction of one's life" [emphasis in the original] (*2014 ACA code of ethics*, 2014, p. 3).

[8] A panel of the U.S. Court of Appeals for the 11th Circuit ruled in 2020 that therapy bans "violate the First Amendment because they are content-based regulations of speech that cannot survive strict scrutiny" (*Otto v. City of Boca Raton*, 2020, p. 2). Some federal courts had previously upheld therapy bans, but the Supreme Court criticized those decisions in a 2018 decision on another issue: "Some Courts of Appeals have recognized 'professional speech' as a separate category of speech that is subject to different rules. . . . But this Court has not recognized "professional speech" as a separate category of speech. Speech is not unprotected merely because it is uttered by 'professionals'" (*NIFLA v. Becerra,* 2018, pp. 2371–2372).

[9] The 11th Circuit panel which struck down local therapy bans in Florida said, "Under strict scrutiny, content-based restrictions [on therapist speech] are presumptively unconstitutional. And they can be justified only if the government proves that they are narrowly tailored to serve compelling state interests." The panel later went on to examine the alleged harms of SOCE: "Defendants say that the ordinances 'safeguard the physical and psychological well-being of minors.' Together with their amici, they present a series of reports and studies setting out harms. But when examined closely, these documents offer assertions rather than evidence, at least regarding the effects of purely speech-based SOCE" (*Otto v. City of Boca Raton*, 2020, pp. 19–21; internal quotation marks and citations omitted).

harmful to the people who undertake it. In other words, legislators or regulators should ask proponents of such therapy bans for convincing evidence that undertaking such efforts is likely to leave the individual *worse* off than they were *before* SOCE, and worse off afterwards than if they had not undertaken SOCE.

This question—whether science provides such convincing evidence that SOCE is harmful—is the one that this article examines.

Why This Paper?

As noted above and in the accompanying notes, I have previously written several papers about sexual orientation change efforts, and in them I have documented that there is an abundance of evidence in support of the effectiveness of SOCE, as well as a lack of evidence that SOCE is generally harmful (Sprigg, 2014, 2018b, 2018c, 2019a). However, in the last three years I became aware of a document labeled, "Peer-Reviewed Journal Articles and Academic Books on 'Conversion Therapy' Outcomes That Include Measures of Harm." This multi-page document lists no less than 79 academic sources.

The document itself does not include the name of an author or editor or any indication of who compiled it. Nor has the document itself been published in any peer-reviewed journal, as far as I know. However, it was re-published as an appendix in a 2019 book by Christopher Doyle titled *The War on Psychotherapy* (Doyle, 2019, "Appendix C: Measures of Harm," pp. 365–374.)

Doyle reports in this book that he received the document from Dr. A. Lee Beckstead.[10] Beckstead is a psychologist from Utah who has done research on SOCE (several of his articles are among the 79 sources listed in the document). Beckstead was a Mormon who experienced same-sex attractions. He resolved the conflict between Mormon teaching against homosexual conduct and his own attractions by renouncing Mormonism and embracing a "gay" identity.

Beckstead is a critic of SOCE, but one who has been willing to engage in respectful dialogue with therapists who hold other points of view and who practice SOCE. He acknowledges the importance of religion to the personal identity of some clients, and he admits that it is unrealistic to expect all such individuals to prioritize their sexuality over their faith. Therefore, this paper should not be taken as an attack upon Beckstead personally—especially since it is unclear whether he compiled the list of 79 sources that he passed on to Doyle.[11] As I have noted, previous research I have done on this topic has led me to conclude that there is no evidence that SOCE is generally harmful to those who undertake it (see especially Sprigg, 2018c). Therefore, when I first saw what I will call the "Measures of Harm" document, I was skeptical. First, I was skeptical that there were that many sources with any convincing evidence of harm from SOCE; but more specifically, I was skeptical that there were that many sources that included actual "measures of harm"—a term which would seem to imply some actual quantitative analysis, not merely anecdotes or a compilation of expert opinions.

[10] Doyle writes, "Regarding the harmful outcomes of 'conversion therapy,' there is not an exhaustive or comprehensive bibliography yet published. My thanks to Dr. A. Lee Beckstead for providing me an extensive bibliography that can be viewed at Appendix B" [sic; it actually appears as Appendix C] (Doyle, 2019, p. 107).

[11] It is also unclear whether Beckstead has personally reviewed all 79 of the studies, or whether he vouches for the accuracy of the list. However, it seems unlikely that he would circulate it if he had serious doubts about its accuracy or credibility.

I concluded that the only way to determine if the "Measures of Harm" document lives up to its billing was to undertake my own literature review of all 79 sources listed.

The 79 sources include:

- 1 book
- 1 doctoral dissertation
- 4 book chapters
- 73 articles or other writings[12] in academic journals

Note: The sources included in the "Measures of Harm" document are also included in the Reference List at the end of this article, along with other sources cited. Sources that appear in the "Measures of Harm" document are marked with an asterisk (*).

Methodology

My first task was to acquire the full text of as many of these studies as possible. Some were already in my collection at Family Research Council. Some were freely available on the internet. I was able to obtain about half of the sources by these means. The remainder were located via databases accessed at either the National Library of Medicine or the Library of Congress. The one published book on the list was already in my library, having been purchased online. Although I was prepared to undertake this review without all 79 sources, if needed, in the end I was able to acquire all of them.

Keyword Searches

My initial plan was to personally read all 79 sources in the "Measures of Harm" document. Indeed, I was able to read the majority of the articles in full. However, I realized that some of these sources were quite long and reading all of them in full would make the research even more time-consuming. In addition, I discovered that some articles had many pages of highly technical descriptions of their methodology, including details of statistical analysis, while I was only concerned with any *findings* they might have regarding the harms of SOCE. Therefore, with this minority of articles, I decided to do a keyword search of the electronic text for any words that might allude to the possibility of or a finding of harm.[13] A list of the keywords used can be found in the Appendix. In the end, I read 63 of the 79 sources in full. The remaining 16 were analyzed using keyword searches. *A double asterisk (**) appears next to the studies that were analyzed for keywords in Reference List*.

Preliminary Considerations

Before examining the content of the 79 studies reviewed here, it is important to clarify the right way to think about the question of harm from SOCE.

Zero Harm Is Unrealistic

Even if it can be convincingly demonstrated that some individual, or even some group of individuals, experienced harm as a result of SOCE, that would not prove that SOCE is *generally* harmful. Still less would it justify legal restrictions which would flatly

[12] Some of these were "Peer Commentaries" or letters to the editor, rather than full journal articles.

[13] There were a few older articles of which I was only able to obtain a scanned copy, rather than a searchable electronic text. All of the scanned articles were read in full. For the one published book (Jones and Yarhouse, 2007), I did a keyword search of the book's index. While this is less comprehensive than a full-text search, Jones and Yarhouse include an entire chapter (which I read in full) on the subject of "harm" from SOCE, as well as several other significant passages about it, so I feel confident that I did not miss any major findings about harm from this source.

prohibit SOCE. This is because of a fact well known to the medical and psychological professions, but sometimes ignored when this topic is under discussion—namely, that *all* medical and psychological interventions carry at least *some* risk of harm (Carroll & Frakt, 2015). Aspirin can cause harm, appendectomies can cause harm, cognitive behavioral therapy can cause harm (Schermuly-Haupt et al., 2018)—and yes, SOCE can, presumably, in some clients and on some occasions, cause some measure of harm. The mere *possibility* of harm, or even the proven *reality* of it in *some* cases, is not enough to distinguish SOCE from any other form of medical treatment or psychological counseling or therapy.

Jones and Yarhouse (2007) also note the possibility of individual harm even from practices that are not harmful on average:

> . . . [W]e cannot conclude that specific individuals are not harmed by an attempt to change. It is important to remember that life is dangerous and filled with potential harm. . . . Additionally, specific individuals may be psychologically fragile in such ways that well-meaning interventions that would not cause harm to most other persons may be traumatic to those persons. (p. 376)

Santero et al. (2018) suggest that SOCE critics are misusing the traditional dictum of medical ethics, "First do no harm," which really means "avoiding deliberate embracing of predominant known harm"—not a therapy "totally free of side effects." As they note, "Zero harm is not realistic, nor probably attainable for any type of therapy," since "serious sequelae may accompany even good therapy. . . . Minimalization [of harm] is a much more realistic goal" (p. 14).

Instead of merely asking whether harm from SOCE is *possible*,

> [T]reatment decisions must be made according to a thoughtful and well-informed benefit-risk analysis. . . . [A]ll treatments and interventions have potential risks. The question cannot be simply, Are there any risks? But rather, how do I weigh the potential gains from this intervention against its potential risks? (Jones and Yarhouse, 2007, pp. 361–362)

How Many Are Harmed, and How Much?

To determine whether the possibility of harm is a problem serious enough to justify discouraging or even outlawing SOCE (as opposed to merely acknowledging a risk of harm in the process of informed consent), we need to ask several additional questions:

- **What *Percentage* of SOCE Clients Experience Harm?** If only a small percentage of such clients experience harm, there would be less justification to discourage or outlaw SOCE. If all or a large majority of clients experience harm, the case against SOCE would be stronger.
- **Are SOCE Clients *More Likely* to Be Harmed than Helped?** Some critics of SOCE simply dismiss the possibility that some clients are *helped* by SOCE. They may also fail to recognize that even clients who fail to experience a major change in all the elements of sexual orientation could still be helped by SOCE in other ways. Finally, SOCE critics fail to recognize that a client could be *both* helped in some ways and harmed in other ways by the process of SOCE. If more clients are helped than harmed, it would weaken the argument against SOCE; while if more clients are harmed than helped, or if the level of harm exceeds the level of benefit in clients who experience both, then the case against SOCE would be strengthened.

- **How *Serious* Is the Harm That Is Alleged to Result from SOCE?** The most dramatic illustration of this is the question of suicide. Some critics assert that SOCE increases the risk for suicidality (which may consist of suicidal thoughts, suicide attempts, or completed suicides). If, say, only 5% of clients are harmed by SOCE, but a large percentage of those become suicidal (and especially if a large percentage *actually commit suicide*), that would be a much greater reason for concern than if 5% of SOCE clients experience a mild or temporary increase in stress or anxiety.[14]

Harmful—Compared to What?

Just because a person undergoes SOCE and subsequently experiences a negative state of mental health (such as depression, for example) does not prove that SOCE must be deemed "harmful." For one thing, we would need to know what that person's state of mental health was *before* SOCE, for comparison. But even beyond that, we would need some kind of comparison to other groups of people. Sexual orientation change efforts exist for the benefit of people with *unwanted* same-sex attractions. Therefore, outcomes for people with unwanted SSA who undergo SOCE should be compared with:

- People with unwanted SSA who receive *no* counseling or therapy;
- People with unwanted SSA who receive counseling or therapy that is not designed to address their sexual orientation;
- People with unwanted SSA who receive what is called "gay affirming therapy" (GAT), which urges clients to accept SSA and embrace a "gay" identity.

While the population of others with unwanted SSA is the most relevant comparison group, it would also be interesting to note the outcomes or mental health status of those with same-sex attractions who do *not* consider them unwanted or seek to overcome them, but instead are willing to accept or even embrace a lesbian, gay, or bisexual identity. Again, it would be helpful to break down this population into:

- Those who receive *no* counseling or therapy;
- Those who receive counseling or therapy that is not designed to address their sexual orientation;
- Those who receive "gay affirming therapy" (GAT), if any.

Finally, it would be useful to compare the mental health of all of these groups with that of people who do *not* experience same-sex attractions—again, broken down into those who do or do not receive some type of counseling or therapy for any issue. One of the "Measures of Harm" sources described this need for comparisons:

> Our numbers acquire meaning when we answer the question, Compared to what? When comparing against a nonpatient population, we are asking, Is this person more distressed . . . than the average person on the street? When comparing against an outpatient mental health population, we are asking, how intensely is this

[14] A publication from the National Association for Research and Therapy of Homosexuality (NARTH) gave another illustration: "[A] drug that cured cancer in only 1 percent of those who took it—but that failed in 99 percent of patients, and that caused short-term nausea as well—would not be taken off the market; in fact it would be ethically endorsed as at least worth a try. . . ." (Phelan et al., 2009, p. 47).

> person distressed compared to the average person currently in treatment for psychological or emotional concerns? (Jones and Yarhouse, 2007, pp. 334–335)

Although I will reserve most of the conclusions of this paper until the end, let me offer the answer to this question right here. *Almost none of the 79 studies on the "Measures of Harm" list uses any control group to compare to those who had SOCE—and none does all of the comparisons recommended here.*[15] This is important to bear in mind from the outset. Even the studies in which some subjects reported that they were harmed by SOCE or reported experiencing negative mental health conditions subsequent to SOCE offer *no answer* to the all-important question—harm *compared to what?*

What Is Not Harm?

While I was reading through the 79 sources analyzed here, it became clear that some critics who assert that SOCE is harmful use a very broad definition of "harm" that includes some concepts which should not actually be counted as "harms," especially in the context of debates over legal restrictions upon SOCE. The following, though sometimes cited in the literature, should *not* be considered "harms" for our purposes:

- **"Failure to change"**—Some writers argue that SOCE clients have automatically been harmed if the counseling or therapy does not succeed in bringing about fundamental change in the client's sexual orientation. However, this is nothing but a re-statement of the claim that SOCE is ineffective. The claim that SOCE is ineffective and the claim that it is harmful are usually presented as *two separate* claims in support of arguments for discouraging or restricting SOCE; counting the failure to change as a *form* of harm is really a form of double-counting as far as claims supporting arguments against SOCE are concerned.
- **"Waste of time and resources"**—Some critics of SOCE assert that clients are harmed if they spend time and money on an unsuccessful attempt to change their sexual orientation. This, too, is simply a double counting of the claim that SOCE is ineffective and should not be counted as a separate argument on its own.
- **"Delay in coming out"**—Some critics argue that clients are harmed because SOCE delays their "coming out" as gay, becoming integrated into the "gay community," and enjoying whatever pleasures or satisfactions they may experience from engaging in homosexual relationships. These critics assert that an eventual acceptance of a "gay" identity is virtually inevitable (because SOCE cannot prevent it), and that it is a positive thing in and of itself. However, from the perspective of a person seeking to *resist* same-sex attractions and a gay identity and to abstain from homosexual relationships, a delay in "coming out" would be seen as signifying the *success* of SOCE, not a harm from it. As is noted in one of the "Measures of Harm" studies, even some participants who had persisting same-sex attractions, but who

[15] Jones and Yarhouse (2007) did compare results for psychological distress in their sample "against nonpatient norms"—those not in therapy—and "against outpatient mental health norms"—those in therapy for other issues (p. 336; see Tables 9.1 and 9.2, pp. 338–341). Another of the studies, Santero et al. (2018), also compared their results with data from *other* sources on outcomes for other types of therapy. See my analyses of these studies later in this paper. However, neither of these studies used a formal control group that was recruited as part of *their own* study.

considered their therapy successful because they adopted a lifestyle of chastity, "regard themselves as having reestablished their sexual identities to be defined in some way other than by their homosexual attractions. No data . . . suggest that this is a maladaptive or unsustainable outcome" (Jones and Yarhouse, 2011, pp. 422–423).

- **"Reinforces homophobia"**—Some critics claim SOCE is harmful simply because it reinforces negative attitudes toward homosexuality itself—attitudes sometimes referred to as "homophobia" or "homonegativity." Often the assertion is that it reinforces "internalized homophobia"—a belief within the client that there is something undesirable about same-sex attractions, which in turn may damage the client's self-esteem. Sometimes critics claim SOCE is harmful simply because it reinforces "societal homophobia"—the belief by anyone (not just the client) that homosexuality is undesirable. Davison (1978), for example, says that "to assume that people are not being hurt by the prevalent prejudices is . . . naïve. . . . [P]eople are being hurt by the availability of change-of-orientation programs, and these include people who are not themselves seeing therapists" (pp. 171–72). Similarly, Burack (2015) charges, "The ex-gay movement encourages the flourishing of a morality" that fails at "connecting the ideology and public policies they espouse . . . to the forms of harms that befall these same-sex attracted people." However, she is referring to individuals "damaged by the culture wars" before they even seek therapy—not people "damaged" by SOCE itself (225).

The question of whether any aspect of homosexuality (same-sex attractions, homosexual conduct, or an LGB identity) is desirable or undesirable, though, is in large part a question of morality, ideology, and personal opinion. Jones and Yarhouse (2007) point out that a different ideological construct results in a completely different evaluation of what is harmful, noting that

> anecdotes of harm from the attempt to change must be counterbalanced against counter anecdotes, specifically the type that circulate in ministry circles of individuals who experience despair in the gay community because they do not know that the possibility of an alternative to the gay lifestyle exists. (p. 361)

Jones and Yarhouse therefore assert that, as part of "informed consent,"

> clients should also be told of the potential benefits, risks and costs of *not* attempting the intervention; in the case of homosexuality, for example, we do not know what the potential risks would be for conservative religious clients of limiting treatment options to only those approaches that aim to integrate experiences of same-sex attractions into a gay identity. (p. 381)

The idea that SOCE "reinforces homophobia" is essentially an ideological conviction, not an objective harm.

What Does *Constitute Harm?*

There are, of course, several things that could legitimately be counted as "harms," if it could be proved that they are a result of participating in sexual orientation change efforts. Some are clear-cut harms, and some others at least raise legitimate concerns. These include:

- **Depression and anxiety**—Any noticeable deterioration in a person's mental health as a direct result of a particular intervention could legitimately be labeled harmful. Depression and anxiety are two of the most common manifestations of poor mental health.
- **Other "psychological distress"**—There may be other mental health consequences that do not fit strictly under the label of "depression" or "anxiety" that could still be counted as harms. "Psychological distress" is a broad term intended to capture these possibilities.
- **Suicidal thoughts or actions**—The most dramatic negative mental health result possible is when an individual commits suicide. Any intervention that can be shown to result in higher levels of suicidality—including suicidal thoughts, suicide planning, suicide attempts, and actual completed suicides—would certainly be considered harmful.
- **"Shame"**—Critics of SOCE frequently claim that SOCE not only results in "shame" in clients, but intentionally operates by instilling "shame." Many SOCE therapists would take issue with this, insisting that clients come *into* therapy with a sense of shame, and one of their first goals is to overcome it (see, e.g., Nicolosi, 2010). If "shame" is defined as the equivalent of "guilt," some people would suggest it is not really a harm—just as pain serves the important function of warning about physical harm, guilt serves the important function of warning about moral harm. There are some things of which we *should* be "ashamed."[16] However, to the extent that "shame" reflects a lack of personal self-esteem, it may be considered a legitimate mental health concern.
- **"Aversion" therapy**—A key tactic used by critics of SOCE is to recount horror stories of clients subjected to what is called "aversion" (or "aversive") therapy. This is a form of behavioral therapy in which a negative physical stimulus (such as a mild electric shock or nausea-inducing medicine) is applied in connection with homosexual arousal, in an effort to create an "aversion" to homosexual arousal or conduct via the negative association with physical pain or discomfort.[17] Similar methods have been used for other purposes, such as helping people to quit smoking. Throckmorton's (1998) review of the literature cited five articles on "[a]versive therapies . . . to change sexual orientation" between 1935 and 1974.[18] In their debunking of "myths" about aversion therapy, however, Byrd & Phelan (2011) declare, "Aversion techniques are no longer used to treat unwanted homosexual attractions."[19] The most recent documented use of *physical* aversion

[16] The article by Burack (2015) offers an explanation of "the conservative Christian interpretation of guilt" (pp. 223–224).

[17] A milder variant of the "aversive" concept is what is called "covert sensitization," defined by the American Psychological Association as "a behavior therapy technique for reducing an undesired behavior in which the client imagines performing the undesired behavior . . . and then imagines an unpleasant consequence. . . . (American Psychological Association, 2020). For a comparison of (physically) aversive therapy and covert sensitization, see McConaghy et al. (1981).

[18] Throckmorton (1998) cites an additional four articles on "the use of covert sensitization" published between 1970 and 1976.

[19] This appears to refer to physical aversion techniques, not to "covert sensitization," which may have persisted longer in some quarters. One of the most recent studies on the "Measures of Harm" list (Santero et al., 2018) includes "covert aversion" as a SOCE technique recalled by 82 of the study's 125 subjects. However, they also found it the least beneficial of 15 such techniques (Table 3, p. 6). The most recent documented use of *physical* aversion techniques that I have found is forty years ago, in McConaghy (1981).

techniques that I have found is forty years ago, in McConaghy et al. (1981). (Any reports of its more recent use should therefore be greeted with skepticism. See Sprigg, 2018a.) Theoretically, aversion therapies could and should be subjected to the same tests for long-term negative mental health consequences as any other therapy. However, the fact that they involve the application of physical pain or discomfort, and the fact that virtually all SOCE therapists have renounced such techniques, is sufficient reason to consider any use of physical aversion therapy as a "harmful" approach.

With that preliminary framework for how to think about this issue established, let's now take a look at what the 79 studies in the "Measures of Harm" document actually show.

Results

No Harm Mentioned

The first finding is perhaps the most surprising—18 of the 79 studies (23%) do not contain *any* assertion or even discussion of the possibility of "harm" to individual clients resulting from SOCE. This must cast doubt on the credibility of the "Measures of Harm" document right from the start.

The studies that do *not* assert that SOCE causes harm—and therefore should never have been placed on the list—are:

Borowich (2008)
Burack (2015)
Davison (1978)
Drescher (1998)
Drescher (2009)
Fetner (2005)
Fischer & Good (1997)
Freund (1960)
Freund (1977a)
Freund (1977b)
Hill & DiClementi (2003)
Hoffmann (2012)
O'Donohue & Plaud (1994)
Pfaus et al. (2012)
Ponticelli (1999)
Reamer (2014)
Savin-Williams (2016)
Schrimshaw et al. (2013)

This collection of sources is diverse. The fact that they do not assert that SOCE harms individual clients does not mean they are not critical of the practice.

Drescher, for example, is a prominent SOCE critic, the author of four of the sources on the "Measures of Harm" list. In his 1998 article, however, his strongest charge is that SOCE is unscientific, not that it is harmful; he claims that SOCE therapists "obscure their increasingly fundamentalist religious political agendas behind scientific and pseudo-scientific language" (p. 38). Ironically, Drescher's charge that some therapists are "preaching dogma and stifling dissent" (p. 19) could be applied to those seeking to ban SOCE, not just to those who practice it.

Several question the effectiveness of SOCE, but without asserting it is harmful. The earliest source on the entire "Measures of Harm" document, Freund (1960), reported, "Hitherto, there has been no proof of the efficacy of any form of treatment as applied to homosexuals" (p. 324). Hill and DiClementi (2003) argue "internalized homophobia" that causes some clients to *seek* SOCE (not that results from it) could cause them to distort their self-reporting for studies that appear to show the effectiveness of SOCE, such as a widely publicized 2003 study by Robert Spitzer (Spitzer, 2003). Reamer's (2014) book chapter offers 20 pages about ethical and moral challenges, calling SOCE "questionable" and "controversial," but its most direct critique says, "Social workers who use intervention

approaches for which there is no empirical support violate ethical standards" (p. 242). However, his only suggestion of "harm" relates to Christian social workers who might refuse to treat, refer out, or terminate treatment with LGBT clients—not ones who offer them SOCE (p. 241).

Three of the articles on this list deal with the role of "conditioning" in the development of sexual arousal or behavior. This is the concept behind "aversion therapy," but none of these articles assert harm to individual clients. O'Donohue & Plaud (1994) give a historical overview of research on "the relationship between conditioning and human sexual behavior" (p. 321), including experiments on homosexuals and pedophiles, but they do not report harms. Although the title of the Hoffmann (2012) paper is "Considering the Role of Conditioning in Sexual Orientation," the paper itself only includes a single paragraph directly related to SOCE, which concludes that "the effectiveness of these procedures is difficult to assess"—despite the paper's broader conclusion that "descriptive and some experimental research support a role for experience, and in particular conditioning, in the development of sexual arousal patterns in humans" (p. 67). Pfaus et al. (2012) is a study not of humans but of *rats*, which "describes how experience with sexual reward strengthens the development of sexual behavior and induces sexually-conditioned place and partner preferences in rats" (p. 31). In this startling experiment, some rats were not only conditioned to tolerate, but to actively prefer, sex with partners that smelled like dead bodies. Despite this demonstration in animals of "a high degree of plasticity" (p. 52) and "an extraordinary level of flexibility" in sexual arousal, the authors asserted, "This does not mean that sexual orientation and preferences can be altered once they are established" (p. 55).

Two of these sources focus on media, rather than on therapy or counseling per se. Drescher (2009) discusses "techniques of distorting science in the media." Only two pages of this twelve-page article are devoted to SOCE, including a paragraph on a widely reported series of ex-gay newspaper ads that led to a *Newsweek* cover story in 1998 (pp. 217–218). Drescher acknowledges, "Political distortions of science can occur on the right and left wings"—but all of his examples are on the right (p. 213). Ironically, however, many of his criticisms could apply directly to distortions of the facts about SOCE by its critics:

> [S]ound policy making requires objective scientific data . . . [but] special interest groups often try to distort scientific findings . . . Also troubling is the publicizing of "research" created solely to support political agendas. Such activities raise the troubling question of whether science as we know it can survive politicization . . . [including] contemporary attacks on science in what have come to be known as the "culture wars." (p. 213)

Drescher even acknowledges conservative criticisms "that mainstream mental health organizations like the two APAs, which for decades have had openly gay, lesbian and bisexual members, have been taken over by 'gay activists' within the organization" (p. 223).

Fetner (2005) analyzes the same 1998 "Truth in Love" ad campaign and the response to it from LGBT organizations. However, according to Fetner, the response of those organizations in 1998 to the claim that sexual orientation can change was *not* to claim that efforts to change are harmful, but to re-establish "a symbolic foundation that

understands LGBT people to be an oppressed minority group" p. (84).

At least a third of Burack's (2015) paper is devoted to "the application of psychoanalytic theory to interpret the deep structure and unconscious meanings of ex-gay ideology" itself (p. 224).

Sources That Assert Harm, but with No Subjects

More than a third of the sources on the "Measures of Harm" list—28 of 79, or 35%—do assert or suggest that SOCE may be harmful, but feature *no* study subjects. In other words, these are either literature reviews or opinion pieces, but ones that do not involve any direct examination of clients who have undergone SOCE. They have a sample size of *zero*.

Of course, there is a place for literature reviews—such as this one. However, some of these sources barely merit even the label of "literature review." In fact, four of the sources I have classified in this category *do not cite a single source* that demonstrates harm from SOCE. Those are:

> Forstein (2001)
> Haldeman (1994)
> Tozer & McClanahan (1999)
> Wakefield (2003)

Douglas C. Haldeman is one of the most prominent critics of SOCE and author of four of the sources on the "Measures of Harm" list. Even before these four sources, in 1991 Haldeman published a book chapter on "sexual orientation conversion therapy for gay men and lesbians" (Haldeman, 1991), which represents the earliest use of the term "conversion therapy" that I have yet discovered.[20] Although his 1994 article describes anecdotally several harms that may ensue from SOCE, such as "increased guilt, anxiety, and low self-esteem," it is significant that he admits a complete absence of data on the topic:

> Not one investigator has ever raised the possibility that conversion treatments may harm some participants. . . . The research question, "What is being accomplished by conversion treatments?" may well be replaced by, "What harm has been done in the name of sexual reorientation?" *At present, no data are extant.* (Haldeman, 1994, p. 225; emphasis added)

Tozer & McClanahan (1999) report on a 1997 American Psychological Association resolution that was critical of SOCE, but note, "The resolution addressed the sociopolitical context in which conversion therapies take place rather than targeting specific techniques of psychotherapists," adding that "it did not explicitly ban reorientation therapies." Part of the reason is that the chair of the panel that passed the resolution admitted, "Researchers have yet to show conclusively that conversion therapy is indeed harmful" (p. 732).[21]

Forstein (2001) says that an ethical response to "a patient who wants to change

[20] I have a theory that Haldeman's use—and perhaps coining—of the term "conversion therapy" may be the reason why it is the term favored by SOCE critics, even though practitioners virtually never use it. Perhaps the use of the word "conversion" is a subtle way of suggesting that SOCE is essentially a religious undertaking, not a therapeutic one. It could even represent a deliberate effort to conflate all SOCE methods with the similar-sounding "aversion" therapy. I have only come across two articles in which a practitioner or defender of SOCE uses the term "conversion therapy" in a neutral or favorable way (Throckmorton, 1998; Rosik, 2001).

[21] Tozer & McClanahan cite the October 1997 issue of the *APA Monitor*, p. 15, for the latter quote, but do not give full bibliographic information.

their homosexual orientation" would require "[i]nformed consent that includes . . . what the risks and/or benefits might be, including outcomes which could seriously hinder social, sexual, and psychological functioning," but also noting "that there are no studies as of yet published in peer-reviewed, scientific, respected journals to provide these data" (p. 177).

Another nine of these sources cite *only one or two sources* that support the charge of harm. Those are:

Bright (2004)
Diamond & Rosky (2017)
Drescher (2003)
Friedman (2003)
Gonsiorek (2004)
Herek (2003)
Lasser & Gottlieb (2004)
Miville & Ferguson (2004)
Steigerwald & Janson (2003)

Fifteen of the "zero-subject" sources cite three or more sources related to SOCE harm:

Arthur et al. (2014)
Beckstead (2012)
Cramer et al. (2008)
Drescher (2001)
Grace (2008)
Green (2003)
Halpert (2000)
Hein & Matthews (2010)
Jenkins & Johnston (2004)
McGeorge et al. (2015)
Morrow & Beckstead (2004)
Schreier (1998)
Serovich et al. (2008)
Silverstein (2003)
Walker (2013)

Sources That Assert or Discuss the Possibility of Harm That Include Reports on Actual SOCE Clients

Only a minority of the sources found on the "Measures of Harm" document—33 of 79, or 42%—include a discussion of harm in the context of studies or case reports on individuals who have undertaken SOCE. However, some of these have sample sizes so small that it would be impossible to draw general conclusions from them. Nine of these articles reported sample sizes of *seven or fewer* SOCE clients. Four of them reported on *only one client.* They were:

Ford (2002)
Johnson (2004)
Moor (2002)
Schneider et al. (2002)

Here are the remainder of these "small-sample" sources, with the number of SOCE clients on which they report:

Dickinson et al. (2012)	7 clients
Green (2017)	2
Haldeman (2001)	4
Haldeman (2004)	3
Haldeman (2012)	2

Sources with Eight or More Subjects

That leaves a total of 24 sources on the list—only 30%—that discussed harms and examined samples of eight or more subjects. Fewer than half of these (11) featured sample sizes of 50 or more. They are discussed in "The Six Key Studies" (below). Here are the 13 articles that discussed samples of at least eight but less than 50 subjects:

Fjelstrom (2013)
Flentje et al. (2013)
Flentje et al. (2014)
Jacobsen & Wright (2014)
Johnston & Jenkins (2006)
King et al. (2004)

Krajeski et al. (1981)
Krajeski (1984)
Maccio (2010)
Maccio (2011)
Moran (2007)
Smith et al. (2004)
Tozer & Hayes (2004)

Generally, the larger the sample size of a study, the more reasonable it is to conclude that its findings might be generalized to the larger population the sample is intended to represent (in this case, the population of clients who participate in sexual orientation change efforts).

The Six Key Studies (50 or More Subjects)

The 79 sources on the "Measures of Harm" list represented only *six* studies which discussed harm and included samples of *50 or more* SOCE clients. Because some of those who conducted this research wrote more than one article on the resulting database, there are *eleven* articles in the list of 79 which are based upon these six most significant studies. Here is a summary of the key studies included on the "Measures of Harm" list:

***Dehlin et al. (2015)* and *Bradshaw et al. (2015)*[22]**

Sample Size: 1,612 (76% male, 24% female).

Sample Type: Web-based survey entitled "Exploration of Experiences of and Resources for Same-Sex-Attracted Latter-day Saints"; respondents had undertaken activities to "understand, cope with, or change" their sexual orientation; data collected from July–September 2011.

Assertion of Harm: 37% "of those whose therapy focused on SOCE evaluated the experience" as "harmful"—21% "moderately harmful" and 16% "severely harmful" (Bradshaw et al. 2015, p. 398.) "The clear evidence . . . is that dutiful long-term psychotherapeutic efforts to change . . . carry significant potential for serious harm. . . ." (Bradshaw et al., 2015, pp. 409–410).

Discussion: This study has two major advantages over most in the field:

- It has the largest sample size of any study on the "Measures of Harm" list; and
- It distinguished between different types of sexual orientation change efforts.

However, the sample was not random—it consisted of self-selected internet users. The authors admitted, "Our reliance on convenience sampling limits our ability to generalize our finding to the entire population. . . ." It also targeted *only* people who are (or were once) Mormons.

The study listed nine "SOCE methods:"

- Personal righteousness
- Individual effort
- Church counseling
- Psychotherapy
- Support groups
- Group therapy
- Group retreats
- Psychiatry
- Family therapy

"Personal righteousness" (including "prayer, fasting, scripture study") and "individual effort" (such as "journaling," "self-punishment," and seeking to "date the opposite sex"—Dehlin et al., 2015, 99) hardly qualify as SOCE (and certainly not as "conversion therapy").[23] The biggest

[22] An additional detailed analysis (and critique, from a pro-SOCE perspective) of these studies can be found in Rosik (2014).

[23] Even "church counseling" may carry a different connotation in the LDS context from what it might imply to Protestants or Catholics. Mormons do not employ a professional clergy but are instead led

methodological weakness in this study, however, was that experiences with SOCE were rated on a single scale with "harm" and "effectiveness" at opposite ends. This is conceptually misguided, since harm and effectiveness are two different questions. A particular approach could be *both* "effective" (that is, result in some significant change in sexual orientation) *and* harmful (for example, result in an increase in depression and anxiety). On the other hand, a SOCE could be *neither* "effective" (because it results in no change in sexual orientation) *nor* harmful (because it results in no change to, or even an improvement in, other areas of mental health).

Nevertheless, the authors used a scale of 1–5, asking respondents to identify their experience as:

- 1 = severely harmful
- 2 = moderately harmful
- 3 = not effective
- 4 = moderately effective
- 5 = highly effective

(Dehlin et al., 2015, Table 1, p. 99[24])

An average rating above 3.0 for any particular method would indicate that for the average participant it was *more effective than harmful*. Despite the authors' generally negative tone toward SOCE, nearly half of these scores (8 of 17)[25] were above 3.0 (and a ninth was exactly 3.00). A *minority* of the scores showed the method more harmful than effective. Of the formal methods more commonly referred to as "therapy" or SOCE—psychotherapy, support groups, group therapy, group retreats, psychiatry, and family therapy—8 of 11 ratings were above 3.0, or more effective than harmful (Dehlin et al., 2015, Table 1, p. 99).

When exact percentages for each rating were reported, for a majority of methods (5 of 9), positive answers indicating SOCE was "effective" exceeded negative answers indicating it was "harmful."[26] No method of SOCE was rated "harmful" by a majority of respondents, and none was rated "severely harmful" by more than 27% (Dehlin et al., 2015, Figure 1, p. 100). In addition to the subjective self-rating, the authors employed some "pre-existing measures assessing psychosocial health" (Dehlin et al., 2015, p. 97). The authors reported that "SOCE participants in this sample showed no differences in quality of life from those who had not engaged in SOCE" (p. 102), and they also found no significant differences in self-esteem between these groups (Table 2, p. 101). This undermines any theory that SOCE would cause lasting damage that leaves people worse off than those who did not undertake SOCE.

A follow-up article (Bradshaw et al., 2015) focused on respondents who said they had undergone psychotherapy.[27] Respondents had been invited to write an open-ended narrative about their experiences. Strikingly, reports of "benefit" from

by "laypersons . . . without professional training in theology"—let alone in psychology (Keller, 1992, p. 288).

[24] Confusingly, the ratings were reversed when reported in the second journal article based on this survey, with 1 being "very effective" and 5 being "severely harmful." See Bradshaw et al. (2015), p. 398.

[25] With nine different methods, and results reported for both sexes, a total of 17 average scores were reported. One method, family therapy, had no women who pursued sexual orientation change as a goal.

[26] For two of the methods, positive answers were *more than double* the negative ones (Group Retreats, 48% effective to 20% harmful; Support Groups, 41% effective and 20% harmful).

[27] Only a little over half of their respondents (898 out of 1,612, or 56%) reported that they had undergone psychotherapy (Bradshaw et al., 2015, p. 394); but of those, only 367 (330 men and 37 women) reported that "they actually worked on sexual orientation change in therapy" (p. 399).

psychotherapeutic SOCE clearly outnumbered reports of "detriment." The authors even acknowledge this, stating that "experiences of harm or . . . distress were much less frequent than reports of benefit" (Bradshaw et al., 2015, p. 406). For example:

- 109 indicate that therapy overall was "positive" or "helpful," with 12 even describing it as "life-saving." In contrast, only 29 reported that they "felt worse after" therapy.
- 98 respondents said the therapy resulted in "improved self-esteem," while only 33 said they were "damaged" or found it "harmful."
- 80 reported that "depression and anxiety" were "decreased" by the therapy, while only seven said they "increased."
- While four respondents said they had attempted suicide after therapy, *fifteen* respondents said the therapy helped them *avoid* suicide (Bradshaw et al., 2015, Table 5, p. 407).

The data presented in these two articles simply do *not* support the authors' sweeping conclusion that there is "clear evidence" of a "significant potential for serious harm" from SOCE (Bradshaw et al., 2015, pp. 409–410), especially when psychotherapy is the method utilized.

Weiss et al. (2010)

Sample Size: 338 (267 "ex-gay," 79% male; 71 "ex-ex-gay," 82% male—Table 1, p. 297).

Sample Type: "Participants in this study were individuals who posted to Internet message boards related to changing one's sexual orientation from gay to straight. . . . This search resulted in three message boards for ex-gays and two for ex-ex-gays" (p. 294). "Five coders were involved. . . . [W]e read approximately 1,000 posts and created codes for any idea or expression that seemed relevant . . . [then] we identified core themes and grouped codes according to these larger thematic units . . ." (p. 296).

Assertion of Harm: "In both samples, statements of negative feelings during the ['conversion therapy'] process were far more common than those of positive feelings" (p. 305). "Participants in both studies reported depression, suicidal ideation, and deficits in self-esteem. Socially, both participant groups reported loneliness, social isolation, and lack of social supports while beginning or ending conversion therapy" (p. 312).

Discussion: By the authors' own admission, "This study used *qualitative* methodology," (p. 291, emphasis added), not *quantitative* methodology, suggesting it does not really belong on a list of studies with "*measures* of harm." With any study using "convenience samples" (that is, self-selected volunteers), there is no way of knowing whether the participants are representative of the larger population (in this case, of people who have undertaken SOCE). The authors argue that their methodology (of "online 'surveillance,'" p. 295) avoids the risk of participants volunteering for the study in order to promote a particular viewpoint ("response bias," p. 293). However, there is also no way of knowing whether people who voluntarily choose to post on a publicly available message board are representative of the larger population, and this methodology injects the possibility of bias not only on the part of the participants themselves, but of those "coding" their comments.

In addition, it is worth noting that most of those posting on the "ex-gay" message boards were people still in the process of seeking change, while those on the "ex-ex-gay" message boards were, by definition, people for whom SOCE was a *past* event. This creates an apples-to-oranges comparison between *current* SOCE clients pursuing change and *past* SOCE clients who

had since abandoned any effort to change any aspects of their homosexual orientation. The study omits the entire category of SOCE "successes" who may have *completed* the change process and now do *not* embrace a "gay" identity.

Even the title of this study indicates that it is about "ex-gay and ex-ex-gay *experiences*" (emphasis added) in general, not about specific facilitated "change efforts" or "therapy" in particular. Although critics routinely refer to all SOCE as "conversion therapy," it is striking how few of the subjects in this study reported having undertaken actual "therapy." On the ex-gay message boards, out of 57 messages regarding "strategies tried," less than a third involved "therapy" (16 religious, 2 secular). That is smaller than the number who participated in a religious "support group" (19), and about the same as those who used what we might call informal religious methods ("prayer," "accountability partner," "reading ex-gay books," or "confession"—16 total; Table 2, p. 298). On the ex-ex-gay message boards, only four out of fifteen reported "strategies tried" involved "therapy"—fewer than the number (5) who saw "marriage" as a "strategy" (Table 3, p. 300).[28]

Although it is true that comments which were generally negative in tone exceeded those generally positive in tone on both message boards (according to the coders), it is still striking how few reported some of the "harms" usually raised in critiques of SOCE. For example, on the ex-gay message boards, out of 540 coded comments, only 18 indicated experiences of "depression" (13 "explicit" and 5 "implicit"), and 15 indicated some form of suicidality (13 "active" and 2 "passive"—Table 2, p. 299). On the ex-ex-gay message boards, out of 105 coded comments, only 4 indicated "depression" and only 2 indicated "suicidal ideation or attempt" (Table 3, p. 300). Notably, the authors indicated:

> The majority of respondents that reported being suicidal stated that it was the prospect of being gay . . . that led them to thoughts of suicide, rather than the struggle of trying not to be gay. (p. 306)

Since "ex-ex-gay message boards" might be expected to attract a disproportionate number of people asserting harm or expressing bitterness about the change process, it was actually surprising how positive some of their comments were. They certainly undermine, rather than support, the claim that SOCE generally causes lasting damage. As the authors report:

> Most of the posters to the ex-ex-gay boards report currently being in overall good psychological health. The most common statements . . . were that they valued their journey through the process. . . . By and large, ex-ex-gay posters view their experience in the ex-gay movement as having yielded positive results in the long run. . . . (pp. 308–309)

Beckstead (2001); Beckstead (2003); Beckstead & Morrow (2004)

Sample Size: 50 (45 men, 5 women).

Sample Type: Convenience sample of people "who had undergone therapy to change their sexual orientation" from various sources in Utah and in Mormon circles, as well as "snowball sampling" (referrals from other participants) between 1997 and 2001.

[28] While some participants may enter SOCE with marriage to an opposite-sex partner as an ultimate *goal*, I am not aware of any therapist or counselor who would recommend it as a *strategy* to accomplish change, and most would strongly caution *against* any rush toward marriage by an individual who has struggled with same-sex attractions.

All "had experienced a Mormon religious upbringing or conversion." Forty-two chose to be interviewed; "Of these, 20 (2 women, 18 men) reported only positive outcomes and were classified as 'proponents,' and 22 (2 women, 20 men) reported primarily negative outcomes and were classified as 'opponents.' . . . In addition, 8 other individuals (1 woman, 7 men) who had also undergone conversion therapy" participated in "a focus group discussion" (Beckstead & Morrow, 2004, pp. 656–657).

Assertion of Harm: "Most opponent participants believed . . . that 'conversion therapy damages each aspect of an individual.' . . . Overall, 4 proponent and 4 opponent participants attempted suicide after counseling . . ." (Beckstead and Morrow, 2004, p. 671).

Discussion: As with Weiss et al. (2010), Beckstead and Morrow (2004) acknowledge, "Qualitative methods were selected for this investigation," methods "that sought to understand the subjective meanings participants attributed to their experiences" (p. 654). Methods that are "qualitative" (rather than "quantitative") can produce anecdotes; but they cannot, by definition, produce "measures" of harm. Furthermore, the authors state explicitly, "The results of this or any qualitative study are not intended to generalize to the larger population of individuals who have undergone conversion therapies" (p. 683.).

In Beckstead (2001), the potential for harm is not even listed as one of the two key issues "surrounding the ethics of sexual reorientation therapy"; instead, client "self-determination" and the therapy's "efficacy" are cited. In Beckstead's writings in general there are extensive discussions of the potential for harm, but most of the "harms" asserted fall in the categories that I have mentioned as *not* being the type that might (if sufficiently prevalent and severe) justify legal restrictions on pursuing the goal of sexual orientation change in therapy. For example, Beckstead & Morrow (2004) cite "lost loves and friendships, wasted time and resources, a slowing down of the 'coming-out' process," and "decreased capacity for same-sex intimacy" (p. 671); and Beckstead (2003) claimed that SOCE reinforces "negative stereotypes of the lives of lesbian, bisexual, and gay individuals" (p. 423).

However, Beckstead & Morrow (2004) admit, "Both proponent and opponent participants described positive experiences with conversion therapy, which was an unexpected finding . . ." (p. 668). Yet another "unexpected finding was that several opponent participants expressed a need for the option of conversion therapy because as they explained, it gave them the space to explore being an 'ex-gay' as they met others like themselves" (p. 673).

Beckstead and Morrow (2004) acknowledge that "proponent participants . . . reported only conversion therapy benefits, no therapeutic harms, and heterosexual functioning" (pp. 684–685). A separate article (Beckstead, 2001) focuses entirely on the views of SOCE "proponents." It notes that SOCE therapy "seemed to develop for participants a new sense of belonging, self-efficacy, and acceptance" (p. 101), and says, "Participants referred to this increased self-understanding and self-acceptance as finding 'wholeness' and congruence" (pp. 102–103).

Beckstead and Morrow (2004) say that "it is important to value the successes made by proponent participants" (p. 686) and that "we must accept that participants' self-identifications and constructed perspectives are valid for them . . ." (p. 685). Although they ultimately "denounce" SOCE—asserting that its benefits can be obtained by other means (p. 686)—they are more respectful than most SOCE critics of the fact that for many clients, "their sexual identities [are] peripheral to their religious identities" (p. 663), and "not all same-sex-attracted

individuals are able to enter into or benefit from . . . therapy that focuses solely on identifying as LGB" (p. 686).

***Santero et al. (2018)*[29]**

Sample Size: 125 (all male).

Sample Type: Participants recruited from "[e]x-gay ministry groups and affiliated private therapists throughout the United States," surveyed between January and February 2011 (p. 3). A large majority (97%) had undergone professional therapy, but most (86%) had also participated in "less formal" methods (p. 4). The sample was highly religious, with 98.6% having an "[a]ctive belief system" and 89% identifying themselves as some type of Christian (p. 3). Religious reasons were the most common reason cited (by 64%) for entering SOCE (p. 4).

Assertion of Harm: "The techniques that participants rated as the most harmful to SOCE overall (all responses combined) were 'going to the gym' (16 percent), 'imagining getting AIDS' (used as 'covert aversion' 13.6 percent), 'stopping homosexual thoughts' (12.8 percent), and 'abstaining from masturbation' (10.4 percent)" (p. 9). "Only one participant reported extreme negative effects, which were on suicidality and self-harm" (p. 11).

Discussion: Among the hypotheses tested by Santero et al. were that SOCE "produces more harm than help" and that it is "more harmful than therapies on completely different unwanted problems" (p. 3). However, the authors found that SOCE was overwhelmingly more helpful than harmful to those they surveyed. Participants experienced "moderate-to-marked decreases in suicidality, depression, substance abuse, and increases in social functioning and self-esteem. Almost all harmful effects were none to slight" (p. 1).

The authors asked respondents to rate seventeen therapy "techniques" by endorsing "one response only from [the] entire [9-point] harm/help range" (p. 6). The weakness of using such a single scale has already been noted with respect to the Dehlin et al. (2015) and Bradshaw et al. (2015) studies. "Overall, the hypothesis that any technique was predominantly harmful was strongly rejected,

[29] The Santero et al. study passed peer review and was published in a peer-reviewed journal, *The Linacre Quarterly* (the official journal of the Catholic Medical Association), in 2018. However, less than a year later, the journal formally retracted the study due to what they called "unresolved statistical differences," asserting that "a statistical review of the paper, which was recommended during peer review, had not been conducted." When the editor commissioned such a review "after receiving questions about the article," the review identified "concerns regarding the methodology," such as this: "No common intervention was given to participants that would allow for a valid conclusion to be drawn." Specifically, the editor (or the "statistical reviewer") asserted that "the paper did not clearly address whether all respondents were treated according to the same (or similar) protocols and for the same periods of time, and/or by therapists of like or similar training and expertise." This standard, however, is one that virtually none of the "Peer-Reviewed Journal Articles" on the "Measures of Harm" list would be able to meet. (Compare, for example, the nine widely varying techniques studied by Dehlin et al., 2015, as noted above.) The authors responded, "The only uniformity needed and employed, was SOCE and therapeutic involvement." The editor did not indicate that the authors had in any way mis-stated or misrepresented their data or statistical analyses in the published paper, noting explicitly "that the retraction is not based on any action taken by the authors but only the statistical concerns outlined above." Nevertheless, she stood by the retraction. See: Retraction notice: Effects of therapy on religious men who have unwanted same-sex attraction (2020). Co-author Neil Whitehead has given a further detailed defense of the study and its statistical methods (Whitehead, 2019). In 2021, a completely new and original peer-reviewed analysis of the same data set was published, and the authors "found pursuit of SOCE to be associated with enhanced psychological well-being for a large majority of participants, with negative effects being reported by less than 1 in 20 consumers" (Sullins et al., 2021, p. 15).

and effect sizes . . . were all large" (Santero et al., 2018, p. 9).

With respect to six different "mental health issues," however, "respondents were asked to give both positive and negative experiences" (p. 14). In this analysis, "Positive effects on self-esteem were all marked or extreme, and the three respondents with initial suicidality all experienced an extreme beneficial effect" (p. 9). "Participants reported improvements (with large effect sizes) in self-esteem and social functioning, and similarly decreases in suicidality, substance abuse, depression, and self-harm. Before therapy, they had experienced an average of three of these problems" (p. 12). Therefore, "The hypotheses that harm predominates is rejected strongly because calculated probabilities are extremely low" (p. 10). "Most importantly, the overwhelming majority—70 percent of the participants—claimed only beneficial effects from the therapy" (p. 14).

Santero et al. were among only a few authors on the "Measures of Harm" list (together with Jones and Yarhouse, 2007 and 2011) who compared the potential benefits and harms of SOCE with those of other types of therapy. "The study . . . had a similar harmfulness rate compared to general psychotherapy. The percentage of patients leaving treatment worse off than when entering is 5–10 percent. . . . The current study had a similar rate (12 percent) for depression. . . . In the present study, increased suicidality was 8.9 percent, but intensity was slight, and other unwanted problems were less than 5 percent" (pp. 13–14). Therefore, note the authors, "This therapy is not really exceptional but should be considered in the ranks of the conventional . . ." (p. 15).

Shidlo and Schroeder (2002); Schroeder and Shidlo (2002)

Sample Size: 202 (90% male, 10% female).

Sample Type: Convenience sample recruited by various means including "gay and lesbian Web sites and E-mail lists," "newspaper advertisements in the gay and lesbian and the nongay press," and "direct mailings to gay and ex-gay organizations and to a national professional association of conversion therapists" (Shidlo and Schroeder, 2002, p. 251).

Assertion of Harm: "One group (155 individuals)" who now identify as gay "experienced significant long-term damage from the conversion therapy. . . . Many consumers of conversion therapies reported to us that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination" (Shidlo and Schroeder, 2002, p. 254). "These negative effects include depression, poor self-esteem, and difficulties with intimate relationships" (Schroeder and Shidlo, 2002, p. 161).

Discussion: Even though it is now nearly two decades old, Shidlo & Schroeder (2002) is still probably the most widely cited article in support of the proposition that SOCE is harmful. (A companion article, Schroeder & Shidlo, 2002, focuses primarily on ethical issues involved in the actions of SOCE therapists, rather than on outcomes for clients.) That is probably because at the time it was published, "No large-scale study ha[d] been made with the specific goal of looking at the harmfulness of conversion therapies" (Shidlo & Schroeder, 2002, p. 249).

Initial recruiting for the study was heavily biased. Advertisements bore the headline, "Homophobic Therapies: Documenting the Damage," and openly declared the conclusion before even undertaking the study, saying that the authors "intend to use the results to inform the public about the

often harmful effects of such therapies" (Shidlo & Schroeder, 2002, Appendix A, p. 259). Nevertheless, "After the first 20 interviews, we discovered that some participants reported having been helped as well as harmed" (p. 251). Therefore, they changed the project's name to "Changing Sexual Orientation: Does Counseling Work?" and declared more neutrally, "We want to know how it affected you" (Appendix B, p. 259).

As with several other key studies, the authors acknowledge that the "structured interviews" they used (Shidlo & Schroeder, 2002, p. 250) were a form of "qualitative analysis" (p. 251). They also admit that their "open-ended question" about harm ("Do you feel that this counseling harmed you or had a negative effect on you?") "was not a quantitative measure. . . ." They then followed up with "a checklist of symptom areas . . . developed in our pilot interviews" (listing 13, from "self-blame for not trying hard enough to change" to "alcohol and substance abuse").

Yet somewhat surprisingly, Shidlo and Schroeder declared, "We do not report here on the frequency of responses to these items . . . ," admitting that their methodological choices "came at the expense of sensitivity, reliability, and content and construct validity" and even that participant reports may not be an "accurate recollection. . . . Our results, therefore, focus on the meanings of harm attributed by clients, and the accuracy of these attributions remains to be determined . . ." (p. 254).

The one finding on which Shidlo and Schroeder did report specific data was suicide attempts: "Twenty-five participants had a history of suicide attempts before conversion therapy, 23 during conversion therapy, and 11 after conversion therapy" (Shidlo & Schroeder, 2002, p. 254). Since this suggests a rate of suicidality less than half as high after therapy as it was before, it is hard to see how this provides support for the theory that such therapy is harmful. The opposite would appear to be the case.[30]

Some of the specific "harms" reported by gay-identified participants are things which would be considered "successes" by individuals still pursuing SOCE. For example, under the category of "Intrusive imagery and sexual dysfunction," one male reported, "In a sex act, I can imagine . . . my wife . . . and I find that disturbing. . . . The first time I attempted to have anal intercourse with my lover, I couldn't. . . ." The authors also cite "loss of same-sex partners or missed opportunities to commit to long-term relationships with same-sex persons" as "harms" (Shidlo & Schroeder, 2002, p. 255).

Given the bias with which Ariel Shidlo and Michael Schroeder undertook their study, it is remarkable that 23% of their participants were people who did *not* report being significantly harmed by SOCE, including 26 (13%) who considered their therapy to have been "successful" and 21 (10%) who were now gay-identified but "reported few or no long-term damaging effects and actually felt strengthened by their experience of having tried to change" (Shidlo & Schroeder, 2002, pp. 253–254). From my own analysis of Shidlo and Schroeder's reported ratings for specific interventions, it appears that although 85% of interventions were reported to have been harmful at least to *some* degree, a remarkable 61% of

[30] Warren Throckmorton—a Christian psychologist who was once a defender of SOCE but has become increasingly critical of it (Ward, 2017)—has argued that the high rates of suicide attempts reported *during* SOCE therapy could be taken to suggest that the therapy is harmful, and the lower rates after SOCE could suggest it is *quitting* therapy that is beneficial. However, Throckmorton acknowledges that "one cannot make any conclusive statements about reorientation and suicide risk from Shidlo and Schroeder's data" (Throckmorton, 2011).

interventions were also reported to have been *helpful* to some degree (p. 257).

In the end, though, Shidlo & Schroeder's often-cited study cannot bear the weight that has been placed upon it by critics of SOCE—as their own words demonstrate:

> *The data presented in this article do not provide information on the incidence and the prevalence of failure, success, harm, help, or ethical violations in conversion therapy.* (Shidlo & Schroeder, 2002, p. 250; emphasis in the original)

Jones and Yarhouse (2007, 2011)

Sample Size: 98 (72 men, 26 women) at the beginning of the study (Time 1, or T1); 73 at T3; 63 at T6, "a 6-7-year retention rate of 64%" (Jones and Yarhouse, 2011, p. 410).

Sample Type: Participants within the first three years of pursuing "religiously mediated sexual orientation change" were recruited from sixteen different ministries affiliated with the umbrella organization Exodus International.[31]

Assertion of Harm: Data for one small subset of their sample, those who abandoned the change effort early, "would appear to indicate that the Time 1 dropouts were considerably distressed. . . . Those opposed to attempts to change sexual orientation might well argue that this is the evidence of harm that they anticipated; it would appear that the change process produced significant distress and was fruitless for these individuals" (Jones and Yarhouse, 2011, p. 358).

Discussion: Jones and Yarhouse first reported their findings in a detailed, 414-page book in 2007, then more succinctly but with added longitudinal data in a peer-reviewed journal article in 2011. They sought to meet several standards for a strong research study, which they said should:

- "be *longitudinal*, following participants over time";
- "be *prospective*, starting with participants who are initiating the change process";
- "examine the experience of a *representative sample*";
- "gather data . . . with the best existing *standard measures* . . . of sexual orientation and other variables;" and
- "examine a *large* sample" (Jones and Yarhouse, 2007, pp. 106–107).

They also note that many of these criteria overlapped with those recommended by the American Psychological Association (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 6) for further research in this field (Jones & Yarhouse, 2011, p. 406).

The authors therefore seem fully justified in declaring, "This study is the best designed and implemented study to date on religiously mediated change of sexual orientation," and in adding, "The study, although not above criticism, is significantly stronger than any other existing study" (Jones & Yarhouse, 2007, p. 143). Rather than a "qualitative" exploration of the SOCE experience, as in so many other studies, Jones and Yarhouse used a standardized tool:

> Psychological distress was measured by the 90-item SCL-90-R [Symptom

[31] At one time, Exodus International was the leading umbrella organization of Christian ex-gay ministries. However, during the period from 2007 to 2013, the president of Exodus, Alan Chambers, began publicly moving away from the belief that "change is possible" with respect to sexual orientation. This led many member ministries to resign from Exodus and form a new umbrella organization, Restored Hope Network (https://www.restoredhopenetwork.org/), and Exodus International was disbanded in 2013. For an account of these events, see Feldmann (2013).

> Check List-90-Revised[32]] . . . a measure designed for use in research and clinical settings. . . . We focused on the SCL-90-R's three global indices of the degree of respondent distress: . . .
> - the number of symptoms and intensity of distress; . . .
> - the intensity of distress symptoms experienced; and . . .
> - the number of discrete psychological symptoms regardless of intensity (Jones & Yarhouse, 2011, p. 412, bullet points added).

The authors report,

> Our analysis yielded no support for the hypothesis that our participant's scores . . . would show significant movement toward worsened psychological functioning as a result of [SOCE]. . . .
>
> [T]he one consistently statistically significant shift was the shift in the Positive Symptom Distress Index in a direction of *less distress.* In other words, . . . participants reported that their intensity of distress symptoms changed for *the better* to a statistically significant degree. . . . (Jones and Yarhouse, 2007, pp. 370–371)

Jones and Yarhouse (2007) also sought to analyze the spiritual well-being of their participants using the 20-question Spiritual Well-Being Scale (SWBS), as well a 38-item Faith Maturity Scale (FMS). With respect to the SWBS, "*every* reported mean difference . . . indicat[ed] an improvement (however modest) in spiritual, religious, and existential well-being. A number of these changes were statistically significant" (p. 348). With respect to the FMS, there were few changes over time, but "there is no evidence . . . that involvement in the change process caused a decline in faith maturity" (p. 352). In summary, "If involvement in [SOCE] is supposed to be detrimental to the spiritual well-being of the participants . . . , we find no evidence of it in this population" (p. 349).

The bottom line is that the authors found

> little evidence that involvement in the . . . change process was harmful to participants in this study. Taken together, these findings would appear to contradict the commonly expressed view of the mental health establishment . . . that the attempt to change is highly likely to produce harm for those who make such an attempt. (Jones & Yarhouse, 2007, p. 387)

Conclusion

As noted above, several of the earlier journal articles and sources cited in the "Measures of Harm" list not only did not provide "measures of harm" from SOCE, but they included specific acknowledgment that no scientific evidence of such harm had been discovered (Haldeman, 1994, p. 225; Tozer & McClanahan, 1999, p. 732; Forstein, 2001, p. 177). A turning point appeared to come with the publication of Shidlo & Schroeder's 2002 study, documenting harms reported by some of their sample of 202 former SOCE participants. As noted above, however, these authors conceded that they used "qualitative data" and "qualitative methods" (250), and thus could not provide "a quantitative measure" of harm (254). Their own caveat could not have been more clear:

[32] "The SCL-90-R is a ninety-item self-report inventory . . ." (Jones and Yarhouse, 2007, p. 333).

> *The data presented in this article do not provide information on the incidence and the prevalence of failure, success, harm, help, or ethical violations in conversion therapy.* (Shidlo & Schroeder, 2002, p. 250; emphasis in the original)

Despite this rather sweeping acknowledgment of their study's severe limitations, Shidlo & Schroeder (2002) are often cited as the definitive source proving the harmfulness of SOCE.[33]

The other most frequently cited source in support of the belief that SOCE is harmful is a 2009 Task Force Report that was published by the American Psychological Association. After conducting their own "systematic review of the peer-reviewed journal literature" on SOCE, they concluded that such efforts "involve some risk of harm" (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. v). However, they found the *level* of risk impossible to quantify:

> We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 42)

Nevertheless, as with Shidlo and Schroeder's study, the Task Force's rather modest assertion that change efforts "involve some risk of harm" has been inflated in the subsequent re-telling. The California Legislature's findings in SB 1172, the nation's first therapy ban, said, "The task force concluded that sexual orientation change efforts can pose *critical health risks* to lesbian, gay, and bisexual people" [emphasis added] (*Sexual Orientation Change Efforts*, 2012)—although the term "critical health risks" appears nowhere in the Task Force Report, which never applied the term "critical" at all to the potential "risk of harm" it identified. (In fact, in their effort to be comprehensive and to communicate accurately about what they did and did not find, the APA Task Force Report made a number of concessions about SOCE that seriously undermine the case for placing legal restrictions upon it (see Sprigg, 2018b).

Exaggerations of what the scientific evidence shows even reached the White House, under former President Barack Obama. In response to a petition, Obama Senior Advisor Valerie Jarrett in 2015 endorsed efforts to prohibit SOCE, claiming, "The *overwhelming scientific evidence* demonstrates that conversion therapy . . . can cause *substantial* harm" [emphasis added] (Jarrett, 2015). It is odd that a White House advisor could reach such a sweeping conclusion, when the APA's own Task Force had stated that "recent studies do not provide valid causal evidence of . . . [SOCE] harm" (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Most of the 79 studies on the "Measures of Harm" list suffer from significant methodological weaknesses. Several are explicitly "qualitative" rather than

[33] For example, one 2019 article flatly declared, "The evidence actually shows that conversion therapy is harmful to those who undergo treatment"—citing only Shidlo and Schroeder (2002). See Romero (2019), 213.

quantitative, which means by definition that they cannot provide "measures" of harm. The two strongest studies methodologically (Jones & Yarhouse, 2007 and 2011; Santero et al., 2018) show the most positive outcomes and the fewest reports of harm. While these 79 studies do provide anecdotal evidence that *some* SOCE clients *report* the experience was harmful, they do not provide scientific proof that SOCE is more harmful than other forms of therapy, more harmful than other courses of action for those with SSA, or more likely to be harmful than helpful for the average client.

If the alleged "overwhelming scientific evidence" of "critical health risks" caused by SOCE cannot be found in the 79 studies on the "Measures of Harm" list—and it cannot—then it is questionable whether it can be found anywhere.

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Note: References marked with an asterisk were included in the list of 79 sources labeled, "Peer-Reviewed Journal Articles and Academic Books on 'Conversion Therapy' Outcomes That Include Measures of Harm." *Those marked with a single asterisk (*) were read in full by the author; those marked with a double asterisk (**) were analyzed with a keyword search (see Appendix).*

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Appendix

Keywords Searched in 24 of the "Measures of Harm" Studies

In the studies which the author of this paper did not read in full, keywords related to possible harms of SOCE were searched. These terms included negative ones (e.g., danger, harm, risk); neutral ones (consequence, outcome, result); and positive ones which might be contrasted with the negative (benefit, help, safe). All forms of a word were included (noun, adjective, singular, plural, etc.). Each time a relevant word was identified in the text of the study or article, the context was examined to determine if it was actually a reference to harmful outcomes attributable to SOCE. Not all of these words were searched in every article; instead, this list was continually expanded as new possible keywords were identified. Nevertheless, I feel confident that this search was thorough enough to identify any references to harms of SOCE in the articles not read in full.

abuse
adverse
anxiety
aversion
benefit
breakdown
complication
consequence
concern
damage
danger
death
decrement
depression
destructive
deteriorate
detriment
difficult
discomfort
distress
effect
exacerbate
exploitation
guilt
harm
help
hindrance
homophobia
hurt
impact
maladaptive
negative
outcome
problem
psychotic
reaction
recondition
result
risk
safe
self-destructive
sensitization
sequelae
severe
shame
suicide
symptom
torture
troubled
violate
well-being
worse
wound

Nature and Nurture: Proposing a Reconciliation

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This article addresses an historically controversial topic: the question of whether the same-sex attraction (SSA) in men is innate or acquired. Several studies in the field of genetics have shown that there is a possible genetic influence on SSA. On the other hand, psychology debated contributions from psychoanalysis on this subject, such as the perspective of the absent, abusive father as well as traumas caused by other members of the same gender leading to defensive detachment. Presently, there appears to be a consensus that same-sex sexuality develops from both biological and environmental influences. But how? In this article, I posite a possible route for such interaction. I raise the hypothesis that biological factors involved in the homosexual tendency would manifest themselves in the high sensitivity of some children, since this trait would predispose boys to defensive detachment as well as to gender wounds caused by other men. This hypothesis suggests a possible way to integrate the various published studies which show that the causes of the origin of SSA in men could be both genetic and environmental.

Keywords: homosexuality, biology, psychology, sensitivity, conciliation

The question of whether SSA is innate or acquired has been very controversial, leaving us with apparently good hypotheses for both biological and social environmental influences. Several studies argue that same-sex attraction has a biological cause mainly of genetic and hormonal origin (Alanko et al., 2010; Bailey et al., 2013; Goodman, 1997; Schwartz et al., 2010). On the other hand, there are works defending that homosexuality is acquired, such as those of Taylor (1999), Crowson & Goulding (2013) and Vandenbosch and Eggermont (2014), which hypothesized that influences from culture, including the

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media, and some kinds of socialization may be required for SSA to manifest itself.

Also in this line of thinking, Elizabeth Moberly, in 1986, published an article in which she theorized that SSA could be related to difficulties in the father-son relationship, resulting in a deficit in the relationship with the same-sex parent. This relationship deficit, she hypothesized, would result in a break in the connection between father and son. As a result, the son does not have his natural emotional needs met. The boy develops a disidentification with the male parent and starts to have a feeling of ambivalence in relation to men in general. This ambivalence, in turn, results in a generalized defensive detachment; that is, the boy moves away from the male universe in order to protect himself from being hurt again.

As soon as this detachment occurs, a search for attachment repair, which in adolescence turns into an erotic attraction for other men, begins. This man will later seek to fulfill his emotional needs for acceptance and love through sexual relationships with other men. From the various models that try to explain SSA as acquired, I have chosen that of Elizabeth Moberly, because it is the closest to what some clinicians observe in the narratives of non-heterosexual men: distancing from parents as well as from the male universe. Bieber et al. (1962) had reported relationship problems between non-heterosexual children and parents quite some time ago. I believe defensive detachment could also be one of the causes of the high rate of psychiatric disorders found in non-heterosexual people.

From a biological point of view, studies of genetics have been published in order to find some inherited factors related to SSA. Bailey & Pillard (1991) studying twins found concordance for non-heterosexuality in 52% of monozygotic twins and 22% of dyzygotic twins. In a study carried out in Sweden, Langstrom et al. (2010) found a genetic heritability factor of 34% to 39% in men and 18% to 19% in women. Ganna et al. (2019), studying around 477 thousand people from Europe and the United States, demonstrated definitively that 32.4% of factors that differ in nonheterosexuals as a group from heterosexuals as a group are attributable to variation in genes. Genes tested in the Ganna et al. study, taken together, accounted for 8% to 25% of this genetic variation. The figure of 32.4% in the genome wide analysis study by Ganna et al. matches the figure of 32% found in the meta-analysis by Poldermann et al. (2015) of 50 years of twin studies. Hence, 32.4% is the best figure to date.

Other studies have investigated whether prenatal hormones are involved in the manifestation of SSA, but findings remain inconclusive (Mayer & McHugh, 2016). Studies of epigenetics, the science that studies the influence of environmental factors on the activation and deactivation of genes as well as their modulation by the same factors, have found interesting results in behavioral change in animals, but nothing conclusive in humans (Wang et al., 2019). Jannini et al. (2010) stated that an important difference between biological and non-biological environmental lines of study is that the vast majority of researchers who defend the biological factors for SSA also recognize the importance of environmental factors, but those who maintain that this trait is developed after birth usually deny any biological influence.

In this article I have come up with a possible conciliatory explanation in which I theorize that the biological factors that involve same-sex attraction would manifest themselves as a personality trait that increases a boy's predisposition to develop non-heterosexuality, namely,

greater sensitivity or hypersensitivity. Guerim et al. (2015) reported in their studies that this trait of human temperament is more pronounced in non-heterosexual men. Ganna et al. (2019) did not find genes that they specifically identified as associated with sensitivity, but they did find that genetic predispositions to depression and anxiety were associated with same-sex behaviour. Such predispositions may make a boy more vulnerable to developing depression, anxiety, or suicidality as a result of adverse experiences, hence may cause a boy to be more sensitive.

Returning to the hypothesis raised by Moberly (1986), who coined the term defensive detachment, I believe that not only can the absence of fatherly love cause this detachment from the male universe, but also wounds caused by other men (sexual abuse or bullying, for example), called gender wounds, can cause trauma, particularly in a hypersensitive child. I believe these wounds are more pronounced when they are directed at the child's sexuality. Therefore, wounds caused by men (gender wounds), which are related to the child's sexual identification (such as sexual abuse), are more likely to cause defensive detachment, in addition to deep trauma.

Several studies report that non-heterosexual people, both male and female, have a higher prevalence of developing psychiatric disorders such as generalized anxiety, depression, and suicidal ideation (Chakraborty et al., 2011; Fredriksen-Goldsen et al., 2012; Mayer, 2016). The authors of these studies argue that the main factors that might be related to the higher incidence of these disorders in this specific population could be the non-conformity with their sexual orientation caused by the prejudice and discrimination they suffer from society. I do not deny these factors, but the same psychiatric problems occur in non-heterosexual adolescents and adults who grow up in developed countries which have liberal atitudes toward sexuality (Björkenstam et al., 2016; De Graaf et al., 2006; Hatzenbuehler, 2011).

I present the hypothesis that both the gender wounds the hypersensitive child suffers, as well as the defensive detachment that isolates him from the male universe, add up to, or may even surpass, the impact of discrimination and prejudice previously mentioned with regard to the development of psychiatric disorders. Hypersensitivity could translate into what Kagan (2018) called high reactive children. Kagan proposes that children, in response to different sensory stimuli, could be divided into two types of temperaments: those of more reactive temperament and those of less reactive temperament. These traits are related to the nuclei of the amygdala, which are part of the limbic system. High reactive children are characterized by a greater response to unexpected events, such as crying and limb movements, being less sociable with unknown partners, in addition to presenting greater symptoms of social anxiety and depression.

Another biological factor that could influence how boys react to bullying and abuse is a predisposition to aggression. Aluja et al. (2015) demonstrated that the human androgen receptor (AR) gene can present different polymorphic extensions of the CAG codon, and when this codon appears in its smallest version, the AR receptor is more sensitive to free testosterone. These authors found a positive relationship between shorter CAG codons and a higher rate of aggressive behavior in men. Other studies have found similar results finding that aggressive men tend to be more extroverted and to have a more uninhibited personality (Jonsson et al., 2001; Turakulova et al., 2004).

Boys who are more aggressive and have a more uninhibited personality could face situations of abuse and stress in a less traumatic way, since they have a stronger reaction towards the aggressor and do not allow themselves to be hurt continuously. I hypothesize that one genesis of SSA is an interaction of two main factors: biological factors, which contribute to the high or low reactive temperament inherited by the boy (Kagan, 2018), as well as a more or less aggressive personality (Aluja et al., 2015), and a gender wound, which is a trauma caused mainly by significant male figures such as father and friends. This wound may lead him to defensive detachment.

Figure 1 shows how this interaction could occur:

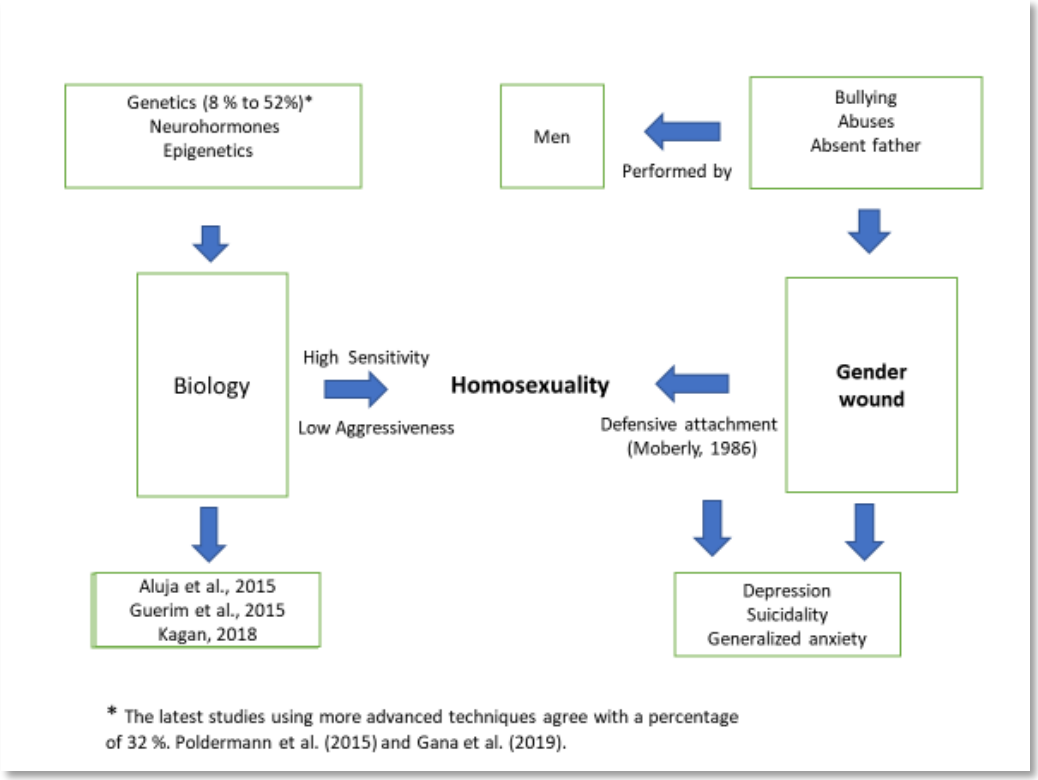

Figure 1. A possible interaction between biological and emotional factors in the genesis of the homosexual tendency.

The choice of sensitivity as a candidate for a possible biological factor that could contribute to the development of homosexuality was made for three main reasons:

A-This trait of human temperament is more pronounced in non-heterosexual men (Guerim et al., 2015);

B- It could explain, together with the gender wound and defensive detachment, the genesis of the emotional unsteadiness that can happen due to the trauma suffered by the child;

C- It could be directly influenced by biological factors such as neurotransmitters (Antonio et al., 2017) and plausibly by genetic predisposition to depression or anxiety (Ganna et al. 2019).

As a result, SSA would be the outcome of the interaction between two variables: the boy's already innate hypersensitivity, which is influenced by biological factors as well as the gender wounds to which he

was subjected. Each of these variables can have different intensities as well as different interactions in each individual. These different dynamics would explain the many variations that exist in the sexuality of non-heterosexual people.

Several points still need to be clarified so that the presented model can be consistent. One of them is how the different known biological factors (genetics, neurohormones, epigenetics etc.) might influence children's sensitivity. Kagan (2018) comments, in his studies about human temperament, that high reactive children have greater activity in the region of the amygdala in the limbic system. I hypothesized that this could be a cause of different levels of sensitivity that children have.

Another matter that needs further clarification is what would explain the case of non-heterosexual men who do not have a genetic influence. I hypothesized that they could be less sensitive, but would have been exposed to a deeper gender wound, such as sexual abuse, quite common in the history of people with SSA (Mayer et al., 2016). There may also be other causes of SSA. For example, Nicolosi (2009) reports that he saw some men who did attach to their father in early childhood, but they experienced gender wounds later in childhood or adolescence, and their father failed to provide much needed emotional support. As a result, they experienced painful feelings about themselves as men and may have detached from their father.

Future research should look into potential ways that biological and environmental influences may intersect leading to SSA. The *APA Handbook of Sexuality and Psychology* (Rosario & Schrimshaw, 2014, in Tolman & Diamond, v. 1, p. 583) says, "Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors. A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful."

I believe that this work can contribute in this direction.

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Researching Against the Cultural Tide: An Interview with Walter R. Schumm and D. Paul Sullins

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There are many challenges to doing research in a controversial and contentious arena, particularly when one is finding and interpreting results that may go against the tide of "conventional wisdom," not to mention the policy interests of powerful mental health organizations, advocacy groups, and government agencies. The study of sexual orientation and gender certainly constitutes a supreme example of where such challenges are to be found. Yet there are a few researchers who have had the courage and statistical acumen to enter into this fray. In this article, I interview two preeminent researchers who have sometimes challenged the "scientific consensus" of the field in this arena. Walter R. Schumm, Ph.D., Emeritus Professor of Applied Family Science in the Kansas State University Department of Applied Human Sciences, has conducted research on gender identity, sexual identity, sexual attraction, and same-sex relationships and parenting since 1999. D. Paul Sullins, Ph.D., is with the Leo Initiative for Social Research, Catholic University, and the Ruth Institute, Lake Charles, LA. In this interview, Drs. Schumm and Sullins reflect on how they became researchers, changes they have seen in the field over the years, challenges and hopeful signs within this area of research, and some suggestions for others who may be thinking about doing controversial research.

Keywords: Research, sexual orientation, gender, controversy, career guidance

Rosik: Since I do not believe it is possible to understand a scholar's work without knowing something about his or her personal history, I'm hoping you would not mind sharing a little of your background with the journal audience (e.g., family, religious, cultural upbringing).

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Schumm: When I was in second grade, my professor predicted I'd become a college professor. But a year or two later, I told my father I might want to get a Ph.D. in psychology, to which he responded that any fool could get a Ph.D. in that area. So, I focused on another interest, astronomy for a time, eventually majoring in physics at William and Mary. Meanwhile, my brother, twenty years older than myself, had earned a Ph.D. in chemical engineering, was an officer in the Army Reserve, and was married with four children, so that became my copycat path.

So, I ended up similarly, both with Ph.D.'s, both retired colonels in the Army Reserve, and myself with seven children. In college, advanced calculus was about as far as I could go successfully in math, so I tried out social science courses and did very well without nearly as much work as physics required. In physics if I tried a new idea, it was discouraged, even ridiculed in class by some of my professors, but in social science, the professors generally welcomed new approaches.

For my senior project, I replicated some work being done in my brother's corporate labs, but my professors doubted it would work until they saw it work with their own eyes. Then it took them only five minutes to come up with an explanation. In one of my anthropology classes, I did a project that showed how incest rules were associated with creation narratives in terms of how many humans were created at the beginning of time, at the same time.

My father was born the son of a New York architect, but his parents divorced when he was about five or six, and so poor that one Christmas he cried because he was so happy to get even a bar of soap as a present. He dropped out of high school as a junior to take admission tests for the U.S. Naval Academy, and he got in, nonetheless, graduating in 1927 and fighting in 18 battles in the Pacific in World War II on the *U.S.S. San Diego*. Later he was captain of the *U.S.S. Okanagan* and the *U.S.S. Salem*. After that he taught high school math at St. Stephen's Episcopal High School in Alexandria, Virginia, from which I graduated in 1968.

I was baptized and confirmed in the Episcopal Church when I was about twelve. A friend in high school introduced me to Young Life and that's when I learned about having more of a personal relationship with God.

Sullins: I was raised Southern Baptist, became an Episcopal priest, and have now become a Catholic priest. This journey has shaped my life and my research. I have continually examined my beliefs and sought deeper and clearer understanding of what was presented to me as true.

The constant in this journey has been an evangelical personal relationship with Christ, which I first discovered as a Baptist and has not changed much through all the religious changes. I sometimes describe myself as a completed Baptist. For those interested, my journey into the Catholic Church was the subject of an episode of the Catholic TV program "The Journey Home" (online at https://chnetwork.org/journey-home/dr-paul-patti-sullins-former-episcopalians-journey-home-program/).

I also wrote a book on former Episcopalian now Catholic priests, most of whom are married: *Keeping the Vow: The Untold Story of Married Catholic Priests* (Oxford, 2015), available at https://www.amazon.com/Keeping-Vow-Married-Catholic-Priests/dp/0199860041. The book, based on interviews with over 100 married convert Catholic priests, doesn't tell my personal story exactly, but gives a composite picture of the personal and intellectual journey such a man takes. My journey fit the typical pattern.

How is this journey related to my research? Here's a hint: The book describes men like me as "truth converts." The single most common, striking characteristic of the convert Catholic priests is that they (and I) were willing, even happy, to suffer the loss of income, position, prestige, and reputation in order to live authentically in accord with the truth, as they (and I) had come to understand it. We were true Protestants, willing to risk all for the truth of Christ and the scripture; only this commitment, ironically, brought us back to the Catholic faith.

What led you to become a researcher and particularly one willing to study controversial topics that even conservative social scientists nearly always shy away from?

Schumm: My brother had done research on how propellers move water and found that a third of what we thought we knew was actually incorrect. That helped develop a skeptical attitude toward accepted wisdom or conventional scholarship. My physics professors could not comprehend how my senior project could work until they believed in it after they saw it.

When I was a master's student at Kansas State, my major professor had done work on sexual standards and had "found" that people with lower levels of intelligence were more likely to have traditional or double standards. I challenged that theory and later got my version published. My physics background probably helped me be less worried about what others might think; I had risked flunking out of college and going to Vietnam and risking death by running with a senior project that no one thought would work and satisfy my graduation requirements. If that wouldn't get me to compromise, what else would? My personality type is INTJ, which is basically a researcher personality type, so that helped. My experience has been that often you learn the most from the most difficult questions. So I look forward to hard challenges.

Sullins: As my previous answer suggests, this is in large measure an outgrowth of my spiritual life and journey. I'm actually not reliably conservative economically or politically. (Full disclosure: I am a lifelong Democrat, of the stripe often called "Reagan Democrats"; though in recent years I have voted almost exclusively for Republicans. We still have some strong pro-life anti-corruption local Democrat politicians in Maryland.) I am a committed Catholic Christian, which in the current state of cultural discourse makes me a default conservative on most social issues, and emphatically so on the issues of the body—sex, sexuality, gender, abortion—and by extension religious freedom. Jesus was no zealot, but he was not shy to dispute the Pharisees over conflictual issues (paying tax, working on the Sabbath, associating with sinners) that clouded people's access to God's kingdom and grace. I am honored to do the same in a much smaller and more limited degree.

I sometimes remember (probably inaccurately) an image from the writings of Alan Paton, the South African novelist, of a man who had been brutally beaten while helping oppressed blacks during apartheid. When asked why he chose to do this, he told of a dream in which he had died and stood before God, and God asked to see the scars from his life's suffering. He replied that he had no scars to show. And God said, "No scars! Was there nothing in your life worth being scarred for?" Paton's character said to his questioner, "I could not face that question. Like our Lord, I do not want to reach heaven unscarred." I feel the same way. The purpose of my life is not merely to make it to death comfortably.

You have been conducting research for a long time. Have you seen changes over the years in the environment within which social science research is conducted? If so, could you describe the most important of these changes?

Schumm: When I started in social science, if you could overturn some accepted wisdom, you were like a hero and publishing journal articles, especially with your graduate students, was the gold standard for academic success. As time went on and university budgets got tighter, getting grants eventually overtook publishing as the key to getting promotions and university awards. At first rocking the boat was respected, but later it was probably seen as a threat to the financials and therefore discouraged. At first, professors were able to stir up controversy in class to get discussion going, but as time went on, that became dangerous, because one student complaint could get one into much trouble.

In later years, I was criticizing journal articles in a graduate class, but one student took it personal, and in the end I received a letter of reprimand over it. Another time, I showed in a class how some medical researchers had engaged in scientific misconduct, and two students dropped the class immediately because their fathers were physicians and they could not accept the idea that any doctor would do that.

Research became an instrument of politics and confirming one's own biases so that if you dared to disagree it was taken as an insult personally. One time I had challenged some research on same-sex parenting, and a lesbian scholar yelled at me in a public meeting that I was an idiot who didn't know anything about research. When I asked an older colleague about it, he said that my research might mean that she would lose her children and like a good mama bear she was fighting against that threat.

Later I was banned from ever attending my professional organization's annual conferences because in 2018 I had offended someone over something; I didn't even get so much as a hearing about it, just a letter (or two) stating the banishment. To this day, I don't know what I actually said or did that triggered someone else. Since I've been critical of LGBT research and have done some research on Islam, there are many ways my research could have upset someone.

Sullins: The major change, described by many, is the loss of a common arena of discourse where very different perspectives can be respectfully debated. When I was in college (early 1970s) a popular show called "Crossfire" featured conservatives debating liberals on a range of policy and moral questions. They went at it hammer and tong, no holds barred but without personal attacks. Today such a show could not be aired; the conservative position would be labelled hate speech and censored from YouTube and other media channels. I know this personally: Several popular blog interviews that I have given about homosexual parenting or the link between homosexual priests and child sex abuse have been defunded or disappeared.

The social sciences and academia generally are hardly immune from such bias; if anything, it is even stronger for being cast in high-minded intellectual categories. In psychology the root bias is not against conservatism as such but against any form of naturalism or even rationalism, that is, the idea that there is order, purpose, and reason in nature and especially human nature. It is not Burke and Locke they hate so much as Aristotle and Aquinas.

Rejecting the non-rational element of embodiment, modern intellectuals seek to find identity in the abstract "self" that theoretically underlies all human conditionings (race, class, gender . . .). Any element that appears to limit the pursuit of

this myth, for example by affirming human finiteness or real limits to human potential, becomes problematic, with the result that human life has increasingly become the object of technological control, even when such control manifestly does not work. Such technology—even as it fails—is claimed to be necessary for human right and dignity. In fact, however, such technology only furthers degenerate, illusory, or even horrifically destructive goals. Attempting to become superhuman, it becomes subhuman. This is an old story, in fact the original story of rebellion. As a culture, we have said, "I will be like the Most High God," with the result that we have lost both knowledge of God and knowledge of ourselves.

In the social sciences, in university faculties and journal reviews and editorials, this hubris has advanced in many places to the point of rejecting the scientific method and even reason itself. Propositional argument—if A is true, then B must be true—is rejected as defectively male, white, Western (or choose another qualifier). Even the canons of the scientific method, which are rooted in the West's Christian heritage, are derided as religious and therefore defective. This isn't true everywhere, but the tendency is widespread in Western academic culture. If it continues, we can expect to see the West concede scientific dominance to the global East (Asia) and South (Africa and Latin America), a process which has already begun.

Do you see much of a future for publishing conservative perspectives on topics related to sexual orientation or gender?

Schumm: There are so many journals, I see a future in it but not in mainstream, politically correct journals, unless you know precisely how to navigate their hurdles. Right now, people are losing some of their means of communication for making negative comments on transgenderism. If this gets to where you could lose email access, it could do real damage to the careers of conservative professors or researchers. On the other hand, it is a "target rich" environment because politically correct articles are often scantly reviewed by peers who don't want to look politically incorrect by being too critical. Thus, major errors often get by peer review and into print, just like plums waiting to be plucked as low hanging fruit.

Sullins: Yes, but decreasingly in traditional publications. The system of anonymous peer review, like faculty review for faculty appointments, enables those with anti-conservative bias to effectively censor opposing points of view. But this only true, even today, in Anglophone Western countries, e.g. USA, England, and Australia. French and Spanish language journals, even those of liberal Scandinavia, have little systematic bias against opposing views in social science publications, and almost none at all in hard science journals. Italian social science journals, many of which also publish in English, actually favor what in America are considered conservative perspectives.

Globalization is rapidly draining the oxygen from USA-led anti-conservative publication bias. Top journals are increasingly open source and Eastern. The back office of almost every journal today is run by contractors in India or Indonesia, where there is much more appreciation for conservative wisdom. The editorial offices, editors and committees are also becoming more populated by scholars from traditional social and intellectual cultures. While one may be stonewalled from publishing in most prestigious Western publications, the possibilities for publishing in alternative, non-Western journals of high quality and growing reputation today are many and are growing.

Former Alliance President A. Dean Byrd used to attend the American Psychological Association conference's town hall meetings and ask the officials, "Is there a place in the APA for someone like me?" He would usually get affirmative responses, though I sometimes wondered if that "place" was generally limited to paying the annual dues. What has been your experience with the professional mental health associations and is there hope for a substantive inclusion of clinicians and scholars such as those aligned with the Alliance or even the Alliance point of view?

Schumm: I am sure professional organizations will take your money and allow you to be involved in "safe" research presentations. The challenge comes when a person thinks they are an oppressed person and you are the oppressor. Almost anything you say can be interpreted in a hostile way, through what researchers call "negative sentiment override." Once it's interpreted that way, the person may "feel" unsafe and alert the organization about this hostile person who is making them not want to attend future meetings and the only remedy is to ban that person for life from coming back and reoffending them. Those who have continued to attend my professional organization tell me they dare say nothing critical of research by any potentially oppressed/minority group person lest they be targeted for removal from the conferences or even the organization.

Sullins: I'm sorry to report that my experience in this regard has been consistently negative. My academic specialty as a sociologist was sociology of religion, so each year I would attend the Society for the Scientific Study of Religion and/or the Association for the Sociology of Religion as well as the American Sociological Association annual meetings.

These meetings were friendly until I began publishing articles that challenged prevailing liberal orthodoxy. As I wrote first on abortion, then the Catholic priesthood (opposing women priests and yes, married priests; to understand this irony, read my book!), and then gay parenting and "not born that way," my relationships, even my ability to present my views, deteriorated rapidly. Collaborations disappeared. At the 2003 meeting, the president of ASR, a Catholic religious scholar with whom I had had many friendly conversations on research topics, pointedly and publicly refused to shake my hand or speak to me. In 2007 gay scholar/advocates continually interrupted my ASA presentations (encouraged by the session moderator) so that I was effectively unable to continue. A more serious problem with these associations, for me, was that they rarely addressed questions that were of interest or value to me. I could find no one interested in discussing, say, Aquinas' view of sexual morality or the social benefits of marriage or prayer. The negatives of being shunned were not balanced by any positive reasons to attend, so I stopped attending these meetings.

On the other hand, I have had valuable and positive experience with newer, alternative conservative-orientated scholarly associations, similar to the Association for Therapeutic Choice and Scientific Integrity. I call such groups in the Catholic context "reconstructionist" because they are restoring what was, in Catholic settings, a vibrant ecology of faithful orthodox scholarly groups that flourished in the mid-20th century. The Fellowship of Catholic Scholars, Society of Catholic Social Scientists, University Faculty for Life, and similar organizations offered a positive setting in which I could discuss and dispute important questions, build fruitful scholarly relationships, and contribute a little to advancing this strand of intellectual life. I found in the SCSS especially an outstanding

forum for engaging scholars of all types on issues at the intersection of faith and scientific knowledge. I have served on their Board for over 15 years and am currently blessed to serve as Chaplain of this association. But all such groups, like the ATCSI, are extremely valuable for intellectual culture today, even though they are usually small and certainly not very powerful, because they create a space to hear and consider ideas that can be uttered almost nowhere else. In the middle of an intellectual culture of death, they are a spark of life.

From my reading of relevant surveys, about half of the American population has doubts about the trustworthiness of social science research. What do you foresee as the future for the social sciences? Is there any hope for a return to a valuing (in actual practice) of diverse perspectives on areas of study relevant to contested social policies?

Schumm: This is a hard issue. For example, we have published an article where we showed that 90% of 72 reviews of the literature believed "X" to be true, except that "X" isn't true. Some liberal scholars who dared to suggest that "X" might be true, were severely criticized, even twenty years ago, for putting forth harmful information that would hurt minorities. One scholar has argued that nearly all initial research will turn out to be incorrect. That's because most initial research is biased by small and nonrandom samples, as well as other methodological problems. It can take decades for research to reach a valid consensus; meanwhile, incorrect research will be used, as the best available, to promote public policy changes. Once policy is made into law, even if the research corrects itself over time, the laws will take much longer to change. This situation can put a premium on cranking out a lot of premature, low quality, largely incorrect research as long as it supports the policy objectives. If there is social pressure to avoid normal criticism of such research, proponents will argue that no one has challenged it, so it must be valid. Some scholars have felt that the social sciences will become similar to the humanities rather than to science.

Sullins: I don't foresee a revival of truth in the social sciences anytime soon, but there is always hope. Hope (with faith and love) is one of the three virtues a Christian can never relinquish, and history attests to recoveries from intellectual deserts more sparse than our own age. But I see our task today as one of carrying on a culture of truth and discourse in restricted, limited communities of discourse that will not prevail in social policy anytime soon; may even be outlawed and suppressed; but will preserve this culture or civilization until a day when it may thrive once again. For this reason it is important that we speak out even when it seems that we will have no effect, in the spirit of bearing witness to an eschatological truth, until such time as (who knows?) God may take up our faltering witness and from it make a new world.

Dr. Sullins, you have conducted a very important reanalysis (Sullins, 2021) of a study by Blosnich et al. (2020) that purported to find exposure to SOCE associated with greater suicidality. Could you tell our readers something about this study and what you found in your reanalysis?

Sullins: I found that Blosnich et al.'s conclusion neglected to examine whether the suicidality occurred before or after SOCE participation. They reported suicidal thoughts or attempts made before any SOCE exposure, for example, as being "due to SOCE." After correcting for this error, I found that there was no association between SOCE and post-

SOCE suicidality. In fact, after an initial expression of suicidality, persons who subsequently had undergone SOCE were less likely to persist in suicidal behavior than those who had not undergone SOCE. I should note that this study is still undergoing peer review, which could find errors in my analysis that undermine the findings, so please don't put too much weight on these results just yet.

What do you think the implications of your findings are for the body of this SOCE-causes-harm literature?

Sullins: If confirmed, these findings reverse the false narrative that undergoing SOCE increases suicide risk. On these results, "banning" SOCE would increase suicide risk, by removing from sexual minorities an effective resource to reduce suicidality. The findings would also challenge the whole minority stress hypothesis, which holds that the psychological struggles of sexual minorities are due wholly or largely to social stigma. Ilan Meyer (source of the minority stress theory) was a co-author of Blosnich's study, and virtually all evidence for minority stress features similar global, uncontrolled lifetime associations.

How does someone best position himself or herself to become a researcher?

Schumm: The most important thing is to be a creative thinker, to be willing to think where others have never gone or at least don't want to go at the moment. Second, you probably need to become very good at doing statistics and management of larger data sets, as well as good at collecting your own data. We are probably talking about taking 30 or more graduate credits in research methods and statistics. But I am biased since I had about 55 such credits in graduate school, if my memory isn't failing me. But you also need to know how to dig through the research literature and set up your ideas for testing.

You also need to learn how to write well technically—and ideally, for ordinary audiences as well. On a more positive note, I think that anyone who can honestly look at any question from multiple angles is often way ahead of other scholars, who may limit themselves to only one way of looking at the world, maybe even only one scholarly theory (e.g., sexual minority theory). You should be willing to consider how your own biases might be helping you overlook important concepts or ideas or distort their meaning. It helps to be willing to ask ordinary persons about their views rather than assuming they must be like this or that.

Sullins: "Best position"? Earn a graduate degree, preferably a Ph.D., in a social science field with a specialty heavy in quantitative statistics; forego academic teaching positions; apprentice in an active conservative research agency for 3 to 5 years; grow the skin of an elephant; and become independently wealthy. I am half kidding about the last two, but only half. If being doxed by the SPLC [Southern Poverty Law Center] or HRC [Human Rights Campaign] is going to hurt your job prospects, or being shunned or publicly disparaged is going to hurt your feelings, you are not cut out for this work.

I hold an occasional meeting of aspiring and current conservative quantitative researchers, called the "Pro-life Quants," where we talk about both general and specific issues relating to entering a research career devoted to important controversial social questions related to the natural law. I provide a meal, one or two people present on a current project they're doing, then it opens to questions and general discussion. Lately it has become hybrid, with folk dialing or Zooming in from afar. I have also sponsored "Meet and Greet" sessions at the SCSS for

the past few years, where conservative graduates newly on the job market can interact with representatives of schools looking to hire same. This is mostly for aspiring faculty, not researchers per se, although researchers have also participated; and I hear that faculty even sometimes do research. Participants in these things trend mostly Catholic and younger, but persons of any age, state in life and religious or non-religious preference are welcome to take part. If anyone is interested, just send me that in an email (sullins@cua.edu) and I will put you on the list for the next one.

What advice and guidance would you offer to someone who is interested in researching and publishing studies that may be viewed as "non-affirming" or otherwise run against the conventional wisdom of the age?

Schumm: I'd suggest you have a second career option readily available. For me, it was being in the Reserves, where full-time positions or several-month temporary positions were often available for the asking. But you need to have a heart for truth that is greater than the fear of man or of losing your job. It reminds me of a story where a speaker asked a group of highly religious persons if they were willing to die for Jesus. All said, "Yes!" Then the speaker asked how willing they would be to be embarrassed for Jesus? Not so many hands went up for that idea. Academic humiliation is far more likely than physical harm, so one should be prepared for it.

Sullins: My previous answer already speaks to this question. The first thing I always say to someone who inquires about this is that engaging in such research is an academic career killer. This overstates somewhat, but only somewhat. What I really want to see is how timorous the inquirer is. Most of them don't get back to me after this. If they do, then we can continue the conversation.

Besides this journal, are there any other journals that are sympathetic or at least would consider publishing research that might challenge the "conventional wisdom" regarding sexual orientation, change efforts, and gender?

Schumm: I was editor of *Marriage & Family Review* for eleven years, and under my tenure we welcomed a diversity of ideas and research. *Linacre Quarterly* seems willing to consider conservative ideas, but the editor seems very concerned with not appearing to be hostile towards minorities (your tone must not be deemed too offensive as you present the truth or facts). It's hard to say in general because editorial policies last as long as the editors last. One journal presented some conservative research and the editor was not long for his job there. Perhaps his tenure was up soon anyway. There are many open access journals now that probably need your financial support badly enough they will be more open to diverse opinions. Market forces may be driving greater diversity for open access journals.

Sullins: Yes, and, as I mentioned above, the number of them is growing, but they are not likely to be US-based or the most prestigious journals. As you know, we just had a SOCE-affirming study published in *F1000Research*, a new open source journal that shows some bias but was still willing to publish it. The *Linacre Quarterly*, the journal of the Catholic Medical Association, is a highly respected medical journal founded in the 1920s that has published many studies that contravene conventional wisdom (although they declined to publish the SOCE study, so there's a limit). *Issues in Law and Medicine*, the journal of a pro-life research institute, is a core PubMed journal that welcomes studies

from a conservative perspective, particularly ones pertinent to current judicial disputes. Its list of referees reads like a roster of top conservative scholars.

The family of "Sage Open" journals advertise that they do not reject articles based on point of view, only methodological merit, and I have found that to be often though not always the case. The family of "MDPI" journals, with editorial offices in Switzerland and Bulgaria, have published many studies of sexuality from a conservative or traditional perspective, in particular the *International Journal of Environmental Research and Public Health* which, despite the clunky name, is a well-respected journal also automatically indexed in PubMed. The journal *Frontiers in Psychology*, also a PubMed journal based in Switzerland, is also open to, even looking for, sexuality studies from a conservative perspective. These journals require top notch statistical competency, however; qualitative studies or essays will not make the grade.

Many journals today ask the author to recommend possible reviewers. I suggest you give them the name of several conservative scholars who are not likely to be biased against your findings. The journals don't promise to use your suggestions, but they often use at least one of them; and if you get one positive review and one negative one the editor will often seek out a third, objective reviewer to settle the discrepancy, thus increasing your chances of acceptance.

What research or other professional activities with which you have been involved have generated the most "push back" from those who disagreed with you? How did you handle this?

Schumm: Publishing my book on same-sex parenting seemed to generate the most push back. The same week the book came out, the university fire marshal showed up to inspect my office and found that I had stacks of papers more than two inches deep and books lying flat on my bookcase shelves (so did Einstein, by the way). Once I got those things cleaned up, then I was told that instead of having six/six file cabinets and bookcases in my office, I could only have one/two. I got it done but what a mess! It eventually led to my moving my office to my home, even before COVID made other professors have to do that. I handled it by going into a phased retirement for two years so I could stay long enough until my wife was eligible for Medicare.

When I was banished from my organization's annual conferences, I spiritualized it by reminding myself that being shamed and ostracized was part of Jesus's life as well, even though He was perfect, unlike myself totally. When other faculty members who had served their universities for 40 years were recognized by the governor of Kansas in a web video, my name was not among them, even though I was put forth on the list initially with forty or more years of service. When the university held a Zoom retirement ceremony, my audio was lost and the moderator said it would take too long to fix, so I could not hear the provost's short blurb on my past service, which was just as well since he only discussed my military service rather than my teaching or research at the university. As the program ended, my audio returned without any intervention on my part. But again, it points to the futility of expecting rewards this side of heaven. Then again, it helps me appreciate the award granted by the Alliance several years ago.

Sullins: The most adverse reactions I have gotten has been for my work on same-sex parenting, which has shown emotional problems to be much higher among children with same-sex parents, especially if those same-sex parents are married. Almost all the

opposition has been related to political uses of my findings, not the substance of the studies themselves. In 2015 my study "Emotional Problems among Children with Same-Sex Parents: Difference by Definition" was critiqued, along with a study by Mark Regnerus, by the APA and ASA briefs in Obergefell. Mark and I (aided by Loren Marks) defended our work in our own brief, written under the auspices of the American College of Pediatricians.

In June 2016 I published an article in the journal *Depression and Research Treatment* titled "Invisible Victims: Delayed Onset Depression among Adults with Same-Sex Parents." The study showed, using high quality longitudinal data, that a significant percentage of children raised by same-sex parents who appeared unaffected during childhood and adolescence manifested depressive symptoms by their late 20s. A gay activist scholar wrote a negative commentary on it full of falsehoods, which the journal published along with my rebuttal. There matters sat for over a year; the article was viewed about 200 times, with about 25 downloads.

Then in August 2017, during the run-up to the Australian gay marriage referendum, a shadowy far right group put up a salacious poster in Melbourne citing one finding in the paper: all forms child abuse in same-sex parent families was 93%. This is not as extreme as it sounds, as it includes even minor verbal abuse; among all families the same measure was 69%. I had reported it in a table, since it was a significant finding, with only a brief mention in the narrative. The hostile critique by the gay activist never mentioned it.

But this single politically sensitive use of my study set off a firestorm. Gay scholars around the world, and all the Australian media, fulminated against my hateful stigmatization of gay parents. Editorials denounced me for writing and the journal for publishing such hate speech. No matter that the finding was accurate and that I upon publication I had purchased the copyright from the journal. The journal launched an investigation into the article's reviews and approval, scrutinized every model and claim in it, and finding nothing amiss published an "Expression of Concern," an action just short of retraction which usually describes the questionable practices that should lead scholars to question an article but in this case affirms that no questionable practices were found.

The final chapter in this story is laughable. A friendly attorney urged me to sue the journal for defamation. (It is incorporated in England, where the bar for such suits is apparently lower than in the United States.) But he eventually decided we had no case. Why? In order to sue one has to show damages. And when we checked, we found that after the EOC and denunciation, worldwide readership of the article had skyrocketed. In the three weeks after the fracas the article was viewed and downloaded five times more than it had been in the year before. Since then the pace has hardly diminished. Today, not quite four years later, the article which was almost ignored in its first year has been viewed over 85,000 times with over 4200 downloads and a dozen citations. Versions of it have been reproduced and posted on 21 family friendly organization's websites. By denouncing this study, the gay activists and the journal ensured that it would be read and considered by tens of thousands more people than would have been the case otherwise!

(Free preprint copies of all papers mentioned are available at https://ssrn.com/author=2097328 . The study "Invisible Victims" is online at https://www.hindawi.com/journals/drt/2016/2410392/?fbclid=IwAR3G1xCoSLMZCsUbC56IwQCLhWCo0uOtyc1fOGZsYzf_nu4YNlHOaUpKbkY)

What is the most humorous experience you have had in doing research?

Schumm: There is humor in finding things to be different than you expected, which should happen often with genuine research (otherwise, why bother?). The most consistently humorous thing was that people would come by my cluttered office and ask me for a certain journal article and I usually could find it somewhere in my stacks of papers. I used to kid people that my office was like therapy; it just had to make you feel better about your own clutter problems. I still have the same issues—now they are in my own home, much to my wife's frustration. Once I am fully retired, I have about 40 projects to wind down, so the plan is to reduce the materials as each project is completed. One time a couple dozen family scholars were asked to prepare autobiographies which were published as a book. What was funny was that some of the book's critics said the authors did nothing but talk about their own careers in a prideful way. Well, what were they supposed to do? Talk about someone else's career or how terrible their own career had been? They did what they were told to do—but that wasn't acceptable to these critics!

Sullins: In 2010 I submitted a presentation "Homosexual Identity: The Case Against Innateness" to the convention of the Eastern Sociological Society in Boston. I presented a list of "ordinary" reasons, like temporary prison homosexuality and the defection rate from homosexual identification from age 18 to age 40, to question the narrative that homosexuality is innate. The organizers put me in a session "Theoretical Approaches to Gender and Sexuality," which had only one other presenter. After I made my presentation the other presenter came up and introduced herself as Widow Centauri: Sociologist, Sex Educator, Dominatrix, Stand-Up Comic. She identified as nonbinary, insisting on the pronoun "xe", and of course as lesbian. Sort of. In a rambling stream-of-consciousness narrative she reported that she frequently changed her sexuality and sexual identity, like a suit of clothes, depending on how she felt, who she was with and other random factors. I could not have made up a better illustration of the non-innateness of homosexual identity if I had tried. When asked what she had thought of my presentation, she said, "I couldn't agree more with Dr. Sullins. All our sexual identities are a social construction and nothing more." I wasn't totally sure I wanted this endorsement from such a creature, but it was definitely a hoot. She was hilarious. Widow and I got together later in the day and had a wonderful, strange, nonlinear conversation. We actually got along pretty well. She poked fun at my normality and conventional religiousness, as she saw it, and I poked fun at her deviance and transgressiveness. Nothing mean or judgmental, just a meeting of minds coming from two radically different universes and laughing at the difference. She has since finished her degree and, for reasons that mystify her, has had trouble landing an academic position.

Any other final thoughts you would want to convey to Alliance partners?

Schumm: If you have the character traits of humility, willingness to be proven wrong, a strong desire for the truth, an eagerness to learn more, an acceptance of doing hard work, an ability to think creatively, you are so far ahead of any scholar who lacks such traits. If you allow the Holy Spirit to build such traits into yourself, even if you may be lacking them as natural talents, you are so much better off in the long run. Frequently, I would run into seemingly intractable problems, and I had no recourse but to ask

God, “Where do I go from here? What am I missing? What ideas don’t I get? Help!” And I found God to be very faithful in giving me keen insights into things far beyond what I could have figured out on my own.

Sullins: I think of Hebrews 11, which recounts the trials of prophets and people of faith throughout history, but in the middle of talking about them being tormented and deserted inserts these words (verse 38): of whom the world was not worthy. As a final thought, I want to say to your partners, if it is not too presumptuous: do not be afraid or discouraged. When darkness prevails, even a small light is powerful. You may be small and disregarded, harassed and despised, but you are far more important than you know in God’s plan and way. Don’t give up! Keep shining.

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Sexual Attraction Fluidity and Well-Being in Men: A Therapeutic Outcome Study

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Recent legislative efforts initiated by politicians and activists have limited or threatened to limit the autonomy and self-determination of individuals desiring sexual attraction fluidity exploration in therapy (SAFE-T), claiming that SAFE-T is ineffective and harmful. The American Psychological Association has claimed that there is not enough rigorous research to draw conclusions about the efficacy or beneficence and nonmaleficence of SAFE-T. The present longitudinal study examined the sexual attraction fluidity (SAF) and wellbeing of psychotherapy clients while participating in SAFE-T. Participants were 75 adult male psychotherapy clients reporting both same-sex attraction experiences (SSAE) and the desire to participate in SAFE-T to achieve SAF. Well-being was measured with the OQ-45.2, SSAE, and opposite-sex attraction experiences (OSAE) with a Likert scale, and sexual attraction identity (SAI) with a Likert-type item. Results of *t*-tests of the means of baseline and final well-being measures revealed a clinically and statistically significant improvement in well-being. A linear mixed model was used to analyze the SSAE, OSAE, and SAI data obtained at baseline, 6 months, 12 months, 18 months, and 24 months, with results showing

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statistically significant fluidity of all three factors. SSAE decreased, OSAE increased, and SAI moved toward heterosexual identity.

Keywords: sexual attraction fluidity, well-being, OQ-45.2, SAFE-T, psychotherapy

The American Psychological Association and other mental health organizations (American Psychiatric Association, 2013, 2018; National Association of Social Workers, 2015; Substance Abuse and Mental Health Services Administration, 2015) have provided guidance to psychologists to dissuade clients from exploring sexual orientation change (American Psychological Association, 2019, 2012, 2021) or what we call *sexual attraction fluidity* (SAF). The American Psychological Association (2012) defines "sexual orientation" as "the sex of those to whom one is sexually and romantically attracted." The organization acknowledges that while persons commonly may identify—or be identified—as lesbian, gay, bisexual, or heterosexual, "sexual orientation does not always appear in such definable categories and instead occurs on a continuum" (p. 11). Also, "research indicates that sexual orientation is fluid for some people. This may be especially true for women (e.g., Diamond, 2007; Golden, 1987; Peplau & Garnets, 2000)" (p. 11).

The 2012 American Psychological Association's *Practice Guidelines* state that "efforts to change sexual orientation have not been shown to be effective or safe" (p. 14). In defense of this position, they state that there is insufficient research evidence to demonstrate the impact of sexual orientation change efforts (SOCE) on the well-being and SAF potential of individuals. The organization critiques existing research as inadequate for providing clear, empirical support for *sexual attraction fluidity exploration in therapy* (SAFE-T), saying that the research includes "biased sampling techniques, inaccurate classification of subjects, assessments based solely upon self-reports, and poor or nonexistent outcome measures" (American Psychological Association, 2012, p. 14). Paradoxically, they use similar research to support their opposition to SAFE-T. The revised guidelines produced in 2021 contain no improvements in the quality of evidence supporting the APA's opposition to SAFE-T, despite amplification of the claims of harm (American Psychological Association, 2021; see *Guideline Four*). The references are largely replicated from the original guidelines. One exception is a newer retrospective, observational study (Blosnich et al., 2020) comparing lifetime suicidality of participants who had not explored their sexual attraction fluidity with participants who had received primarily religious interventions (81% of the participants experienced only religious interventions) at some point in their lives. They found that participants who had sought assistance also had higher suicidality. The 2021 guidelines imply that this descriptive, retrospective, non-experimental design study demonstrates that professional psychological SAFE-T instigates suicide. Again, this is despite the observational, descriptive, and retrospective design of this study of predominantly religious mediation and despite Blosnich et al.'s extensive discussion of the inadequacy of the study for making such inferences (p. 1029). The study instead seems to communicate that individuals who experience distress are more likely to seek assistance. Taking into consideration this confusing guidance, we agree with the APA's original assertion (2012) that the clinical outcome research for SAFE-T is inadequate and needs to be updated.

Prominent SAF researchers Bailey et al. (2016) agree, at least in principle, with the need to pursue SAFE-T outcome research,

stating "the more politically controversial a topic, the more it is in the public interest to illuminate it in a revealing and unbiased manner" (p. 46). The level of efforts of activists and politicians to regulate this clinical practice establishes SAFE-T as a controversial topic. Such efforts have included attempts to remove the rights of individuals to receive, and mental health professionals to give, therapeutic support for pursuing SAFE in no less than 20 states and several municipalities (Movement Advancement Project).

The literature review provides a theoretical foundation for continued SAFE-T outcome research followed by an overview of the psychotherapy harm research. The previous research provides a rationale for conducting this and future research on SAFE-T, despite the American Psychological Association's injunction against supporting clients' goals to explore SAF.

Literature Review

Theoretical Foundations

Sexual Attraction Fluidity

Arguments against allowing individuals to pursue SAFE-T rest on a long-held presupposition that homosexual attraction is immutable. However, this presupposition is contradicted by evidence of *sexual attraction fluidity* (SAF). The Laumann et al. (1994) study of human sexuality observed that people do change the objects of their sexual attraction over time. More recently, Diamond and Rosky (2016), in their comprehensive review of the SAF literature, unequivocally concluded that sexual attraction is mutable, apart from any professional therapeutic assistance. They support their claims, in part, with evidence from failed attempts to discover chromosomal and other biological evidence of programming for sexual attraction, and from the broad body of literature demonstrating that SAF is the norm, particularly for people who have had same-sex attraction experiences (SSAE). The antecedents and influences of SAF include relational, emotional, cultural, and biological elements (Diamond, 2008; Diamond & Rosky, 2016; Farr et al., 2014), with life experiences having a particularly significant influence (Diamond & Rosky, 2016; Silva, 2017). Typically, SAF moves toward opposite-sex attraction experiences (OSAE; Diamond & Rosky, 2016).

Further, in contradiction to the narrative that accepting and embracing a "sexual orientation" is the best option for psychological health (American Psychological Association, 2012, 2021), Diamond notes an association between psychological maturity in women and the rejection of self-labeling in accordance with sexual attraction experiences (Diamond, 2008). Finally, the American Psychological Association agrees that individuals can and do experience SAF, stating, "sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid" (2009, p. 14).

If, as Diamond and Rosky (2016) conclude, sexual attraction experiences can change with apparently no conscious effort, it is reasonable to assume that some individuals should be able to influence their attractions as a byproduct of processing trauma and other emotions or relational concerns while participating in SAFE-T. Further, a person may choose to intentionally change or influence the effects of the relational, emotional, cultural, and/or biological factors which have contributed to or otherwise co-occur with their experience of sexual attraction. This logic is corroborated by decades of research. Reports of self-determined SAF exploration include accounts of individuals successfully utilizing a variety of means in support of this process.

Some individuals report assistance through religiously mediated interventions (Jones & Yarhouse, 2011; Shidlo & Schroeder, 2002; Spitzer, 2003) and others using psychotherapeutic interventions (Karten & Wade, 2010; Nicolosi et al., 2000; Phelan, 2014, 2017; Phelan et al., 2009; Santero, 2012; Shidlo & Schroeder, 2002).

Reported Beneficence and Harm for Persons Who Participate in SAFE-T

As established earlier, the American Psychological Association has claimed that SAFE-T is "not safe," i.e., harmful, without the benefit of rigorous empirical evidence to support their assertion (American Psychological Association, 2012, 2021). It is problematic that they support their position with research that has "a host of methodological problems . . . including biased sampling techniques, inaccurate classification of subjects, assessments based solely upon self-reports, and poor or non-existent outcome measures" (2012, p. 14). Additionally, the context of the general harm literature is omitted from the American Psychological Association's evaluation of the potential harm of SAFE-T, which calls the validity and wisdom of the assertion into question. As Rosik states, "any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general" (2014, p. 112). Accordingly, we provide a general background concerning the helpfulness (beneficence) and harmfulness (maleficence) of psychotherapy practices in general before reviewing their relevance to therapy outcomes for sexual minorities.

General Population Beneficence and Harm. There are various definitions for the term *harm* in the psychotherapy outcome literature, including damage (Dimidjian & Hollon, 2010), negative side-effects, and clinical deterioration (Bergin, 1966; Lambert, 2013). It should be noted that embedded in the harm literature are accounts of non-effective therapy resulting in no change in the client's presenting problem. It appears that every established approach to psychotherapy, even when documented as generally effective or helpful, is frequently ineffective for client goals that are approved by the American Psychological Association (e.g., reducing depressive symptoms). For example, one study determined that 45% of clients presenting with depression experienced no reliable change (Kraus et al., 2016). This evidence of the frequent ineffectiveness of psychotherapy is particularly salient to provide a context for the American Psychological Association's concern that SAFE-T is not sufficiently effective.

In contrast to reports of ineffective psychotherapy, "clinical deterioration," i.e., unwanted side-effects or "harm," can and does occur for a relatively small number of clients. A conservative estimate of the range of individuals who get worse while receiving psychological treatment is 3–10% (Berk & Parker, 2009; Boisvert & Faust, 2003; Kraus et al., 2011). Lambert (2013) reports that reviews "of the large body of psychotherapy research, whether it concerns broad summaries of the field or outcomes of specific disorders and specific treatments" lead to the conclusion that, while "psychotherapy has proven to be highly effective" (p. 176) for many clients, all clients do not report or show benefits. In addition, the research literature on the "negative effects" of psychotherapy offers "substantial . . . evidence that psychotherapy can and does harm a portion of those it is intended to help." These include "the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment" (p. 192). Such findings have been reported in the therapeutic and scientific communities for over three decades (Lambert, 2013; Lambert & Bergin,

1994; Lambert et al., 1977; Lambert et al., 1986; Lambert & Ogles, 2004; Nelson et al., 2013; Warren et al., 2010).

Harm can occur through acts of commission or omission. Acts of commission may range from explicit violations of ethics, such as sexual exploitation, to the practice of therapeutic interventions no longer recommended for the treatment population, such as catharsis induction with victims of trauma or aggressive confrontation with substance abusers (Berk & Parker, 2009; Dimidjian & Hollon, 2010). Examples of omission include the failure to make a referral to another professional for more appropriate or effective treatment (Berk & Parker, 2009), ignoring systemic concerns such as family of origin influences (Castonguay et al., 2010), and overlooking intercultural conflicts (Wendt et al., 2014). Many individuals who present with distress related to sexual attractions identify family and cultural conflicts (Beckstead & Morrow, 2004). Adapting treatment goals and interventions to every client's specific cultural background is essential for best outcomes (Smith et al., 2011).

In the current study and previous sexual minority research, participants frequently identify strongly with their religious and ethnic culture (Balsam et al., 2011; Parent et al., 2013). This is consistent with the conclusion of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (American Psychological Association, 2009, p. v) "that the population that undergoes SOCE tends to have strongly conservative religious views that lead them to seek to change their sexual orientation." Therefore, the potential harm of ignoring, dismissing, or denigrating cultural identities are particularly applicable for those who seek SAFE-T. The ability to understand and affirm a client's culture appears to influence therapist effects as it communicates to the client that the therapist understands him or her (Smith et al., 2011; American Psychological Association 2009, 2012).

Therapist effects continue to emerge as possibly the strongest correlate of both benefit and harm. Therapist characteristics, such as her or his own mental health, style, personality, approach, philosophy, and especially the therapist's ability to connect to the client and his or her agenda, are strongly associated with (positive or negative) outcomes (Berk & Parker, 2009; Castonguay et al., 2010; Kraus et al., 2011). Therapist effects have a particularly significant influence on dropout rate (Swift & Greenberg, 2014), and incompetent clinical work is correlated with deterioration, increased suicidality, and violence (Lutz et al., 2007).

A review of literature that considers the importance of self-determination theory as applied to psychotherapy demonstrates that supporting clients' self-determination has powerful benefits, including reduction of depressive symptoms (Moore et al., 2020; Michalak et al., 2004; Pelletier et al., 1997; Ryan & Deci, 2008; Sheldon & Houser-Marko, 2001; Zuroff et al., 2007, 2012). Promotion of self-determination includes tailoring psychotherapy to the individual, as opposed to projecting a therapist's agenda, values, and possibly his or her interpretations onto the client (Norcross & Wompold, 2011). Other research has revealed that clients are helped when the therapist displays qualities of presence and empathy, and when they successfully communicate understanding and support for the client's values and goals (Lilienfeld, 2007; Moyers et al., 2016; Moyers & Miller, 2012; Timulak, 2010).

Overall, the general literature on clinical harm provides evidence that regardless of the client's presenting problems and stated goals, psychotherapy can result in poor outcomes. However, it does appear that some psychotherapeutic intervention is better than no intervention for most people suffering

from psychological distress (Lambert, 2013; Lilienfeld, 2007) and privileging the client's agenda is essential for reducing harm (Lilienfeld, 2007; Moyers et al., 2016; Moyers & Miller, 2012; Norcross & Wompold, 2011; Timulak, 2010; Zuroff et al., 2007, 2012).

Sexual Minority Beneficence and Harm. Comprehensive reviews of the sexual minority psychotherapy outcome literature have found that in addition to the problems of conflating psychotherapy with non-psychotherapeutic interventions, there are problems with the quality of the research (King et al., 2008; O'Shaughnessy & Speir, 2017). For example, there are few pretest-posttest designs, few control group designs, and few that use psychometric tests. Most of the research is retrospective (O'Shaughnessy & Speir, 2017; Przeworski et al., 2021) and includes recollections of client experiences from 40 years prior to data gathering (Israel et al., 2008). The data strongly supports self-determination theory with the consensus that poor outcome is frequently attributed to little support for the client's agenda (Israel et al., 2008; King et al., 2008). The Israel et al. (2008) review concluded that 25% of poor results (harmful or not helpful) are associated with the lack of support for the self-determination of the client.

Gay-Affirmative Therapy Outcomes. The American Psychological Association asserts that "the affirmative approach to psychotherapy grew out of an awareness that sexual minorities benefit when the sexual stigma they experience is addressed in psychotherapy with interventions that reduce and counter internalized stigma and increase active coping" (2009, p. 1). Ironically, research is lacking in support of this assertion. In their systematic review attempting to isolate outcomes for gay-affirmative therapy, O'Shaughnessy and Speir (2017) report that there are only four experimental, or quasi-experimental studies that measured gay-affirmative interventions. These studies report that efforts to eliminate or reduce gay-specific symptoms were largely ineffective. As an example, Pachankis et al. (2015) approached their carefully designed study with the assumption that anxiety, depression, alcohol abuse, and risky sexual behavior by men are the result of minority stress, internalized homophobia, and concealment of the participants' sexual experiences. One group received standard CBT and the other CBT modified with interventions targeting the researchers' gay-specific concerns. The results revealed no significant difference between the standard CBT group and the gay-specific CBT group for either depression or gay-specific symptoms. However, there was a decrease in depression in both groups. Because the depression was modified, but the gay-specific concerns remained the same, one might conclude that the depression was not directly tied to the gay-specific experiences.

A similar, more recent study "tested the efficacy of a minority-stress-focused cognitive–behavioral treatment" for sexual minority women dealing with "depression, anxiety, and alcohol use problems" (Pachankis et al., 2020, p. 613) and yielded similar results. The intervention used in this study was adapted from the one used in the Pachankis et al. (2015) study of sexual minority men mentioned above. Participants were tested at onset and at three- and six-month follow-ups and were randomly assigned to receive the ten-week intervention either immediately or after the three-month follow-up assessment. Overall, the women who received the intervention experienced significantly reduced depression and anxiety and a marginally significant reduction of their alcohol use problems. In their discussion, Pachankis et al. (2020) commented that "because the treatment was associated with only small reductions in minority stress processes and did not affect suicidality, future

research is needed to elucidate the potentially unique mechanisms underlying sexual minority women's mental and behavioral health" (p. 626).

Several studies of gay affirmative or "gay specific" therapy (Reback & Shoptaw, 2014) were conducted to help gay men decrease drug use and risky sexual behavior with the goal of decreasing HIV transmission. Over a ten-year period, using replicated, randomized, control trials, Shoptaw, Reback, Larkins et al. (2008), Shoptaw, Reback, Peck et al. (2005), and Repack & Shoptaw (2014) showed that mainstream therapies, culturally adapted mainstream therapy, and a peer counseling model all effectively helped gay men significantly decrease casual same-sex behavior over the course of therapy. These gains were maintained at the six-month and the one-year follow-up. This research provides evidence that same-sex behavior can be effectively decreased through therapy to lower the medical health risks of the participants.

Both the King et al. (2008) and the O'Shaughnessy & Speir (2017) reports conclude that clients prefer affirming experiences in psychotherapy. However, both reviews deliberately excluded studies of sexual minorities seeking SAFE-T and therefore likely eliminated any participants who would have preferred to explore their SAF. It might be more accurate to say that clients who present with an agenda to affirm a sexual minority identity (since these are the only clients included in the report) are not benefited when a therapist ignores their agenda and promotes her or his own agenda.

Like the general population outcome research, sexual minority client outcome research supports self-determination theory. The participants who perceived their therapist as accepting and warm and supportive of their agenda had the best results (Israel et al., 2008; King et al., 2008; O'Shaughnessy & Speir, 2017). Particularly salient to the current study, clients preferred the counselor to see them and their problems outside of their sexual minority status and to not attribute their presenting problems to gay stress. At the same time, they wanted the therapist to be comfortable talking about sexuality issues (King et al.).

SAFE-T Outcome Research. Sutton (2014) has reviewed the SAFE-T outcome research literature and offered clarity on what conclusions may or may not be drawn about its documented harmfulness and benefits. This and the present review confirm the American Psychological Association's (2009) previous assertion that further research is necessary for documenting the beneficence and non-maleficence SAFE-T. As a background for the current empirical study, we highlight limitations of the SAFE-T research. Many are similar to the weaknesses found in the broad body of sexual minority literature (King et al., 2008; Israel et al., 2008) and the gay-affirmative outcome research (O'Shaughnessy & Speir, 2017) discussed earlier.

Clinical outcome studies designed to find evidence-based best practices for the treatment of all intra- and interpersonal difficulties typically use quantitative, prospective methodologies such as control trials, single group pretest-posttest, and other quasi-experimental designs (Des Jarlais et al., 2004; Kendall & Lippman, 1991; Liebherz et al., 2016; O'Shaughnessy & Speir, 2017). Studies investigating SAFE-T that use conventional methodological standards of evidence-based, clinical outcome research are lacking. Instead, the research purporting to investigate SAFE-T is primarily retrospective (Beckstead & Morrow, 2004; Blosnich et al., 2020; Bradshaw et al., 2015; Dehlin et al., 2015; Flentje et al., 2014; Meanley et al., 2020; Nicolosi et al., 2000; Phelan, 2014; Phelan et al., 2009; Salway et al., 2020; Santero, 2012; Shidlo & Schroeder, 2002; Smith et al., 2004; Sullins et al., 2021;

Weiss et al., 2010) and qualitative (Beckstead & Morrow, 2004; Bradshaw et al., 2015; Flentje et al., 2014; Phelan 2014; Phelan et al., 2009; Shidlo & Schroeder, 2002; Smith et al., 2004; Stanus & McDonald, 2013; Weiss et al., 2010). While retrospective and qualitative research is important for helping clinical outcome researchers form questions for evidence-based studies, these methods are not the standard for drawing conclusions and subsequently directing the development of clinical guidelines (Des Jarlais et al., 2004; Kendall & Lippman, 1991; Liebherz et al., 2016). An important exception to the use of a qualitative approach is a recent retrospective study (Sullins et al., 2021) reporting that 42.7% of 125 men pursuing sexual orientation change experienced reduction in same-sex sexuality. With its quantitative design, the Sullins et al. study provides an example of the type of research needed for offering evidence-based clinical guidance.

In addition to the basic design problems, there are some notable problems with participant selection. For example, the Shidlo & Schroeder (2002) study, which is highlighted as providing guidance for the development of the 2012 American Psychological Association LGB practice guidelines introduced bias at the outset when asking potential participants to "help document the harm" of SAFE-T. Both the Shidlo & Schroeder study and the more recent Flentje et al. (2014) study sought only dissatisfied gay-identified participants, consequently biasing the results. The practice of intentionally omitting participants who might have benefitted from SAFE-T from research on sexual minorities in psychotherapy is all too common. For example, O'Shaughnessy & Speir (2017) systematically excluded SAFE-T studies when reviewing the literature to assess the state of psychotherapy with sexual minorities. It seems the narratives of those who might have benefited from SAFE-T have too often been methodically excluded from the literature, *a priori*.

Most of the research reporting outcomes for individuals exploring SAF are investigations of the effects of non-psychotherapeutic experiences such as support groups, and religious or educational interventions (Dehlin et al., 2015; Jones & Yarhouse, 2007, 2011; O'Shaughnessy & Speir, 2017; Przeworski et al., 2021). Also, many studies intermingle these non-psychotherapeutic experiences with psychotherapy (e.g., Beckstead & Morrow, 2004; Blosnich et al., 2020; Bright, 2004; Przeworski et al.; Shidlo & Schroeder, 2002; Spitzer, 2003) resulting in unclear reports of the results and unanswered questions about the factors that lead to beneficent or harmful psychotherapy outcomes. These studies are often quite clear that the reports do not exclusively address outcomes of clinical interventions. For example, Blosnich et al., (2020) state that 81% of the participants in their study took part exclusively in religiously mediated interventions, not psychotherapy. However, these studies continue to be presented in counseling and psychology journals, representing the results as if they are related to psychotherapy outcomes.

An additional problem with this body of literature is obfuscation of terminology related to the practice of SAFE-T, resulting in misleading conclusions or no conclusions at all. For example, SAFE-T is not clearly defined by its opponents and is often labeled erroneously—and pejoratively—as *conversion therapy*, *reorientation therapy*, or using the generic term, *reparative therapy*, which was based on the specific SAFE-T model of psychotherapy labeled "Reparative Therapy" that was developed and promoted by Nicolosi (1993, 2020). Although often mistakenly presented as a specific approach to therapy, SAFE-T is an umbrella term for all therapeutic modalities or interventions which

support client self-determination in relation to SAF exploration (Rosik, 2016, 2017).

Finally, much of the literature induces additional confusion by attributing reports of harm to the exploration itself, as opposed to any specific interventions or therapist effects. For example, decades-old accounts of SAFE-T client experiences include descriptions of long-discredited psychotherapy practices that were once used for a variety of presenting problems and later discontinued (Lilienfeld, 2007). These include recovered memory techniques, rebirthing, aversion therapy, and misuse of electroconvulsive therapy (Israel et al., 2008). These same interventions were historically performed for the presentation of depressive symptoms (and other presenting problems) and were discovered to be similarly harmful to these clients. However, there is no current campaign against assisting clients wishing to influence their depression symptoms in therapy. Many authors who are critical of SAFE-T confuse or combine the treatment goals (sexual attraction fluidity exploration) with the treatment interventions and subsequently contend that the goals are harmful, as opposed to isolating the interventions as producing the harm.

Conclusions have been drawn about SAFE-T in the professional and public arenas without sufficient evidence. The concerns of professional organizations, mental health practitioners, politicians, and activists, regarding the beneficence and effectiveness of SAFE-T, can only be addressed with additional research employing prospective, empirical designs.

Method

The purpose of the current study was to determine the effects of sexual attraction fluidity exploration in therapy (SAFE-T) on well-being and sexual attraction fluidity (SAF). The participants were adult males presenting for psychotherapy with the desire to explore their SAF potential. Using a quasi-experimental, single-group, longitudinal, repeated measures design, the study evaluates the fluidity of opposite-sex attraction experiences (OSAE), same-sex attraction experiences (SSAE), sexual attraction identity (SAI), and well-being in male adult psychotherapy clients.

Participant Recruiting and Selection

The researchers received permission to recruit participants from new clients at two private practice psychotherapy clinics known for providing SAFE-T and sharing licensed clinicians. The researchers were not affiliated with these clinics and were not employees or contractors. The intent of the design was to allow observation of real-life client experiences in a clinical setting, providing more generalizable results than a controlled setting, such as a university psychotherapy training clinic (Weisz, Donenberg et al., 1995; Weisz, Jensen et al., 2005). Male adults reporting SSAE and a desire to explore SAF were provided a letter of invitation to participate in the study. Potential participants were assured that their participating in the study, or declining to participate, would have no impact on their clinical services. Further, consent for treatment and consent for research participation were clarified as distinct processes. Clients who agreed to participate, reviewed, and signed consent-for-participation forms that included research evidence related to the harm and beneficence of psychotherapy. The research assistant reviewed the consent form with each participant to address any questions.

One hundred and five participants ages 18 to 76 were recruited and began participation by the completion of pretests, and 75 participants completed the study. The 30 participants who did not complete the study included one participant who was withdrawn from the study when it was discovered that his clinician violated the

research protocol when asking the participant to elaborate on a posttest SAE item. Six of the non-completers withdrew from the study. One stated that he no longer experienced same-sex attractions, another that he did not want to be associated with the study, and four stated that they did not need further psychotherapeutic services. Twenty-three participants discontinued clinical services prior to the 6-month SAE posttest measure.

Instruments

OQ-45.2

Well-being was measured using the Outcome Questionnaire 45.2 (OQ-45.2). The OQ-45.2 is a 45-question instrument administered through an online testing center (http://www.oqmeasures.com). It is designed to provide real-time feedback of psychotherapy clients' progress. The OQ-45.2 is norm-referenced and has demonstrated the ability to detect change even in short-term therapy (Doerfler et al., 2002) with good reliability and validity (Lambert, 2004; Lambert et al., 1996). The measure was designed to assess for improvement and deterioration within three domains of client function: psychological, interpersonal, and social functioning (Lambert, 2012). Each item is rated using a 5-point scale (0=never, 1=rarely, 2=sometimes, 3=frequently, 4=almost always) with a range of possible scores of 0-180. A lower score indicates higher functioning and well-being (Lambert et al., 2001). Following recommendations for the use of the instrument to conduct research, the first (baseline) and last measures were compared.

SAQ

The Sexual Attraction Questionnaire (SAQ) Pretest and Posttest (adapted from Santero, 2012) uses separate Likert scales for two measures: opposite-sex attraction experiences (OSAE) and same-sex attraction experiences (SSAE). OSAE and SSAE items measure frequency of thoughts, feelings, and behaviors (kissing & sex) using a 5-point scale (1=never, 2=almost never, 3=monthly, 4=weekly, and 5=almost daily). Sex is defined as touching genitals, and oral, anal, or vaginal intercourse. The SAQ also measures sexual attraction identity (SAI) using a 6-point Likert-type item (1 = almost entirely heterosexual identity, 2 = more heterosexual than homosexual, 3 = bi-sexual, 4 = more homosexual than heterosexual, 5 = almost entirely homosexual, and 6 = homosexual). Both the pretest and posttest version of the SAQ include demographic questions and the pretest version includes questions about desires and motivations for SAFE-T.

Procedures

Instrument Administration

To obtain a baseline measure of SSAE, OSAE, and SAI, participants completed the pretest version of the SAQ prior to beginning SAFE-T. Subsequent measures were obtained throughout the course of treatment using the posttest version of the SAQ at 6 months, 12 months, 18 months, and 24 months. All SAQs were completed through Survey Monkey (http://www.surveymonkey.com). Additionally, prior to beginning SAFE-T, participants completed a baseline measure of well-being using the OQ-45.2 and repeated measures prior to each subsequent SAFE-T session throughout the course of treatment. The OQ-45.2 measures were administered through the OQ-45.2 online testing center (http://www.oqmeasures.com). If a participant had not completed the testing before the session, he completed the assessment in his therapist's office prior to the session using either his own or the therapist's device.

Intervention

The clinicians who provided psychotherapeutic services used Reintegrative Therapy™ (RT; Reintegrative

Therapy Association, 2017, 2019; Nicolosi, 2017). RT is described as a specific combination of evidence-based, mainstream treatment interventions for trauma and addiction. RT includes the use of EMDR and mindful self-compassion, emphasizing client autonomy and self-determination and is supportive of SAFE-T. While the standard RT treatment protocol was designed for treating trauma and addictions, therapists at the clinics report observations of a co-occurring reduction in SSAE in some men (Nicolosi, 2017).

In routine clinical settings clients autonomously end treatment for a variety of reasons. Often treatment ends because either the client, the therapist, or both believe that the therapeutic goals were met, or have determined that the treatment has plateaued in its effects. Other reasons for ending treatment include geographic relocation, changes in insurance coverage, or the desire to pursue other treatment options. Since this study took place in such a real-life clinical setting, treatment length was individualized according to the needs of the participants and therefore varied for each participant.

Statistical Analysis

Initial data analysis included the performance of *t*-tests comparing the means of the baseline measures of the participants completing services within 6 months and the 75 participants who completed the study with at least one posttest SAQ measure. Additionally, descriptive data, including means and standard deviations at each measure, and SAQ categorical data describing the participants who completed the study was compiled.

The effect of SAFE-T on well-being was evaluated using a *t*-test of the baseline and final OQ-45.2 mean scores with the addition of *Cohen's d* calculation of effect size. The use of baseline and final measure of the OQ-45.2 method has been recommended by others if the goal of the research is to determine the overall effect of the treatment, as opposed to tracking the slope of well-being change (Baldwin et al., 2009).

The linear mixed model was used to analyze the SAQ data (SSAE, OSAE, & SAI). The use of this model has several advantages over the more commonly used repeated-measures ANOVA for the analysis of within-group repeated measures, particularly a study that is conducted in a real-life clinical setting that lacks the controls of a laboratory setting. The conventional approach to the analysis of longitudinal, repeated measures data, the repeated-measures ANOVA, requires that the entire data set be dropped when a single measure is missing, introducing bias, and lowering power. The repeated-measures ANOVA only functions well when missing data is not a problem (which is rare in a two-year study), when comparing independent groups across multiple measures, and when sphericity can be assumed.

Longitudinal research requires analysis of incomplete datasets that does not introduce the bias inherent by dropping entire cases, as is required when using the repeated measures ANOVA. The repeated measures ANOVA requires the same number of repetitions of the measure for each participant in contrast to the linear mixed model. This accommodated participants' datasets if they delayed completing the measure at one of the designated time points or discontinued treatment before the final measure (Seltman, 2018).The linear mixed model performs well with smaller sample sizes, which is particularly important when conducting research in real-life clinical settings with specific and somewhat less common presenting problems, as in the case of individuals seeking SAFE-T. This model also allows for non-independence of observations inherent in a within-subjects design (Seltman, 2018). The analysis of the SAQ data was

conducted using Proc Mixed in SAS 9.4 software.[3]

Results

Preliminary Analysis

A preliminary analysis was conducted to assess for baseline score differences between participants that completed the study with at least one posttest SAQ measure (n=75) and the participants that terminated services prior to the 6-month SAQ measure (n=24). *T*-tests were performed using the means of the baseline measures of well-being (OQ-45.2), sexual attraction experiences (SSAE & OSAE), and sexual attraction identity (SAI). The results demonstrated no statistically significant differences in initial presentation for any of the factors (Table 1). The 24 individuals who completed services prior to the first posttest measure had comparable levels of well-being, SSAE, OSAE, and SAI at the initiation of SAFE-T as the 75 participants who remained in therapy for at least six months.

Table 1

T-test of means of Baseline Scores: 24 month and less than 24 month

Variables	24 Month Mean (Standard Deviation)	Less than 24 Month (Standard Deviation)	df	*t*	*p(2-tailed)*
OQ-45.2	71.27 (n=75) (20.48)	75.63 (n=24) (24.97)	97	-.860	.39
SSAE					
SS Sex	1.63 (n=75) (1.18)	1.93 (n=28) (1.18)	102	-1.140	.25
SS Kissing	1.42 (n=75) (.85)	1.82 (n=28) (1.10)	102	-1.965	.052
SS Thoughts	3.88 (n=75) (1.29)	3.82 (n=28) (1.30)	102	.211	.83
SS Feelings	3.61 (n=75) (1.43)	3.43 (n=28) (1.23)	101	.604	.18
OSAE					
OS Sex	1.38 (n=75) (.879)	1.63 (n=27) (1.00)	101	-1.212	.22
OS Kissing	1.52 (n=75) (1.00)	1.64 (n=28) (1.00)	101	-.560	.57
OS Thoughts	2.38 (n=75) (1.30)	2.29 (n=28) (1.00)	102	.344	.73
OS Feelings	2.74 (n=75) (1.30)	2.54 (n=28) (1.40)	102	.678	.49
SAI	4.2 (n=75) (1.40)	3.86 (n=28) (1.40)	102	1.159	.24

Notes: The n varied for dropouts due to occasional missing data.
Scales for sexual attraction experiences were 1–5; scale for sexual attraction identity was 1–6.
$p < .01$.

[3] Effect sizes for the SAQ data were not calculated. While there are standard methods for calculating effect sizes of paired samples t-tests (we used Cohen's d for the OQ-45.2 t-test), there are no agreed-upon methods for calculating effect sizes for mixed models (Lorah, 2018; Tymms, 2004). Additionally, the design of the study, with repeated measures and no control or comparison group further diminishes the ability to calculate effect sizes for the SAQ data (Tymms, 2004).

A detailed description of the characteristics of the participants who completed the study (n=75) is presented in Table 2. The typical participant was 18–35 years old (52%), Roman Catholic (57%), religious (75% attended church once or more per week), and White (83%). Ninety-two percent of the participants answered "yes" to the question about whether they desired to explore SAF and reported that they were predominately motivated by either religious reasons (30%) or a desire to pursue a traditional marriage (37%).

Table 2

Characteristics of Participants

Category	Total	Percentage (rounded to nearest whole number)
Age		
18–25	27	36
26–35	25	33
36–45	9	12
46–55	9	12
56–65	3	4
66+	2	3
Religion		
Agnostic	5	7
Baptist	3	4
Buddhist	1	1
Episcopal	1	1
Jewish	2	3
LDS	1	1
Muslim	7	9
Non-denominational Christian	7	9
Other Christian	6	8
Roman Catholic	42	57
Religiosity—attends church:		
Daily	8	11
A few times a week	18	24
A few times a month	5	7
1 x per week	25	33
Major holidays	4	5
Rarely or never	15	20
Ethnicity		
African American	2	3
Arabic	5	7
Asian/Pacific Islander	2	3
Hispanic	3	4
White	63	83
Desire for SA fluidity		
Yes	69	92
No	1	1
Not sure	5	7
Motivation for SAFE-T		
Desire for traditional marriage	28	37
Religious reasons	23	30
Social	5	7
Parent's Suggestion	2	3
Other*	17	23

**Note: Most participants citing "other" described it as a combination of two or more of the following: desire for traditional marriage, religious reasons, desire to improve psychological well-being, and a quest for value congruency.*

Well-Being

A *t*-test comparing the means (see Table 3) of the first and last measures of the OQ-45.2 completed by each participant was conducted to detect overall change in well-being. The results indicated a statistically significant difference, with a large effect size in the baseline and final well-being measures (t=6.970, p=.0001; *Cohen's d with Hedges correction*=.80). Additionally, the difference in the means of the pretest and posttest scores of 16.71 points exceeded the OQ-45.2 reliable change index of 14 points (Lambert et al., 1996; Lambert & Ogles, 2004). A change that is equal to or greater than the reliable change index indicates that the change is a true change in the client's clinical condition (Lambert & Ogles, 2004). Additionally, the posttest mean of 54.56 was well below the OQ-45.2 clinical cutoff level of 63 points (Lambert & Ogles, 2004). Therefore, the results indicate both a statistically significant and a clinically significant change in the well-being scores of the participants.

Table 3

Table of Descriptive Statistics

	Mean (Standard Deviation)				
Variable	Baseline N=75	6 mo. N=75	12 mo. N=53	18 mo. N=28	24mo. N=22
SSAE	2.63 (0.86)	2.32 (0.87)	2.19 (0.80)	2.12 (0.75)	2.39 (0.87)
OSAE	2 (0.86)	2.22 (0.9)	2.23 (0.9)	2.29 (1)	2.09 (0.93)
SAI	4.2 (1.38)	3.32 (1.56)	3.19 (1.54)	3.25 (1.53)	3.5 (1.26)
PREOQ N=75	71.27 (20.48)				
POSTOQ N=72					54.56 (23.32)

Notes: Scales for sexual attraction experiences were 1–5; scale for sexual attraction identity was 1–6; scale for OQ-45.2 was 1–100 with a clinical cutoff of 63.

Pearson's-*r* correlational analyses of the well-being measures and length of treatment were conducted to discover any relationship between length of treatment and the pretreatment and posttreatment measures of well-being (OQ-45.2). There were no significant relationships between length of treatment and measures of well-being, pretreatment (r(74)=-.094, p=.425) or posttreatment (r(71)=-.224, p=.059). Additionally, there was no significant relationship between improvement in well-being, measured by the difference in baseline and final OQ-45.2, and length of treatment, (r(71)=.137, p=.250).

Sexual-Attraction Fluidity

A linear mixed model (Proc Mixed in SAS 9.4) was used to analyze the SAQ data measuring SSAE, OSAE, and SAI fluidity. The linear mixed model is ideal for repeated measures data because it accounts for the fact that multiple responses from the same person are more similar than responses from other people. An additional advantage of mixed models, in comparison with the more conventional ANOVA, is that all available data is used (i.e., it allows for missing data). A random factor for subject and a random slope for time were included in the model. The addition of the random slope for time

allows the trajectory of fluidity in SSAE, OSAE, and SAI over time to vary across subjects while the fixed effect for time allows for participant change over time.

Modeling OSAE as the outcome (Table 4), the best fitting model included time as a fixed effect, a random factor for subject, and a random slope for time. The results indicate that OSAE increased statistically significantly during SAFE-T.

Table 4

Final Model of OSAE as Outcome

Effect	*6(SE)*	*df*	*t*	*p*
Intercept	2.0630 (0.0985)	74	20.95	<.0001
Time	.1012 (0.0298)	74	3.4	0.0011

p=<.01

Modeling SSAE as the outcome (Table 5), the best fitting model for SSAE fluidity also included time as a fixed effect, a random factor for subject, and a random slope for time. The result of the analysis shows that SSAE decreased statistically significantly during SAFE-T.

Table 5

Final Model of SSAE as Outcome

Effect	*6(SE)*	*df*	*t*	*p*
Intercept	2.5410	74	27.32	<.0001
Time	-0.1167	74	-3.70	0.0004

p=<.01

The best-fitting model for SAI included SSAE, OSAE, and time as fixed effects, a random factor for subject and a random slope for time (Table 6). Allowing for an unstructured covariance matrix did not improve the model. The results demonstrate statistically significant fluidity of SAI toward heterosexual identity.

Table 6

Summary of Final Model with SAI as Outcome

Effect	*6(SE)*	*df*	*t*	*p*
Intercept	4.0070 (0.3493)	74	11.46	<.0001
OSAE	-0.7232 (0.084)	101	-7.64	<.0001
SSAE	0.57 (0.0947)	101	6.3	<.0001
Time	-0.2127 (0.0523)	74	-3.85	0.0001

p=<.01

Discussion and Recommendations

In terms of the ethical principles of *beneficence* and *non-maleficence* (American Psychological Association, 2017, 2021), the results show that participants in this study experienced significant improvement in their well-being, as measured by the OQ-45.2. The OQ-45.2 measures interpersonal problems and their psychological and social functioning.

In addition, as measured by the *SAQ*, results show that participants experienced a significant *decrease* in the frequency of their same-sex attraction experiences, i.e., thoughts, feelings, and behaviors, including explicitly sexual ones. Participants also reported a significant *increase* in their opposite-sex attraction experiences. Finally, the participants in this study reported significant fluidity or change toward a heterosexual identity.

Overall, the results of this study document that exploring sexual attraction fluidity in therapy can be effective, beneficial, and not harmful. The Reintegrative Therapy™ (RT; Reintegrative Therapy Association, 2017, 2019; Nicolosi, 2017) used by the therapists in this study resulted in participants achieving desired decreases in same-sex attraction experiences (SSAE) and increases in opposite-sex attraction experiences (OSAE). In addition, the participants experienced improvement in their overall intra- and inter-personal well-being. These findings are consistent with almost a century of clinical reports and qualitative and retrospective studies which document that SAFE-T has been successful in helping patients or clients to intentionally diminish SSAE and develop or increase OSAE in a beneficent and non-maleficent manner (Nicolosi et al., 2000; Phelan, 2014; Phelan et al., 2009; Santero, 2012).

A finding that was of particular interest to us was the absence of a relationship between time in treatment and initial measures, final measures, or differences between initial and final measures of well-being. We speculated that the participants ending treatment earlier began with greater well-being, but in fact, there was no relationship between baseline well-being and time in treatment. Further, we wondered if those staying in treatment for twenty-four months had continued treatment because their well-being decreased during treatment, but again, the correlational analysis demonstrated no relationship.

Study Limitations

The most basic limitations of this study are common aspects of contemporary longitudinal clinical outcome research conducted in real world (i.e., outside of lab) settings. This includes the use of a single group, which in this case was warranted by the real-life clinical setting of the study, in which the researchers were observers, as opposed to a lab setting in which participants would be randomly assigned to a separate control, or treatment group. The use of a single group design prevents our knowing if persons who wanted to use SAFE-T to achieve SAF but were not treated would have experienced fluidity anyway. Also, the instrument that measures sexual attraction experiences (the *SAQ*) is self-report. Further, as is typical for longitudinal research performed in a real-life clinical setting, some clients completed treatment before others, resulting in various numbers of posttest measures.

Another possible limitation of the study is the high degree of religiosity of the participants. Eighty-four percent of the participants reported an identification with some variety of Christian denomination, over half (57%) of which were Roman Catholic. The potential influences of this finding on the generalizability of this study's results are unclear. As discussed above, it has been observed that the general population of

clients who participate in SAFE-T "tends to have strongly conservative religious views" (American Psychological Association, 2009, p. v). If clients seeking SAFE-T tend to be "conservatively religious," as were those in the present study, then the results may indeed be generalizable to the larger, general population of clients who undergo SAFE-T, but maybe not to the smaller population of non-religious clients.

Finally, this study focused exclusively on the experience of men seeking SAFE-T. Clinical literature describes that some women for whom same-sex attractions experiences are unwanted participate in SAFE-T and reportedly experience SAF as a result (Hallman, 2008, 2009; Patton, 2009).

Recommendations for Further Research

The real-life clinical setting and the longitudinal and quasi-experimental design of this study in which the environment was not manipulated has strengths that would be diminished with the introduction of control groups, comparison of treatment modalities, and random assignment. However, using control groups and random assignment might provide a clearer picture of the factors that influence SAF and well-being, including treatment modality, time, and external factors. Further, including post-therapy follow-up measures would document what happens to individuals after they leave therapy.

To address the cost of conducting a multi-year study and the problems of missing data inherent in longitudinal studies, future researchers might consider a cross-sectional design. In contrast to the single-group design of this study, a cross-sectional design would allow the researchers to assess several separate cohorts of clients (e.g., pretreatment cohort, 6 months in treatment cohort, 12 months in treatment cohort, etc.) while maintaining the advantages of the real-life clinical setting.

In consideration of the high religiosity of clients seeking SAFE-T, further research is needed to help clarify the factors which influence religiously motivated clients to participate in and to benefit from SAFE-T. In addition to religiosity, research that seeks to identify other cultural and demographic characteristics, including gender, that correlate with desire for SAFE-T would provide a more nuanced, less monolithic characterization by clinical organizations of individuals who seek SAFE-T. Studies including male and female participants and clinicians from various ethnic national, religious, and socioeconomic backgrounds across diverse clinical and geographical settings would facilitate developing a less biased view of these individuals.

Finally, consideration must be given to the recognition that unintended SAF may co-occur when clients are in therapy to help them address trauma and manage and resolve other bio-psycho-social issues. It should be noted that just as gay-affirmative therapists (Repack & Shoptaw, 2014; Shoptaw, Repack, Larkins et al., 2008; Shoptaw, Repack, Peck, et al, 2005) have intentionally worked to help clients diminish same-sex behavior to enhance their medical and mental health, so do the therapists who practice SAFE-T. For over a century now, SAFE-T approaches have been documented as helping clients to experience SAF by helping them to manage and resolve a range of bio-psycho-social issues. These include depression, anxiety, post-traumatic stress, including sexual abuse, substance and behavioral (including sexual) addiction, and codependent relationships. The possible consequence of "unintended" SAF occurring when GLB-identified persons use therapy to

deal with such bio-psycho-social issues also needs to be studied.[4]

Recommendations Concerning American Psychological Association Warnings and Anti-SAFE-T Legislation Advocacy

It is no longer true that there is no scientific evidence concerning whether SAFE-T is helpful or harmful. While this present study is a modest beginning, the studies by Shoptaw, Reback, Larkins et al. (2008), Shoptaw, Reback, Peck et al. (2005), and Repack & Shoptaw (2014) in which "gay specific" (gay affirmative) therapy was conducted to help gay men decrease their risky sexual behavior offer additional examples. In effect, these studies show that SAFE-T can help "gay men" intentionally modify their behavior with no significant negative consequences reported. This past research and the present study document that continued warnings by the American Psychological Association and other mental health associations against clients using SAFE-T are misinformed, unprofessional, and even unethical in terms of meeting the legitimate self-determination needs of clients. Similarly, the past failure of American Psychological Association to instruct those engaged in anti-SAFE-T legislation advocacy that research does not document that SAFE-T is harmful, and that all mainstream psychotherapy has a risk of harm, is no longer acceptable. The organization's future omission to report at least the results of the present study as "emerging" evidence that at least some clients who want to manage and try to resolve unwanted same-sex attraction and behavior have done so, using SAFE-T, likewise will be unacceptable.

The present study shows, through a more rigorous research design, that persons with unwanted same-sex attraction may reasonably expect to benefit from—and not to be harmed by—their participation in SAFE-T. On a professional and humane level, such persons clearly have the right to seek and receive professional assistance to try to do so. Further, on a professional, ethical, and political/legislative level, properly trained mental health professionals have the right to offer such assistance.

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[4] It has been reported that when the Reintegrative Protocol used in this study has been used to treat emotional trauma, spontaneous change in sexual attraction sometimes occurs as a byproduct of trauma resolution. Similarly, when this Protocol has been used to treat binge eating disorder, "unintended" SAF sometimes happens (Joseph Nicolosi, personal communication, August 25, 2020).

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Subjective Experiences in Sexual Orientation Change Efforts: A Mixed-Method Analysis

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Sexual orientation change efforts (SOCE) are practices that individuals go through to modify any non-heterosexual orientation toward a heterosexual orientation. Despite the American Psychiatric Association's renouncing of homosexuality as a mental disorder, there are still a minority of individuals who seek SOCE. Such people may have complex and contemplative attitudes towards their own same-sex attractions (SSA). Little is known about the identities, attitudes, and experiences of those who have engaged in SOCE. A convenience sample of 156 participants who have engaged in SOCE completed a mixed-method online survey assessing attitudes toward their SOCE, SSA-identity congruence, shame about attractions, external motivations for SOCE, and a variety of other quantitative variables for exploratory purposes. Responses to open-ended questions about SSA etiological opinions and both positive and negative experiences/outcomes from SOCE were coded. A multiple regression analysis suggested that believing changing SSA to be immoral, extrinsic motivations (i.e., other than intrinsic motivations to participate), current Kinsey attraction, and SSA-identity congruence predicted negative attitudes toward their SOCE experience. A multivariate analysis of variance revealed significant differences in these variables for those who engaged in certain types of SOCE. Common themes from SSA etiological beliefs were Familial, Cognitive, Social, and others. Negative experiences in SOCE had themes of Emotionally-Related, None, Social-Related, and others. Finally, the themes most commonly reported for positive experiences in change efforts were Personal Growth, Relationship Development, and Therapeutic. Implications for practices and limitations are discussed.

Keywords: sexual orientation change efforts, mixed-method, attitudes, identity, same-sex attraction

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Sexual orientation change efforts (SOCE) are practices that attempt to modify or address possible alternatives to a person's sexual orientation. These attempts can be either self-administered or performed by counselors, therapists, pastors, religious leaders, or other facilitators. Specifically, a same-sex or bisexual orientation is targeted to switch to a heterosexual orientation (McCormick, 2015). These efforts were given a casual label known as "conversion therapy"; however, this term does not encapsulate the entire spectrum of categories including the types that are not associated with licensed psychological or therapeutic care. These can include pastoral counseling, religious activities, life-coaching, weekend retreats, and other non-professional attempts.

In the early 20th century, homosexuality was pathologized as a mental illness. Medical and psychoanalytic clinicians would try to decrease homosexual attractions and develop heterosexual attractions in people using methods ranging from harmful medical and surgical procedures (e.g., lobotomies, hormone therapy, electroshock therapy) to behavioral and psychotherapeutic efforts (Murphy, 1992; Powell & Stein, 2014; Satira, 2016; Walker, 2013; Yoshino, 2004). However, the professional stance shifted rapidly after 1973, when homosexuality was removed from the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM; Drescher, 2015). Subsequently, nearly all scientific and medical associations changed their stance on homosexuality from pathological to normative.

The American Psychological Association (APA, 2009) developed a task force which concluded that there remains insufficient evidence to come to any defining conclusions about SOCE's effectiveness or harm. They also cautioned people to refrain from SOCE on the grounds that homosexuality is a natural part of the human sexuality spectrum. The APA's task force and other articles report (1) little to no successful changes in attractions as a result of SOCE and (2) the widespread use of inconsistent, unreliable, and invalid measures of sexual orientation (Haldeman, 1994; Satira, 2016; Sell, 1997; Walker, 2013).

Despite the relative ambiguities from the APA's task force, some are fervently fighting against SOCE socio-politically. At the time of this writing, any practice that seeks to change sexual orientation is formally illegal for minors in 16 states (Movement Advancement Project [MAP], 2019). More recently, AB 2943 was a bill proposed in California where it was already illegal for SOCE to be imposed on minors. This new bill attempted to illegalize the exchange of SOCE resources for profit, this time, from consenting adults. It would have allowed SOCE participants to sue paid practitioners or therapists for consumer fraud, on the basis that SSA is immutable and cannot change. The bill passed multiple hearings until it was shelved by the senator who introduced it after conversations with religious leaders who felt it to be a threat to freedom of faith and free speech (Mason, 2018). SOCE has also gained negative attention from media arts. Recent films like *Boy Erased* (Edgerton, 2018) and *The Miseducation of Cameron Post* (Akhaven, 2018) and others have raised SOCE, along with the potential associated harms, into public awareness.

Nevertheless, SOCE is prevalent among people looking to change, manage, or explore feelings of SSA, and some research has argued for its potential efficacy (Byrd et al., 2008; Jones & Yarhouse, 2011; Karten & Wade, 2010; Nicolosi et al., 2000; Sullins et al., 2021). There is a growing need to better understand the history of SOCE as well as the experiences of individuals who have participated in it either by their will or against their will.

Summary of Recent Findings

Past research trying to identify conclusions about SOCE has been unclear at best. Recent studies on religious persons found that very few participants reported any sexual identity, orientation, or attraction shifts after engaging in SOCE ranging from personal righteousness (e.g., prayer, fasting, Bible devotions, etc.), ministries (e.g., EXODUS, Evergreen, North Star, etc.), pastoral counseling, individual therapy, family therapy, and much more within large samples (Bradshaw et al., 2014; Dehlin et al., 2015). Spitzer (2003) claimed to show evidence of sexual orientation change within 200 people but later changed his stance on his own findings saying there was no way to prove his participant's claims were valid (2012). Spitzer also made an apology to the lesbian, gay, and bisexual (LGB) community for thinking that non-heterosexual orientations could be changed. Two qualitative studies within the last decade found that the change process for most of their SOCE experiencers were negative in the long-term, but some short-term helpful aspects were reported like therapeutic support and less loneliness (Flentje et al., 2014; Weiss et al., 2010).

Gamboni et al. (2018) encouraged all mental health organizations to establish an ethical code against the practice entirely. However, their conclusions may have been based in part on false premises, as they misread Nicolosi et al.'s study (2000). Gamboni et al. (2018) claimed that 89.7% of their participants felt more lesbian, gay, or bisexual *after* SOCE treatment. In actuality, the article states that 89.7% of the participants felt this way *before* therapy while 35.1% of those participants *remained* in these orientations (Nicolosi et al., 2000, p. 1071), suggesting that the rest did experience some change. Gamboni and colleagues (2018) also made the claim that Nicolosi et al.'s (2000) participants were dissatisfied with their services, but the qualitative evidence from this article and Byrd and colleagues' study (2008) suggests otherwise.

A small number of studies demonstrated positive outcomes from SOCE. Karten and Wade (2010), using a sample of men from private psychotherapy, the National Association for the Research and Therapy of Homosexuality (NARTH), and ex-gay ministries, found that some participants' sexual identity and attraction changed during treatment. They also experienced perceived benefits of SOCE like decreased uncomfortable feelings regarding physical intimacy with men, improved psychological functioning, and other dynamics. Similarly, two separate qualitative studies of patients in SOCE psychotherapy found common themes such as diminishing SSA and similar familial relationships (Byrd et al., 2008; Nicolosi et al., 2000). In therapy, most patients discussed how they had a distant, hostile relationship with same-sex parents and emotionally manipulative, boundaryless relationships with opposite-sex parents. Recently, 68% of 125 men (mostly White and religious) involved with SOCE reported change in their SSA along with increased self-esteem, social functioning, along with lessening in suicidality, depression, and substance use (Sullins et al., 2021). Jones & Yarhouse (2011) found changes in sexual orientation and did not find any increases in psychological distress as a result of their longitudinal study on SOCE ministry participants. It is important to note that social desirability, self-presentation bias toward heteronormative desires, demand characteristics, and limited sample demographics may have impacted these results, warranting careful interpretation. Despite these possibilities, these studies offer some insight into why some types of SOCE may be beneficial to some individuals experiencing complicated feelings about SSA.

Differentiating Between Types of SOCE

SOCE might classify as an umbrella term holding a broad range of methods. Therefore, it could be desirable to understand the details within different types of SOCE. Differentiating between types of SOCE may be useful in understanding which practices are more commonly associated with experiences of perceived or actual harm and which are associated with experiences of perceived or actual benefit.

There is little research addressing SOCE type. Dehlin et al. (2015) included type of SOCE as a variable and found the most harmful and most commonly undertaken type of SOCE was personal righteousness (i.e., religious activities), while group retreats were labeled as the most effective and support groups were rated the least harmful. This suggests that not *all* methods to change, explore, or manage SSA are detrimental. To a specific population, there may be some beneficial elements that are misunderstood. Additionally, although Dehlin et al. (2015) offered useful insight into experiences of SOCE, their sample was almost all Latter-Day Saints (or Mormon) individuals. The authors expressed openness and excitement for more research with individuals from different religions. The current study further addresses possible variable differences across the array of SOCE types.

Internalized Homonegativity and SOCE

Internalized homonegativity (IH), also called internalized homophobia, is the combined negative feelings and attitudes toward non-heterosexuality that are felt by non-heterosexuals themselves (Shidlo, 1994 and Sophie, 1987 as cited in Szymanski & Chung, 2001). It was hypothesized that these feelings may derive from a societal heterosexism that contributes to minority stress and shame regarding unwanted SSA in religiously or culturally conservative people (Walker, 2013). IH may serve as a motivational factor for why some individuals would choose to seek SOCE. Some prior research attempted to assess IH demographically or as an independent or dependent variable paired with other psychological constructs and correlates (e.g., Costa et al., 2013; Davidson et al., 2017; Huang et al., 2020; Morandini et al., 2015). It is crucial to note that most of these authors found significant connections between IH and psychological symptoms like depression using an array of statistical analyses from correlation to structural equation modeling. IH was also studied psychometrically (Flebus & Montano, 2012; Ross & Rosser, 1996; Smolenski et al., 2010; for a review, see Szymanski et al., 2008).

Still, there is a surprising dearth in literature addressing IH in the context of SOCE. A literature search across five databases (i.e., Academic Search Premiere, PsycInfo, PsycArticles, PsycExtra, and Atla Religion) with the terms "internalized homophobia," "internalized homonegativity," "sexual orientation change efforts," "conversion therapy," and "reorientation therapy" yielded zero relevant articles. This highlights the need for more research to understand the widely unknown relationship between IH and SOCE. It is reasonable to assume that accepting heteronormative and homonegative ideals from conservative social, cultural, or religious upbringings may influence feelings of discontent and shame regarding one's own SSA. In this paper, IH will be referred to as SSA shame to pinpoint objective negative feelings about oneself due to attractions. Internalized homonegativity has a theoretical connotation which suggests that these feelings only come from outside factors, hence the need to be *internalized* from the outside.

The Need for Qualitative or Mixed-Method Research on SOCE

In reviewing the ethical considerations for research with non-heterosexual populations, qualitative or mixed-method research has demonstrated to be the most favorable. In this research style, participants are given free permission to express themselves and tell their stories. Some quantitative approaches could possibly carry with it the negative connotation of "homosexuality research," implying offensive, pathological attributions to their identity (Bettinger, 2010). There remains little mixed-method research with a geographically, ethnically, religiously, culturally, and ideologically diverse, non-heterosexual sample on the specific subject of SOCE. This research method will help the public understand perceived feelings of both harm and benefit associated with SOCE in a holistic, personal fashion.

SOCE and Etiological Beliefs About SSA

Investigating the beliefs of those who have complicated feelings about SSA can be informative regarding the virtually unknown cognitive or contextual reasons why some still seek, continue to engage in, and report benefits from SOCE (Byrd et al., 2008; Jones & Yarhouse, 2011; Karten & Wade, 2010; Nicolosi et al., 2000; Sullins et al., 2021). Documented psychotherapeutic practice literature with men and women struggling with SSA have revealed some common themes within their parental and peer relationships and negative beliefs or shame about their gender (Hallman, 2008; Nicolosi, 2016). Providing open-ended questions that document etiological beliefs about their SSA may help to further explain why some would and would not benefit from SOCE. Theoretically, if one adheres to the triadic-narcissistic narrative regarding SSA etiology (Nicolosi, 2016) due to a perceived concordance within their own familial experience, SOCE would be a viable option. In contrast, if one adheres to a natural or innate narrative for SSA etiology, SOCE might be viewed as a cruel or futile option.

Broadening the "Effectiveness" Definition for SOCE

Additionally, the stories that come from qualitative or mixed-method research may provide insight on which SOCE programs or industries are harmful and which of them are subjectively beneficial. In doing so, this study aims to use short-answer questions to collect insights on positive and negative SOCE experiences.

Instead of operationally defining SOCE effectiveness as the degree to which participants' experience change in their sexual orientation, qualitative or mixed-method research may give researchers in this field the ability to expand, and not oversimplify, this notion of effectiveness. Reducing the complex nature of effectiveness to "change" is not sufficient to capture the essence of SOCE seekers' experiences, whether the experience was overall positive or not. Reported SOCE beneficiaries may have participated in subjectively beneficial types of SOCE. In these types of SOCE, they may have explored deeper dynamics of the client's psyche, identity, and values within a nonjudgmental environment with a client-directed tactic (Yarhouse, 2019) not so heavily oriented toward attraction change. In fact, Dehlin et al. (2015) revealed that if participants expressed that orientation change was the goal of the process, it was more likely that the participant would also rate it as harmful. Conversely, if participants did not report change as a goal, they were more likely to rate it as effective.

Even the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI; 2018), a leading proponent of SOCE, stated in their

sixth therapeutic guideline that the strict therapeutic focus on sexual orientation change is an unfavorable and unrecommended goal for mental health professionals to promote. Thus, in their fifth and sixth guidelines for therapists, they mentioned that the informed consent process should make clients aware that there is no guarantee of attraction change (ATCSI, 2018). This therapeutic oversimplification to merely focus on changing attractions could cause harm via immense feelings of frustration, failure, or despair when clients do not feel change. The ramifications of such tempting and often broken promises made by mental health professionals could be costly to the patient, possibly resulting in shame, drastically low self-esteem, and depression (Cates, 2007; Dehlin et al., 2015).

Exploratory, mixed-method work has the ability to expand SOCE research's knowledge on the meaning of effectiveness. Ideally, SOCE effectiveness can be measured either as (1) a reductionist approach in how often the intervention has changed sexual orientation or (2) a holistic approach in the overall positive qualities that have enhanced participant well-being, intrapersonal and interpersonal connectedness, sense of community or belonging, identity, or other outcomes. The latter definition of effectiveness is what this study targets.

Culture, Congruence, and Identity: Theories Expanding the SOCE Topic

Spirituality, religiosity, or lack thereof, learned through a given culture in which one is raised all have been shown to be influential in the neurobiological development of identity. This process was coined as culture ontogeny (Milstein & Manierre, 2012). The theory of culture ontogeny suggests that values engendered by the culture that one develops in may dramatically shape the way humans think about their identities and see the world around them.

With mixed and ambiguous reports regarding the harmfulness, effectiveness, and benefits of SOCE, it is important for researchers and clinicians to know the unique, undergirding cultural and religious values of those who would, and would not, benefit from SOCE. Perhaps those who are religiously inclined or those who assign conservative values to their own cognitive sense of identity would benefit from SOCE. Simultaneously, perhaps those who do not place a high salience on religion or assign more progressive values to their cognitive sense of identity may not benefit from any type of SOCE. To these individuals, changing sexual orientation would be considered a violation to their personhood, or as previously mentioned, their culture ontogeny.

The theory of organismic verses telic congruence may help in understanding reasons why certain people would report harm or benefit from SOCE. Both types of congruences concern different emphases for different values. Someone with an inclination toward an organismic congruence may find wholeness by integrating one's sense of self with what they experience (APA, 2009; Jones et al., 2011). Organismic congruence may explain negative experiences in SOCE, especially if the person was attending any type of SOCE against their own will (e.g., a teenager forced by parents to attend SOCE). In contrast, an inclination toward a telic congruence describes people that place a higher value on a purpose or calling from a higher power to form their sense of self (APA, 2009; Jones et al., 2011). Such people with a telic understanding of self may have contracted strong feelings of well-being or wholeness from SOCE.

The late psychologist Joseph Nicolosi referred to his male clinical population as "non-gay homosexuals" to describe them as men who experience SSA but have complex

feelings about their attractions. Most of his clients had common, deep feelings such as being uncomfortable or disillusioned with attractions, not feeling whole, or just feeling uneasy about accepting sexual identification labels for themselves (1991, 2016). Yarhouse (2005) outlined a three-tier distinction for assessing the client's current thought process surrounding their (a) SSA, (b) homosexual or bisexual orientation, and (c) their own personal sense of sexual identity. Some clients may dis-identify with being gay or bisexual (sexual identity) while maintaining that they have been attracted to the same sex for quite some time (same-sex or bisexual attractions) but feel that their SSA may not be central to who they are, contrasting with an LGB identity (Rosik et al., 2021). Still, there are those who may subscribe to an LGB identity but remain celibate and think of it as a mere label, similar to ethnic labels like Caucasian, Black, or others. Contrarily, there are many individuals who integrate their non-heterosexual orientation into an LGB identity, are affiliated with the corresponding community, and have same-sex romantic partners. Given that experiences of sexual attraction can be dissimilar to sexual identity, clinicians, researchers, and clergy must be careful to not use any language that assumes anything about the client's, participant's, or counselee's identity just because they experience SSA (Cates, 2007; Yarhouse, 2005, 2019). Schumm's (2020) "anti-identity" theory emphasizes the possibility that assuming a fixed central identity could hinder avenues of continued identity development.

SSA-Identity Congruence

In light of the theories of differing congruence emphases and culture ontogeny, one factor that could explain disparities in SOCE experiences and other variables could be the individual's sense of SSA-identity congruence. Mohr and Kendra's (2011) concept of identity centrality, or the perceived sense of centeredness or importance of the LGB identity, was helpful for this current study. The term "SSA-identity congruence" will be used in centrality's place due to "congruence's" conceptual denotation of two ideas coming together (i.e., feelings of SSA and identity) depending on the individual's perception. Identity centrality may hold with it a connotation that presupposes an LGB identity. Those with higher SSA-identity congruence may describe themselves as being part of the broader LGBTQ+ community and feel that their SSA is a trait that significantly contributes to who they are. These individuals may feel that SSA is a normal variant of human sexuality and that the notion of willfully trying to change it is offensive or harmful. Those with lower SSA-identity congruence may describe themselves as being attracted to the same sex to various degrees but have a different source for their sense of self. These individuals may or may not identify as LGB but the lower SSA-identity congruence may account for the belief that their SSA may be a result of sociological, familial, or other environmental sources.

Purposes and Hypotheses of Study

Although homosexuality does not fit the criteria of a mental disorder, to some individuals with SSA, it can be distressing to their identity, especially for those with conservative values, the religiously orthodox, those who believe in external SSA etiologies (i.e., familial) (Byrd et al., 2008; Karten & Wade, 2010; Sullins et al., 2021). The ultimate goal for this study was to gain a richer understanding of SOCE by determining if the SOCE topic can be expanded through other variables and more qualitative accounts.

Heteronormative social-desirability, effort justification, and change expectancy are common biases that act as limitations in SOCE research (APA, 2009). To test this with the current sample, my second hypothesis was that increases in shame regarding SSA feelings would be related to decreases in SSA feelings as well as SSA-identity congruence. In theory, the more shame one has about being attracted to the same sex, the more they might report changes toward heterosexuality and they may identify less with their SSA.

Another purpose of this study was to explore for any significant differences between attitudes, SSA-identity congruence, shame, external motivations, moral beliefs, attractions, and religious importance between SOCE type. Certain types of SOCE were found to be helpful like group retreats (Dehlin et al., 2015; Karten & Wade, 2010), but some were associated with harm or more shame like religious practices, personal righteousness, and counseling from a religious leader (Blosnich et al., 2020; Dehlin et al., 2015).

The final purpose of this study was to obtain an information-rich understanding on SSA etiological beliefs and experiences within SOCE. Differing etiological beliefs of SSA may provide insight as to why some individuals would willingly engage in SOCE. Information about experiences can aid in forming a holistic and inclusive picture of SOCE. Qualitative data in this regard can aid future researchers in theory and model building about why some willingly or unwillingly engage in SOCE and why some report positive or negative outcomes. This study attempts to uncover possibly unknown complexities within SOCE and the people that seek them that have not been studied.

Method

Participants

A total of 168 participants initiated the survey. Twelve participants' data were removed due to them failing to answer at least 60% of the questions, yielding a final total of 156 participants. Most of the sample identified as cisgender male (82.1%) followed by cisgender female (8.3%), Other (1.3%), and Prefer not to say (0.6%). Twelve participants (7.7%) did not report a gender. Current sexual identities ranged from heterosexual (or straight; 26.9%), followed by "These terms do not fit in my identity" (26.3%), homosexual (gay/lesbian; 23.7%), sexually fluid (my sexual attraction changes from time to time; 7.7%), bisexual (equally attracted to both sexes; 7.1%), questioning/unsure (4.5%), not listed (3.2%), and decline to answer (0.6%). Ages ranged from 18–76 years with a mean of 44.77 (*SD* = 14.77). Most participants were White (71.2%) followed by Hispanic/Latino (8.3%), Black/African American (4.5%), Other (1.8%), Asian (1.3%), Biracial (1.3%), and Multiracial (1.3%). Twelve participants did not report an ethnicity.

Religious affiliations included Protestant/Evangelical (60.3%), Other (12.8%), Catholic (9.6%), Latter-day Saints/Mormon (5.8%), Islam (1.3%), Jewish (0.6%), Agnostic (0.6%), Atheist (0.6%), and No Preference (0.6%). Twelve individuals (7.7%) did not select a religion. Most of the participants lived in the United States (83.3%) followed by the European Union (6.3%), Canada (3.8%), Australia (2.6%), Mexico (1.9%), and the United Kingdom (0.6%). Two individuals (1.3%) did not select a country.

Measures

Multiple-item measures. ***Attitudes towards Change Efforts.*** Participants rated their

attitudes towards their SOCE twice in the course of the survey, but due to unitary factor loadings, these items were combined into one scale. First, three semantic differential items beginning with "Trying to change my sexual orientation was . . ." were provided that assessed the following three attitudes on a 6-point scale: Unproductive (0) to Productive (5), Worthless (0) to Worthwhile (5), and Meaningless (0) to Meaningful (5). For the second set of attitude items, participants rated their attitudes on a 5-point Likert basis with seven items answering the question, "In my experience, trying to change my same-sex attraction was . . . ." Items were "something I regret," "a fulfilling process," and others. The scale points were labeled Strongly disagree (1) to Strongly agree (5). An exploratory factor analysis with principal axis factoring and promax rotation found that both scales loaded on one factor. Cronbach's alpha for both scales together was .95 suggesting very good reliability. Both attitude scaling systems were then standardized and averaged to account for differences in scaling (i.e., 6-point and 5-point). To view all multiple-item measures, please see Appendix C.

SSA-identity congruence. Each participant completed a scale that attempted to measure their own subjective sense of congruence between feelings of SSA and their identity. This scale was inspired by the 5-item Identity Centrality subscale from the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011). Four of them were used in this scale and the language was changed from "gay/lesbian identity" to "SSA" language for the purposes of including those who may not identify as LGB. The author added six other original items, creating a 10-item scale measuring the degree to which certain statements describe them on a 5-point system from 1 (Does not describe me) to 5 (Describes me extremely well). Item examples include "When I think about myself, my same-sex attraction immediately comes to mind" (original item) and "My same-sex attraction is a central part of my identity" (item inspired from Mohr & Kendra, 2011). An exploratory factor analysis (EFA) with principal axis factoring and a varimax rotation yielded two factors. Three items were removed due to cross-loadings and a theoretical incongruence. Two additional items were removed to increase the Cronbach's α to .85. A final EFA revealed another two-factor solution with 4 items representing "Congruence" and one reverse-coded item representing "Non-Congruence." The final scale comprised of five items which were averaged together for analyses.

SSA shame. Using inspiration from the 9-item Internalized Homophobia Scale (IHI; Herek, Cogan, Gillis, & Glunt, 1997) and the 8-item Sexual Identity Distress scale (SID; Wright & Perry, 2006), an 8-item scale was developed to measure shame or feelings of unworthiness related to their SSA. Two items were adapted from Herek and colleagues (1997) while only one was adapted from Wright and Perry (2006). The remaining five items were original. Items in the original scales were considered conceptually vague in the sense that they may not be attributed to homophobia or distress. For example, statements like "I wish that I could develop more erotic feelings [toward the opposite sex]" could theoretically be indicative of either internalized homophobia or personal, religious, or moral convictions without entailing notions of self-hatred or phobia toward non-heterosexuality (Rosik et al., 2021). Two items were taken from the IHS and the language was changed from "gay/lesbian identity" language to "SSA feelings" language to include those who may not subscribe to an LGB identity. Scores on this variable were averaged.

External motivations toward change efforts. The reasons for pursuing SOCE were assessed using seven items developed for this study that addressed the degree to which

certain persons may have pressured or encouraged the SOCE (e.g., "My family pressured me to change."). These items were measured on a 7-point Likert scale from 1 (Strongly disagree) to 7 (Strongly agree). One item was reverse coded, which read, "I was self-motivated to change." Scores on these seven items were averaged into a single scale score. This scale had a Cronbach's alpha of .81, suggesting above sufficient reliability.

Single Item Measures. ***Pre- and post-SOCE attractions.*** Sexual attractions prior to and after SOCE methods were assessed using a scale inspired by the 7-point Kinsey Scale (Kinsey, Pomeroy, & Martin, 1998). For the purposes of this study, the language was changed from the more direct "heterosexual to homosexual" to specifically target the direction of sexual *attractions* to the same, opposite, and both sexes. The scale was arranged from 1 (*Exclusively attracted to the opposite sex*) to 7 (*Exclusively attracted to the same sex*). Kinsey Attraction Change was computed by subtracting pre-SOCE Kinsey attraction from current Kinsey attraction.

Religious importance (RI). One item measured the participants' level of religion or spirituality importance on a 5-point basis from 1 (*Not at all important*) to 5 (*Extremely important*).

Moral beliefs. In two separate items, participants were asked to rate the degree to which they believed (a) same-sex behavior was immoral and (b) changing sexual orientations was immoral on a 7-point Likert scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*) with more agreeing equating stronger moral beliefs against it.

Categorical measures. ***SOCE methods and duration.*** Participants were presented with various SOCE methods and asked to check off one or more SOCE methods that they had participated in. One additional "Other" choice had a textbox for alternative methods. Respondents also indicated the degree of time they spent trying to change, manage, or explore their SSA on an ordinal scale from *Less than one year* to *More than 20 years.*

Pre- and post-SOCE sexual identities. Participants were asked to report their sexual identity self-labels for both prior to engaging in SOCE and at present. Choices were heterosexual (or straight), homosexual (or gay/lesbian), bisexual (*I am equally attracted to both sexes*), sexually fluid (*my sexual attraction changes from time to time*), questioning/unsure, these terms do not (or would not) fit in my identity, not listed, and decline to answer.

Qualitative questions. Three short-answer, open-ended questions were analyzed to gather qualitative data on each participant's (1) SSA etiology beliefs, (2) positive experiences with SOCE, and (3) negative experiences with SOCE. Each question had an accompanying text box where participants wrote as much as they wanted about their SSA-related etiology beliefs and SOCE experiences.

Procedure

Upon approval from Azusa Pacific University's Institutional Review Board, links to the online survey developed on Qualtrics were disseminated through convenience and snowball methods to the following: (1) eight private, relevant Facebook groups containing mostly men and some women who have complex feelings about their SSA (comprising 74.3% of the sample); (2) a general Twitter post with relevant hashtags (e.g., #SexualOrientationChangeEfforts, #ConversionTherapy, #survey, #giftcard, etc.; 10.3%), (3) an e-mail list from a large former SSA-related support group (8.3%); (4) a general Facebook post advertised with hashtags (5.1%); (5) a general Instagram post advertised with hashtags (1.3%). Although

74.3% of the sample arrived at the survey from one of the eight Facebook groups, it should be noted that these groups are somewhat different demographically and culturally (e.g., age, ideology, theology, occupation, etc.). In an attempt to attain diverse perspectives, groups that are either (a) known to raise awareness about the potentially negative effects of SOCE, (b) contain SOCE survivors and activists, or (c) general LGBTQ+ Christians were contacted to disseminate the survey, but only one group responded and declined. Only one participant (0.6%) reached the survey from one of these groups somehow even though this group did not respond. Readers should be aware that the author personally knows some of the participants.

Participants who clicked on the link were given an opportunity for informed consent with information about the personal nature of the survey along with resources for mental health care should the survey trigger any psychological discomfort. They were made aware that participation was strictly voluntary and that they could skip ahead to enter the gift card raffle to prevent possible feelings of coercion. Next, they proceeded to the screening questionnaire. To be included in the survey, participants had to (1) have felt SSA at least some time in their lives, (2) experience some sort of SOCE currently or in the past, (3) be 18 years of age or older, and (4) live within the United States, Canada, Mexico, United Kingdom, European Union, Australia, or New Zealand. The fourth inclusion criteria was enforced to ensure participant safety because certain countries criminalize non-heterosexual identities and sexual behavior. After the screening, participants responded to the quantitative measures and items, with qualitative open-response prompts provided at the end of the survey. Participants were then taken to a separate page where they were given the option to enter their e-mail for the chance to win one of two gift cards of their choice between Target, Amazon, or Visa.

Data Analyses

Psychometrics. Exploratory factor analyses with principal axis factoring and a promax rotation were conducted on the multiple-item measures to ensure appropriate factor structure. Cronbach's alpha reliability were computed for identity congruence, shame, external motivations, and attitudes toward change efforts scales.

Correlation analyses. Bivariate correlation analyses were conducted to identify relationships between variables. The relationships between identity congruence, shame, and attitudes were of particular interest to understand possible connections between subjective feelings of identity, shame, and SOCE attitudes.

Attitudes regression. A multiple regression analysis was conducted to determine if SSA-identity congruence, shame, external motivations toward change efforts, Kinsey attraction change, religious importance, moral beliefs about same-sex sexual behavior (SSSB), and moral beliefs about changing SSA predicted attitudes toward change efforts.

SOCE type MANOVA. A multivariate analysis of variance (MANOVA) was conducted to understand possible differences in identity congruence, shame, external motivations, Kinsey attraction change, religious importance, moral beliefs about SSSB, and moral beliefs about changing SSA across the categorical variable of SOCE type (e.g., licensed therapist, weekend retreats, personal righteousness, etc.). Types that were selected by less than 15% of the sample were excluded due to issues in data analysis comparing small groups with larger groups.

Qualitative content analyses. Responses to the three open-ended questions were individually read and coded using a

content analysis technique analyzing words and taking tone and context into consideration. Words were analyzed and codes were produced, informed from previous research and/or documented clinical experience with this population (Hallman, 2008; Nicolosi, 1991, 2016). A faculty adviser guided this process with weekly meetings of exploration and discussion, as well as process journaling.

Results

Descriptive Statistics

Table 1 displays all means and standard deviations for the variables in question. Descriptive results highlighted certain notable traits of the sample. Attitudes were negatively skewed showing higher frequencies of more positive attitudes toward their SOCE experience. There was a high frequency of higher scores in moral beliefs against SSSB while there was a high frequency of lower scores in moral beliefs against changing SSA. There was a high frequency of zero Kinsey attraction change while some participants experienced change toward opposite-sex attraction and still others who experienced a shift to more SSA. The identity congruence histogram showed positive skewness revealing a high frequency of lower scores on congruence between SSA and identity.

Table 1

Means & Standard Deviations of Variables

	Mean	SD
SOCE Attitudes (6-point)[a]	4.43	1.57
SOCE Attitudes (5-point)[a]	4.02	1.05
SSA-Identity Congruence	2.15	1.00
SSA Shame	2.95	1.16
External Motivation towards Change Efforts	2.98	1.31
Moral Belie–s - Same-Sex Sexual Activity	6.08	1.76
Moral Belie–s - Changing Same-Sex Attraction	2.23	1.94
Prior to SOCE Kinsey Attraction	5.24	1.97
Current Kinsey Attraction	4.97	1.87
Kinsey Attraction Change	.24	2.24
Religious Importance	4.56	.88

Note: a = These scales were standardized then averaged together for analyses to account for differences in scaling.

Associations with Attitudes Toward SOCE

A bivariate correlation matrix between all continuous variables is presented in Table 2. There were many significant associations between attitudes toward SOCE, SSA-identity congruence, external motivations, and more. Additionally, a multiple regression analysis was conducted to understand the possible predictive influence the other variables (i.e., shame, external motivations, SSA-identity congruence, moral beliefs, attractions, and religious importance) had on attitudes toward SOCE. The overall model was significant with 65.9% of the variance in attitudes towards SOCE accounted for by the other variables; $F(8,131) = 31.60$, $p < .001$. There were four significant, negative predictors, or predictors of more negative attitudes toward SOCE. The strongest was believing that attempts to change SSA were immoral (β = -.46, B = -1.97, $p < .001$) followed by external motivations toward change efforts (β = -.22, B = -1.43, p = .001), current Kinsey attraction (β = -.16, B = -.70, p = .017), and SSA-identity congruence (β = -.15, B = -1.29, p = .017). Increases in these four variables predicted decreases in overall attitudes toward the participants' experiences in SOCE.

Table 2

Correlation Matrix of all Variables

	1	2	3	4	5	6	7	8	9	10
1. Attitudes towards Change Efforts	-									
2. SSA-Identity Congruence	-.55**	-								
3. SSA Shame	-.10	.16*	-							
4. External Motivation towards Change Efforts	-.63**	.54**	.12	-						
5. Moral Belie–s - Same-Sex Sexual Activity	.31**	-.20*	.17*	-.30**	-					
6. Moral Belie–s - Changing SSA	-.70**	.35**	.00	.48**	-.20*	-				
7. Prior to SOCE Kinsey Attraction	-.09	.09	.12	.02	.06	-.03	-			
8. Current Kinsey Attraction	-.49**	.41**	.35**	.35**	-.07	.37**	.32**	-		
9. Kinsey Attraction Change	.33**	-.26**	-.20*	-.27**	.12	-.33**	.61**	-.55**	-	
10. Religious Importance	.23**	-.10	.04	-.18*	.50**	-.06	.07	-.00	.06	-

Note: "" = Significant at the .05 level, "**" = Significant at the .01 level.*

Variable Differences Across SOCE Types

A multivariate analysis of variance (MANOVA) was conducted to understand any possible differences in all of the variables across the SOCE types. The groups were dummy coded as selected (1) and did not select (0). First, the descriptive percentages in both groups 1 and 0 for each SOCE type were analyzed. Types that had less than 15% of the sample in either 1 or 0 were not used for analysis due to concerns about outliers or overrepresenting types that were rarely selected. Due to this "15% or more" criteria, five SOCE types were not included as

grouping variables for the MANOVA (i.e., family therapy with licensed practitioner, family therapy with non-licensed practitioner, intensive impatient programs, aversion therapy, and other). The remaining eight types were included in the MANOVA (i.e., individual therapy with licensed counselor, individual therapy with non-licensed counselor, religious ministries, religious or spiritual activities, support groups, 12-step groups, weekend retreats, and other self-guided practices).

There were ten significant effects. First, those who selected therapy with a non-licensed counselor held significantly stronger moral beliefs against SSSB (M = 6.31, SE = .33) than those who did not select therapy with non-licensed counselor (M = 5.58, SE = .28); $F(1, 131) = 4.57$, $p = .034$. Next, those who selected change-related ministries (e.g., EXODUS, Love in Action, JONAH, etc.) reported significantly less shame (M = 2.45, SE = .20) than those who did not select change ministries (M = 2.97, SE = .19), $F(1, 131) = 6.09$, $p = .015$.

The next two findings were involved with religious or spiritual activities (e.g., praying, reading religious texts, meditation, etc.). First, the data suggested that those who reported use of religious or spiritual activities had stronger moral beliefs against SSSB (M = 6.49, SE = .23) compared to those who did not select religious or spiritual activities (M = 5.41, SE = .41), $F(1, 131) = 6.62$, $p = .011$. Those who selected this type also significantly viewed their religion as more important (M = 4.74, SE = .11) when compared to those who did not select this type ($M = 3.87$, $SE = .20$), $F(1, 131) = 17.79$, $p < .001$. The fifth finding entailed that those who selected support groups significantly identified with their SSA ($M = 2.10$, $SE = .15$) more than those who did not select support groups ($M = 1.69$, $SE = .20$), $F(1, 131) = 4.03$, $p = .047$.

Weekend retreats had the five remaining significant effects. Specifically, those who selected weekend retreats (1) had significantly more positive attitudes towards change efforts ($M = 4.25$, $SE = 1.56$ vs. $M = -1.49$, $SE = 1.32$), $F(1, 131) = 11.66$, $p = .001$, (2) reported significantly less shame (M = 2.33, SE = .22 vs. M = 3.09, SE = .18), $F(1, 131) = 10.67$, $p = .001$, (3) identified significantly less with their SSA (M = 1.69, SE = .19 vs. M = 2.11, SE = .17), $F(1, 131) = 4.00$, p .047 (4) had significantly less strong moral beliefs against changing same-sex attraction (M = 1.66, SE = .38 vs. M = 2.61, SE = .32), $F(1, 131) = 5.49$, $p = .021$ and (5) had less current SSA (M = 4.11, SE = .36 vs. M = 4.98, SE = .31), $F(1, 131) = 4.90$, $p = .029$ than those who did not select weekend retreats. There were no other significant effects in the MANOVA.

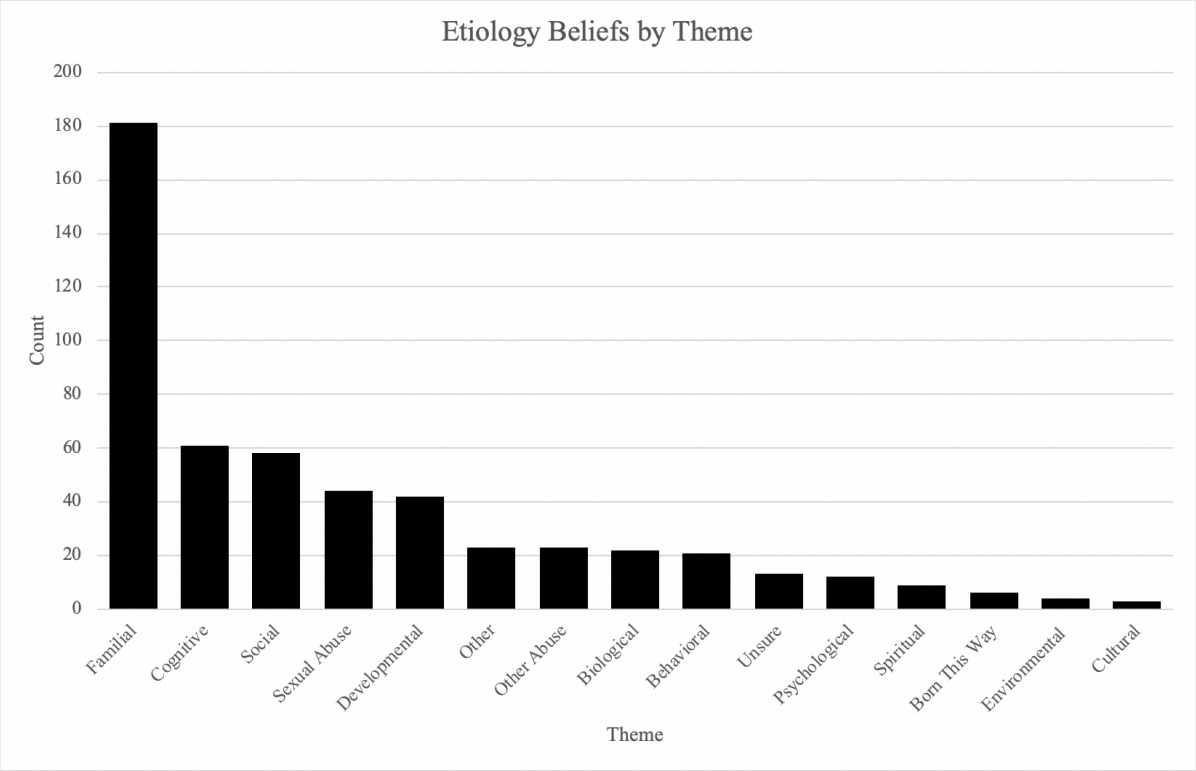
Qualitative Themes

SSA etiological beliefs. The first open-ended question asked the participants, "What do you believe were the factors that led to your same-sex attraction?" to understand their thinking about the origins of their SSA. The most popular themes were Familial, followed by Cognitive, Social, and Sexual Abuse. Same-sex parent issues and opposite-sex parent issues were the two most common Familial codes. Participants frequently attributed their same sex attraction to problems in their relationship with their same-sex parents (most of them fathers), who they often described as distant, abusive, or just a general estranged relationship or lack of relationship entirely. Relationships with opposite-sex parents (usually mothers) were described as emotionally overinvolved, needy, or enmeshed. These relationships were usually coupled together within the same response. Additional familial issues were unmet needs, same-sex sibling issues (usually brothers), and lack of male

affirmation, influence, or involvement within and outside of the home. Cognitive issues were spread out amongst various different types of codes like sexualization of unmet needs, body image issues, preceding childhood shame, fear of the opposite sex, among others. The most common Social code was same-sex peer issues (usually boys) in the form of bullying, estrangement, same-sex peer associated anxiety, or feeling like the opposite of other boys, followed by general lack of same-sex connection within the general social community. Forty-four instances of sexual abuse were reported with 44% of them perpetrated by adult males while 42.5% did not specify the sex of the perpetrator. Figure 1 shows the count of all the themes that emerged from their response to this question.

Figure 1

Count of Instances in SSA Etiological Beliefs Sorted by Theme

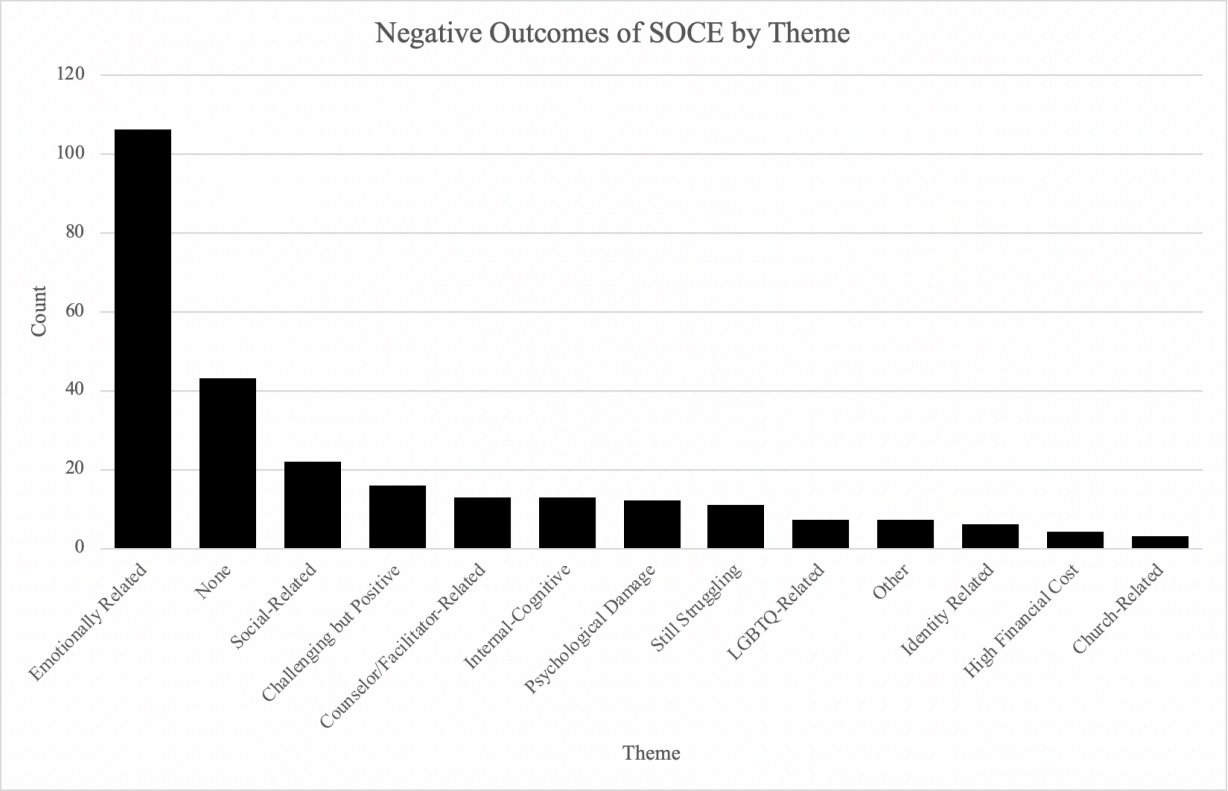


Negative experiences within SOCE. One other open-ended question asked the participants, "Please describe any negative experiences or outcomes in your efforts to change same-sex attraction. If you feel there was nothing negative**,** please feel free to write, 'None.'" The purpose of this question was to gain some qualitative understanding as to how they might have been negatively impacted by their SOCE experience. There were 263 instances of 84 different codes that belonged within one of 13 major themes. The most common was Emotional problems related to SOCE. This was a broad umbrella term that entailed feelings of sadness, disappointment from not changing or ineffectiveness of interventions, feelings of being overwhelmed with the process itself, discouragement, self-hatred, hopelessness, shame, among others. The second most

common theme was None where participants felt like there was nothing negative to say about their SOCE experience. Social Related was the third most common theme entailing tensions with those who disagreed with their disidentifying with the LGB community, rejection felt from people on all sides, feelings of rejection, and unhelpful opposite-sex attracted friends and/or acquaintances. Figure 2 displays the frequency of codes for each theme within Negative Experiences.

Figure 2

Count of Instances in Negative SOCE Outcomes Sorted by Theme

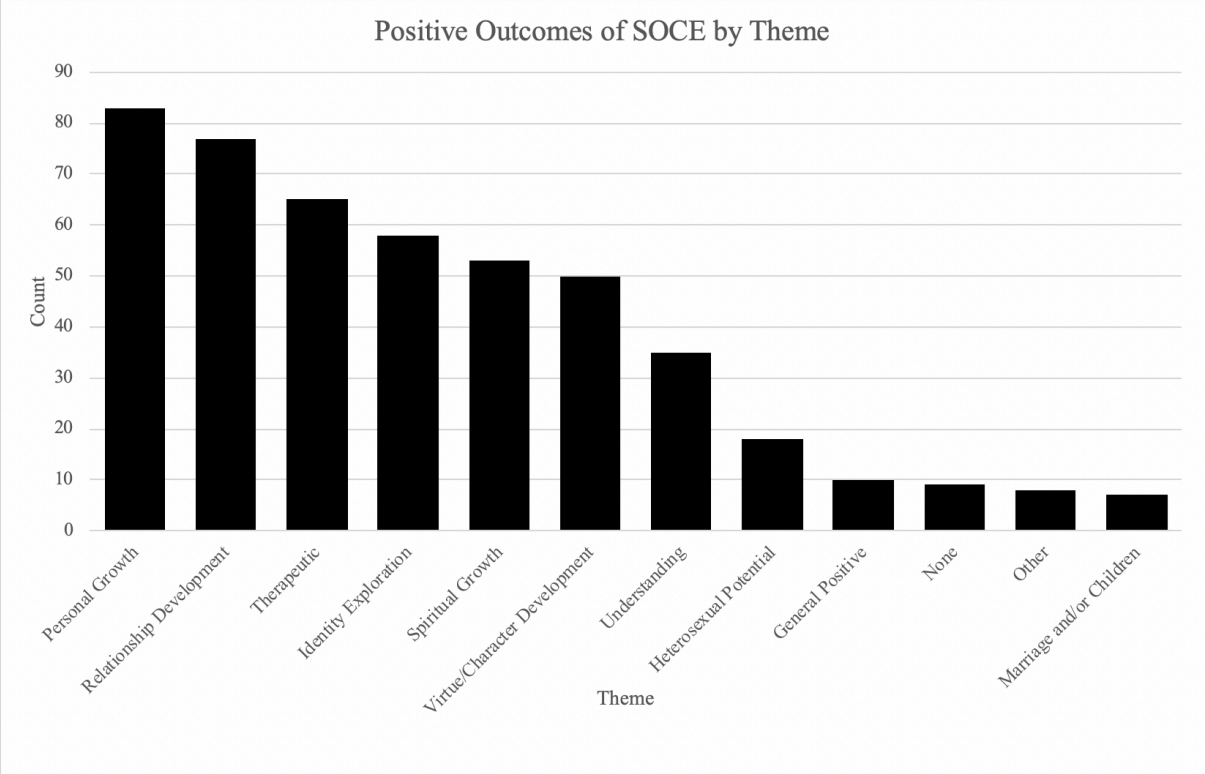


Positive experiences within SOCE. Lastly, another open-ended question asked the participants, "Please describe any positive experiences or outcomes in your efforts to change same-sex attraction. If you feel there was nothing positive, please feel free to write, 'None.'" The purpose of this question was to gain qualitative insight into any perceived positive benefits from their SOCE experience. There were 470 instances of 126 different codes that belonged within one of 12 major themes. The most common theme was Personal Growth, where participants provided sentences expressing newfound confidence, self-acceptance, less acting out with addictive behaviors, less male objectification, and so on. The second most popular theme was relationship development with popular codes including close same-sex friendships, connection and community with people that have similar struggles, positive vulnerability, among others. The third most popular positive experience outcome theme was Therapeutic, which was identified as the lessening of adverse psychological symptoms. Examples include shame, anxiety,

and blame release, less depression, processing past hurts, healing, freedom, decreased social fear regarding men, among others. Figure 3 displays the counts of these codes organized by theme.

Figure 3

Count of Instances in Positive SOCE Outcomes Sorted by Theme



Discussion

This study had one overarching aim, which was to contribute to the literature on attitudes and experiences related to SOCE. This was pursued through quantitative and qualitative methodologies (i.e., a mixed-method approach). The quantitative portion of this project was conducted to investigate relationships between SOCEs and various related attitudes toward and experiences with the change effort process. The qualitative components of this study were designed to gain a holistic participant-led understanding of (a) etiological beliefs, which were expected to be commonly shared among participants (Byrd et al., 2008; Hallman, 2008; Nicolosi, 1991, 2016), and (b) positive and negative experiences and outcomes of SOCE.

This study also aimed to address some unanswered ideas within this field. First, the idea that shame, or internalized homonegativity, is one of the main reasons why people seek and report perceived well-being from SOCE (Walker, 2013). This study included an unvalidated measure of shame to begin to explore this possibility. Additionally, it seemed intuitive that there may be differences in SOCE experiences and attitudes between those who were self-motivated to engage in SOCE versus those who engaged in SOCE against their will or to appease some outside factor (i.e., parents, a

pastor, God, etc.). This study assessed for these external motivations and explored their relationships with the study variables. Lastly, the study investigated an idea, also supported by Yarhouse (2019), that SSA-identity congruence may play a vital role in the engagement of SOCE. This study investigated whether SOCE may be perceived to be more beneficial if the person does not believe their SSA defines their identity.

The qualitative portion of this study obtained first-hand subjective responses to gather information-rich data. Bettinger (2010) recommended doing qualitative or mixed method work due to the favorable quality of giving LGB, and other people who feel SSA, an opportunity to tell their stories without feeling judged and their experiences being oversimplified.

All readers of this report must understand that this was a cross-sectional, retrospective study under which no causal or universal implications can be drawn about SOCE. There are other limitations that will be discussed later in this section. This study addressed a sensitive topic with a population that has been discriminated against for their SSA. The complicating factor was that many in this sample reported experiencing discrimination by those in their lives that affirmed sexual diversity and who disagreed with their choice to seek SOCE. The author was mindful to consider issues of beneficence and justice for the study participants throughout the data analysis.

Quantitative Findings

Retrospective perceptions of change in SSA. Attraction change was calculated by subtracting their current Kinsey attraction score from their pre-SOCE attraction score. Although this was a retrospective, one-item, narrow view of a sexual attraction spectrum measurement, this gives some insight into how participants currently conceptualize their change in SSA. Like recent previous research, most (41%) reported no change in attractions (Bradshaw et al., 2014; Dehlin et al., 2015; Flentje et al., 2014; Weiss et al., 2010) and some reported even further shifts toward stronger same-sex attraction (19.8%); however, this was not as many as those who reported some level of change to the opposite-sex end (37.2%). Still, retrospective measurements are open to various kinds of biases including everything from cognitive recall distortions to impression management, social desirability, and effort justification, especially in the case of research on SOCE in the past (for a review, see APA, 2009). For this very reason, attraction change was not a key variable in this study. Instead, a host of other quantitative and qualitative variables were studied to inherit a richer understanding of SOCE and the people who seek them.

Implications for attitudes. Attitudes toward change efforts was considered one of the more important dependent variables because this study's purpose was to assess the possible connected facets that may influence or support how different participants perceive their SOCE experience. The regression pointed to four significant and negative predictors. Increases in moral beliefs against changing SSA, external motivations for SOCE, current Kinsey attraction, and identity congruence with SSA predicted decreases in positive attitudes (i.e., more negative attitudes toward SOCE).

Although it is difficult to come to conclusions on what came first, moral beliefs and attitudes about SOCE are logically linked because when someone has a negative experience in SOCE (e.g., shame-inducing), they may feel like it is an immoral act for anyone else to experience that same hurt. Likewise, they could have felt that SOCE were immoral before participating. External motivations may lead to experiences that are unfavorable because they suggest that the

person is not participating from their own will and could emotionally react to the experience out of being forced to be there, forced to feel like something is wrong with them while they may not feel there is a problem. Still having SSA or not experiencing change after the SOCE could understandably lower attitudes toward SOCE especially if they had high expectations of change going in. Finally, one's sense of identity and how it relates to SSA can influence attitudes. Those who identify more with SSA, or who feel less dissonance, may think of SOCE as offensive or shaming to one's identity. Those who identify less with SSA and more with other values, who feel more dissonance, may favor SOCE because their identity may not be perceived as threatened, but subjectively enhanced, by SOCE.

Positive attitudes towards SOCE were strongly and negatively associated with identifying more with SSA (i.e., greater identity congruence with SSA). This suggests that those who identify more with their SSA likely viewed their SOCE experience as mostly negative (i.e., unproductive, worthless, meaningless, psychologically harmful, regrettable, shame-inducing according to items). Conversely, positive attitudes toward SOCE were associated with not identifying as much with their SSA feelings (i.e., less congruence). Those who place less cognitive or ideological "identity weight" (Yarhouse, 2019) onto their SSA likely perceived the SOCE experience to be more positive (i.e., fulfilling, enlightening, eye-opening, meaningful, productive, worthwhile). Although this nonexperimental and retrospective study does not warrant causal inferences, one possibility is that SOCE was more beneficial for those with lower identity congruence at the onset of their SOCE. Identity perspectives may explain why some still seek and report perceived benefit from SOCE. This could also suggest that the degree to which one perceives their subjective identity as defined by same sex attraction could moderate outcomes for SOCE. Implications of this finding will be discussed in a later section.

Attitudes toward SOCE were also strongly and negatively related to external motivations toward change efforts. Those who found themselves in SOCE because they were simply appeasing something or someone external (i.e., parents, pastors, friends, religion, bullying experiences, etc.) were likely to have negative attitudes about change efforts when compared to those who were self-motivated to be there. For the respondents with more positive attitudes, there may have been something perceived within the individual, maybe their identity, values, or spiritual relations, or a combination of the three among other intrapersonal factors, that could have been motivating them to actively participate in SOCE. To the knowledge of this author, this was the first study of its kind to quantitatively measure motivations and other variables like identity in the topic of SOCE (cf. Bradshaw et al., 2014; Byrd et al., 2008; Dehlin et al., 2015; Flentje et al., 2014; Nicolosi et al., 2000; Weiss et al., 2010). This finding suggests that perceived outcomes of SOCE can depend, in part, on the motivational factors that influence participation. Those who are participating for themselves and their inherent values may appreciate the process more. Those who are participating due to pressure from someone else may not appreciate the process and the outcomes could be negative or highly unfavorable for them.

Shame about attractions. Correlations with shame are addressed here for exploratory purposes. It may be considered important to understand what may influence or be related to feelings of shame. There was a significant, small, positive correlation between SSA shame and moral beliefs

against SSSB (Pearson's r = .17). Conceptually, it is logical to suggest that same-sex attracted individuals who believe that SSSB is immoral may struggle with shame. For this reason, it was surprising that this association was not stronger. More research is needed to examine this relationship in a more diverse, random sample. Other possible explanations for having shame about one's SSA could be the fact that this sample probably contained a moderate number of men who grew up in the 20th century given the demographic differences between some Facebook groups. The 20th century was a time known for LGB- and SSA-related stigma generally fostered within the older generations (Herek, 2015). Experiences of bullying and feeling strong inadequacy among same-sex peers (see qualitative section below) could possibly attribute to shame.

Shame was moderately associated with current Kinsey attraction in this sample, suggesting the more attracted to the same sex they were, the more feelings of shame they probably experienced. This study contained participants who were almost all Protestant or Evangelical, which are subgroups of Christianity that typically view SSSB as immoral. In turn, some of these individuals also could struggle with internalized heterosexism along with religious stigma; both simultaneously can lead to various mental health challenges and suicidality within young people according to some recent studies (Lytle et al., 2018; Wolff et al., 2016). Szymanski and Carretta (2019) found that the effect of religious-based sexual stigma on psychological well-being and stress was indirectly mediated by internalized heterosexism and religious struggle. Furthermore, medium and high levels of religiosity within the participants were found to be significant moderators of this mediation effect. It is clear through this study and other recent, more rigorous research, that shame, SSA, and religiosity are related in some way. Despite the modest correlation, clinicians and practitioners need to be aware that some clients or participants with SSA, including those who have previously engaged in SOCE, may come in with feelings of shame and inadequacy.

SSA-identity congruence. Bivariate correlations provided some insight to better understand the factors associated with identity congruence. Equating more of one's identity to feelings of SSA was strongly and positively associated with having external motivations toward change efforts. Although speculative, there is some conceptual validity in thinking that those who identify more with SSA may have participated in SOCE to appease someone else, a higher power, or other reasons uninvolved with self-motivation (e.g., wanting to change to decrease stigmatization from others). Additional possibilities include entering the SOCE process after forming an SSA-integrated identity or emotional reactance against the therapist and/or parents, pastors, etc. who suggested they be there. Identity congruence with SSA may be an unstudied and unknown link between the motivations undergirding SOCE and resulting attitudes/outcomes.

There was a significant, yet small, positive correlation between SSA-identity congruence and shame regarding attractions (Pearson's r = .16). Walker (2013) suggested that shame or internalized homonegativity could contribute to the rationality behind seeking such SOCE and reaping perceived benefits, but this data does not confirm that suggestion. If homonegativity underpinned a rejection that one's identity is defined by sexual attractions, then the correlation between shame about SSA and identity congruence would be negative. This finding tentatively suggests that disidentifying with SSA could serve as a very minor protective factor against shame. However, this finding

may be specific to this population. More research is needed to understand this relationship in studies with rigorous and longitudinal sampling methods. As mentioned in the introduction, there remains a dearth of research assessing internalized homonegativity and SOCE together.

Another interesting but more expected finding was that stronger moral beliefs against changing SSA were significantly and moderately related with SSA-identity congruence, meaning that those who identified more with their SSA were more likely to have stronger beliefs that SOCE was immoral. One way to interpret this finding from a theoretical perspective is by considering how moral systems might affect views on SOCE. Depending on the weight a person may place on different moral categories (e.g., care vs. sanctity; Koleva et al., 2012; Monroe & Plant, 2019), the person might form their identity accordingly. One who experiences SSA and identifies with it more could hold care morality (i.e., treating others with respect or making sure to refrain from causing interpersonal harm) to a stronger emphasis. Conversely, a conservative person experiencing SSA may uphold sanctity (i.e., being against certain prohibited behaviors or thoughts) as the more important field of morality. Thus, those who emphasize care morality may be against changing SSA on the basis that the SSA itself is subjectively natural and changing it could equate to a shame-based personal violation. Simultaneously, those who emphasize sanctity may see SOCE as a means of achieving sanctity and not feel any strong moral beliefs against it. This reasoning is entirely theoretical, so more studies are needed to add to this theory of possible morality and identity connections within SOCE.

Like Sullins et al. (2021), current Kinsey attraction was also moderately related to SSA-identity congruence, suggesting that an increased attraction to the same sex, as opposed to opposite sex, may lead a person to express that their SSA plays an important role in who they are. Those who are predominately attracted to the same sex may feel more dichotomous and establish a stronger sense of self-differentiation from the "norm" when compared to being attracted to both sexes or the opposite sex. Attractions with more same-sex salience may influence identity perceptions by including sexuality as an important aspect. Depending on needed recent updates, the number of people reporting to be LGBT in America was 4.5% in 2017 (McCarthy, 2019) suggesting that around 95.5% of the U.S. population is opposite-sex attracted. Since experiencing SSA is not as common as OSA, SSA can be much more noticeable both to the individual and others around them. Such a distinction can feel like an identity differentiation as well, which may be a theoretical reason why those with SSA could place more emphasis on sexual orientation for their identity than opposite-sex attracted people. It could be that many opposite-sex attracted individuals hold a "democratic" (Martinez & Smith, 2019; Mohr, 2002) sense of a heterosexual identity, which does not place emphasis on sexual orientation, probably because they felt little to no reason to analyze it in great detail (Mohr, 2002).

External motivations toward change efforts. Participating in SOCE on the basis of something or someone external was also significantly and moderately correlated with both moral beliefs (i.e., changing SSA and SSSB). The correlation with the moral belief of changing SSA was positive, suggesting that external motivations were associated with stronger beliefs that changing SSA was immoral. It may be that those who extrinsically participated in SOCE had subjectively negative experiences which influenced their later moral beliefs about trying to change. Another possibility is that

they were already externally motivated and had strong moral beliefs against changing SSA going into the SOCE process. There are many possibilities, but there is no causal implication that can be drawn from the data, only a suggestive association. Similarly, the negative, moderate correlation between external motivations and moral beliefs about SSSB suggests that those who were externally motivated to participate in SOCE may have not believed that SSSB was immoral.

On SOCE type differences. Types of SOCE were added into a MANOVA analysis as an independent, grouping variable to discover any possible differences within attitudes, shame external motivation, and others. Therapy with unlicensed counselor and religious practices categories was associated with significantly stronger moral attitudes against SSSB. Also, those who chose religious practices had significantly stronger religious importance scores. The surprising finding was that there were no differences in shame between those who did and did not engage in religious or non-licensed counseling for SOCE given that religiously motivated change efforts were associated with higher odds of mental health adversities and other perceived mental health effects in past studies (Blosnich et al., 2020; Salway et al., 2020; Weiss et al., 2010). Even more unexpected, shame about SSA was lower for those who engaged in religious ministries like Exodus, Love in Action, and so on than those who did not. Even though a longitudinal analysis of people who engaged in these ministries suggested no significant changes in psychological distress (Jones & Yarhouse, 2011), with the anecdotal media attention (e.g., Edgerton, 2018), and the disbanding of some of these ministries, it was expected that more shame, not less, would be associated with these processes. The fact that support groups were connected to more SSA-identity congruence warrants more research into the details of support groups that may lead to more of an SSA-emphasized identity. Vice versa, the participants could have entered the support group seeking help with respect to their already determined SSA-emphasized identity. The nature of this survey lends itself to careful interpretation about causality.

Weekend retreats were associated with several significant outcomes. Specifically, those who engaged in weekend-long retreats reported less shame, less identity congruence with SSA, more positive attitudes, less current Kinsey attraction to the same sex, and less strong immoral attitudes against changing attractions when compared to people who have not been on a weekend retreat. Karten and Wade (2010) found similar results in that their male participants reported one of the most helpful SOCE types were weekend retreats. Future research should further investigate the content of these retreats to better understand whether these findings represent actual changes associated with weekend retreats or other possible factors.

The qualitative responses gave some indication that weekend retreats provided positive benefits to certain participants. When asked about positive experiences in the qualitative portion of this study, one participant explained his weekend retreat experience in this way: ". . . [At the weekend retreat,] I learned to stop identify[ing] myself as gay or homosexual but as a man. There, I forgave my grandmother for her abuse and I felt peace about her after she died." For this participant, his response indicated that disidentifying with his sexuality and identifying more with his gender identity, as well as forgiveness, were both important processes for his positive experience with the weekend retreat. The weekend process also likely introduced people who have similar struggles to each other who can connect and maintain relationships for a long time after

the weekend ends, fostering a sense of connection and community. Another participant who no longer wished to change his attractions still experienced connection and community in his weekend experience: "I attended [the retreat] to understand my SSA issues. I have discovered that I don't wish to be a straight male. Although I appreciate the closeness of being around [retreat] brothers. Knowing that some of them understand my journey." This response suggested that social support seemed to be an important factor in weekend retreats.

Qualitative Findings

Etiological beliefs. Participants were asked about what factors they thought might have led to the onset of their SSA. Familial themes were more frequent, which suggests that there may be some familial reasons for seeking SOCE. The most popular code in the entire qualitative section itself across the three questions was within the Familial theme as "same-sex parent issues" (78 instances). Also popular within Familial were "opposite-sex parent issues" and "unmet needs." Participants expressed estranged, hostile, or uninvolved relationships between the same-sex parent and overinvolved, emotionally boundaryless relationships with opposite-sex parents (Nicolosi, 1991, 2016). A great deal of participants confided that they felt like they missed out on something or were needing something from their same-sex parents and peers. One participant described the family dynamic in this way and how he perceived it to influence SSA:

> Dad never hugged me. He was an alcoholic sex addict and workaholic. Mom used me as a husband as she couldn't get her needs met. She suppressed my masculinity as she hated it. No supports from any male figure. I remember dreaming about hugging my uncle who lived in a different country. I remember thinking, I cannot wait to fall asleep to dream of us hugging. Nobody noticed my emotional needs until I was told that it was normal to love men.

Another respondent put his story in this way:

> [W]hen I was very young, [I had] a busy father with little involvement plus an emotionally needy mother. Then a lack of [socializing] with the same sex due to insecurity and no confidence doing things like sports. My masculine insecurity therefore increased. I ignored the need for masculine connection. At puberty, my need for masculine connection strengthened tenfold, because I was ashamed of my developing sexuality and masturbation, and I wanted to relieve the shame, by comparing myself to males and them admiring/accepting/affirming me in both body and sexual behavior, as they were what I had attached sexuality too from observing my own body, and not being educated well on the topic. I sought out nude male images. I created erotic fantasies and the internet provided adult pornography.

Cognitive was another common theme in etiological opinions, though it was often mixed with Familial, Social, and other codes. Cognitive entailed the childhood and adolescent thought processes that they believed influenced the onset of SSA. The most popular code within Cognitive was "sexualization of unmet same-sex needs." Although similar to "unmet needs" coded into Familial, this code describes a perceived connection or thought process between the

unmet needs from childhood/adolescence being a catalyst for SSA and SSSB. Basically, this code describes feelings of wanting to be close, intimate, platonic with the same sex. There was a sense of a desire or longing to belong and associate with people of the same sex; such a need was perceived by many to be unmet and lacking, which they claimed drove some of the SSA. This would lead to sexual behaviors both with oneself and others. The responses often contained many factors that fit within multiple themes (e.g., Familial, Cognitive, and Social). The other Cognitive codes were quite varied and spread out with many codes only having one- or two-time instances but other slightly more common ones included "body image issues," "childhood shame," "feeling general rejection," "envy of same sex," etc.

The third most common theme within etiological beliefs was Social, describing feelings of rejection, bullying, alienation, disillusionment, discouragement, and other similar feelings regarding peers and other people of the same sex. Under Social, the most common code was "same-sex peer issues" in which participants described experiences of bullying or a childhood shameful feeling of perceived differentiation from peers of the same sex. Another participant describes his combination in this way:

> [. . .] [I had] sex-atypical interests that lead me to be too scared to socialize with other boys. [An] extreme same-sex social anxiety. [I had a] need for same sex affirmation and acceptance, and affection as a result, which got ignored but then intensified during puberty […]

Another respondent described his thoughts on how his dad's lack of fathering and same-sex peer disconnection may have fostered SSA later on:

> […] Also, because my father wasn't around when I needed a man to help me decipher gender roles, my gender identity became a formidable challenge. I was never able to develop necessary friendships with people of the same sex. I always longed for this unreachable male companionship, "belongingship" and intimacy. So, boys became exotic to me, while attraction to girls became shameful and taboo. [. . .]

Another common code within Social was "lack of same-sex connection" also described by the two previous examples above. The other Social codes were scattered with a low frequency of instances (e.g., "LGB labeling during childhood," "lack of masculine affirmation," etc.). For other themes within the etiological beliefs, see Figure 1.

Many of the responses related potential causes of SSA to external issues with only six participants reporting they were born that way. This is one of the factors that make this sample ideologically homogeneous. The author attempted to contact groups that were known to raise awareness about negative SOCE effects to attain diverse perspectives but only one responded and declined to allow the survey. It is impossible to generalize these findings to the general LGB or SSA populations. Nonetheless, it brings insight as to how some people in SOCE discover common shared experiences that are most likely brought up in the SOCE process itself. There are overarching themes within familial, cognitive, and social origins to which many SOCE subjective beneficiaries relate.

Perceived negative experiences or outcomes in SOCE. Participants were asked to describe anything negative about experiences or outcomes of SOCE. By far, the most common and broad theme was Emotionally Related, which was an umbrella

term that encompassed various feeling codes like "shame," "self-blame," "couldn't change," "disappointment," "unproductive or ineffective," and other codes with low numbers of instances. One participant expressed some anger toward his therapist and SOCE as a whole for their overemphasis on attraction change:

> At their core, SOCE are theologically invalid. The shame I felt because of my sexual orientation was only magnified by them. Instead of treating my same-sex attraction, my therapist instead should have pointed me to the biblical reality that same-sex attraction is not a cause for shame. [. . .]

Responses for negative experiences were overall difficult to code because, while reading them, they were hard to decipher between those who would say the pain and "hard work" of SOCE was worth it and those who would say they regretted it, left, and would never go back; not to mention the responses in between this dichotomy. The following response is an example of this difficult and complex nature between some aspects being positively challenging versus regrettable and borderline harmful:

> Nouthetic-style biblical counseling was devastating. They made it feel like all of it was my fault and that it was possible for me to just repent and follow spiritual disciplines and leave it all in the past. They made me feel like it was the worst possible thing and that there was something wrong with me and that all of my life was tainted in some way. And it was all my fault. It has taken me years to restore trust in the Church and in church leadership. Men's weekends have been great and have provided much healing. I think that the damaging part was over promising on change. Also there is a lot of innate homophobia in some of the weekends for men with unwanted SSA. That has not been helpful and has created inner turmoil for me. I think that homophobia runs against the spirit of God as much or more than homosexual behavior. I have found that it is much easier to live life and talk about myself as a celibate gay man than as a same-sex attracted man. There is less social isolation and inner stress. It's a tough call. All of the labels have their flaws.

One can see from this response that there were many aspects that were negative in both the counseling and weekend retreats, but weekend retreats were still described as "great" and "healing." Still, one participant described their whole process with the only words, "mentally scarring and emotionally draining." Another said, "I hate myself with the rejection of these SSA feelings that I experience practically every day. Often struggle with suicidal thoughts."

The second most common theme was "None," entailing that there was nothing negative in their SOCE experience. Many other participants had differing perceptions on what "negative" meant and explained that the SOCE process was hard but worth it. "It has been painful but well worth it," one respondent replied, Another simply said, "Having to deal with past trauma," entailing the emotional reaction of facing one's past.

The third most common theme within negative experiences was Social-Related with most instances belonging to the code "rejection." Although, not the most common code, one participant described the rejection felt from friends and family who did not support his choice to pursue SOCE:

> Many of my old friends shunned me and told me that I would never change. I lost a lot of friends and fell out of favor with family members as well who either [thought] it won't last, or that I was going through "a phase" in the first place. They see the sexuality instead of seeing me.

From a subjective standpoint, the last example provided here represents one of the most unfavorable outcomes of SOCE in that it harmed the relationships the person had with their family members and their sense of God, plus the onset of troubling psychological symptoms:

> I started to believe that I had a bad relationship with my father, and this "father-wound" made me attracted to the same sex, which is untrue. I started to believe that God loved me less for being attracted to the same sex, which is also untrue. I began to hide things from my family and friends for fear it would lead them to guess about my sexuality. I began to feel like God was distant or uninvolved in my life, or worse, that he hated me or was disappointed in me. I think a lot of my shame surrounding my sexuality and efforts to change had an impact on my mental health; specifically, I developed obsessive-compulsive tendencies like washing my hands until they bled, frequently cleaning with bleach, avoiding certain foods because they were "too dirty." I became deeply germaphobic.

Clearly there are some negative outcomes and experiences within SOCE. The quantitative portion of this study suggested that one's identity perspective, level of SSA, and a host of other variables could be predictive of or related to attitudes towards SOCE. The next section will highlight some of the positive aspects that the participants perceived to be from SOCE.

Perceived positive experiences or outcomes in SOCE. Participants were also asked about any positive experiences or outcomes in SOCE. The most popular theme was Personal Growth as an umbrella term for many codes with only a handful of instances, but some of the most common codes within this theme was "less self-medication" (i.e., less subjectively addictive behaviors, mostly pornography), "self-acceptance," "confidence," and "emotionally healthy." Essentially, any positive trait that had a perceived connotation of non-clinical beneficial outcomes were coded into Personal Growth. As stated in the SSA etiological beliefs section, many of the responses in the positive outcomes were also multifaceted containing many instances of various codes. One example of a response with "less self-medication" was accompanied by other positive traits within Personal Growth:

> It made me confident in who I am as a man. I stopped medicating my guilt and shame with porn, drinking, drugs, anger, and depression. I'm at peace with God. I'm confident in my sexuality and being around women. I am no longer filled with anxiety and fear. I love who I am. I no longer live for lust and being obsessed with other men.

The second most popular theme was Relationship Development, which contained codes like "developing close same-sex relationships," "making friends with similar struggles," "positive vulnerability," "community," and others. Having close non-sexual relationships with the same sex seemed to be a common benefit of SOCE, suggesting that some SOCE types could

foster an environment where they can learn how to relate to the same sex in the confines of their own boundaries and values and still feel platonic and intimate, meeting the needs that were perceived to be lacking. One participant put it this way:

> [. . .] Feeling of being a male, not "other" but actually a man—self-esteem improved, my value comes from God, not what other people say. Relating in a healthy and intimate way with men—deep bonding with male friends in healthy way congruent with moral beliefs, feeling "one of the guys." [. . .].

Another respondent also addressed his relationship benefits in a similar way:

> I have become more authentic in all my relationships, trying to be open and honest with everyone. I feel much more at peace with who I am, and I have released much of the shame. I have begun to step out of my comfort zone and seek to meet my needs in healthy non-sexual ways. I know I need more connectedness with other men, which includes healthy male friendships, and I am working toward that goal.

The next most popular theme was Therapeutic, in which participants described connotations of any kind of dissipation of clinically troubling issues or words that reflected therapeutic actions in general. Common examples of codes included "shame release" and "dealt with past hurts" among other codes with low frequencies (e.g., "healing," "freedom," "blame and guilt release," etc.). The following respondent anecdote is an eloquent example of what most of the "shame release" responses communicated:

> I learned a huge deal about how my childhood contributed to me being ashamed all the time and became [aware] of my deep masculine insecurity, and discovered the need for same sex connection in my life, as well as emotional vulnerability and healing from the pain in my childhood that stopped me from connecting. [. . .] I learned to let go of some of the shame of my same sex attractions.

Another participant claimed that some of the most positive things for him were a therapeutic combination of dealing with past hurts, releasing of shame, closeness with his higher power, vulnerability, among others:

> An incredibly deeper understanding of why it developed, getting help for the extreme traumas of my early years, being able to release feelings of shame and inferiority, being able to allow myself to be vulnerable and let people in versus keeping everyone away, growing much closer to God, learning important truths about myself and others, learning more compassion for others, being able to let my guard down. Overall, it was a hugely cathartic and beneficial and healing process for me.

One response entailed a great deal of perceived positive change whereby this person discovered a sense of identity and compassion for everyone around him:

> I have come to the point where my efforts to change my same-sex attraction have become part of my positive personal development. Even though I wouldn't describe my same-sex attraction as having diminished, I

> have developed a new framework of meaning whereby my same-sex attraction is no longer something I experience with shame. Additionally, I have learned how my same-sex attraction has allowed me to develop a certain sensitivity to men's souls, whether gay or straight or in between. [. . .]

Although it did not belong to any of the most common themes, the most popular code collectively chosen was "spiritual connection" with 46 instances. Many times, this code was accompanied by other Personal Growth, Relationship Development, and Therapeutic codes. Subjectively, the following story summarizes what many of them felt they gained from SOCE:

> Early on in my journey to deal with my SSA, I learned that "change" was not a useful goal. Instead, my goal became developing an intimate relationship with Jesus and God. Through this, God began working in my life to address the wounds and issues that—in part—led to my SSA.

Concluding remarks on qualitative findings. Although personal anecdotes are not the always reliable sources of information, they can be quite beneficial for future research in terms of theory and model building. Additionally, they help researchers and lay people understand complex experiences and perspectives that are otherwise not as well understood. These anecdotes have provided content which suggests that SOCE can be brutally damaging for some, ineffective and forgettable to others, and yet still, to a minority, subjectively fulfilling, healing, and enlightening. Many of the participants, whose attitudes toward SOCE were mostly positive, pointed out a crucial notion: Their sexual orientation "change" efforts were really not so much about *"changing" attractions and identity to be "straight"* but actually working on entrenched issues of preceding shame that were there likely there long before any SSA occurred. For this reason, the author believes some of these practices are undeserving of the label, sexual orientation "change" efforts. Instead, maybe the label, attraction reframing processes (ARP) fits better due to their nature that does not overemphasize change. Rather these certain types simply extensively focus on working with the client to mine for cognitive, spiritual, and identity explorative ways in which the client can reframe or reshape their narrative of SSA that fits within their identity and value system. Still, there are interventions that do emphasize change and should rightly be labeled as SOCE. There is just a confusion that this report points to in mistaking all ARPs as SOCE.

Implications for Clinicians, Practitioners, and Researchers

This study, with its plethora of variables and written accounts, supports the notion that therapists or practitioners should assess their clients or participants in their complex perspective of identity before engaging in any type of effort to explore, manage, cope with, or especially "change" feelings of SSA. The following questions are important to consider: Where are the clients in terms of *how* they think about their SSA? Do they place more weight or emphasis on their feelings of SSA for their notion of identity or do they place more weight on something else?

Yarhouse (2019) recently suggested a new approach he coined as "client-affirmative" therapy, different from both SOCE and gay-affirmative therapy. It starts with assessments that guide clients on a path toward their own identity exploration. For those experiencing a discontinuity between

their religion and same-sex sexual feelings, a possible solution may be to carefully incorporate themes from both affirmative and "change" related therapies for the custom needs of the recipient (Cates, 2007). Ideally, a therapist might be able to help these individuals cope by accepting *the presence* of the SSA while maintaining the notion that the client has the choice to decide what aspect of their life holds the most value in determining identity.

On the topic of external motivations, therapists, practitioners, and facilitators of SOCE may do well by carefully asking their clients or participants why they are seeking services. If the client speaks about more external motivations, they may likely not respond very well to attempts at helping them discover their "heterosexual potential" (Nicolosi, 2000, 2016). It is important that therapists and practitioners do not express anger, force interventions, or infer anything about the client's character when facing clients who do not want to be in their service, especially teenagers that may be there according to their parents will and not theirs (Ryan et al., 2018). Instead of focusing on attractions, the therapist, practitioner, or facilitator can focus on something else like their anger or annoyance toward the therapist or possible feelings of anger, hurt, betrayal, and embarrassment associated with parents sending them to such practices. Parents need to be properly informed that no therapist or other professional can simply change attractions directly; however, they can be discussed and framed within the teen's identity exploration process. Parental, religious, and therapeutic efforts to change teenagers' sexual orientations were recently associated with a host of negative effects such as depression, suicidal thoughts and attempts, and health risks (Ryan et al., 2018).

According to guideline six of the ATSCI's (2018) guidelines for researchers and therapists who practice with the SOCE seeking population, it is of utmost importance to never promise or overemphasize sexual attraction change. Focusing less on change and more on underlying issues addressed in most typical therapy sessions may help to prevent such disappointments. Clients and participants of SOCE need help to cognitively reframe the issue around their own sense of identity in such a way where they (a) do not feel pressured to subscribe to an identity label *and* (b) so that they do not feel shame from interacting with the therapist or other practitioner or facilitator. The ARP concept presented in this aligns with the qualitative findings of positive benefits being much less about orientation change and much more about identity exploration, working through shame associated with gender, people of the same-sex, familial wounds, etc. The negative accounts reported here help to inform this as well as many negative reports pointed to a frustration with some SOCEs "hyper-focus" on turning the client to be heteronormative in attractions, behavior, and style. Those engaged in facilitating SOCEs through various professional and other services should exercise considerable caution in light of potential harms.

Limitations and Future Directions

Many limitations in this study have already been addressed throughout this discussion. To summarize, I will begin with issues related to sampling and participants. This was a convenience sample of mostly Facebook groups which housed many people, mostly men, who are still actively engaging in SOCE or another related process. Thus, this sample is ideologically homogeneous. Other groups that might have disagreed with this population were contacted but as previously stated, only one responded and declined. This sample was mostly made up of White men and had a low proportion of females and people of color. This study cannot be

generalized to the full population of people with SSA who have experienced SOCE.

Secondly, none of the measures used in this study have been psychometrically established or validated. Due to the rarity of assessing people with SSA who have engaged in SOCE, not many scales have been developed. The ones that were the most related presupposed an LGB identity and a measure like that simply would not be suitable for such a sample who may or may not identify in that manner. Many of the single-item measures used in this study may not be reliable or complex enough to capture the construct in question. This is especially true of the Kinsey attraction scales where only one facet of sexual orientation was measured (i.e., sexual attraction) as opposed to a more complex measure assessing other areas of attraction (e.g., specifically romantic verses friendship versus sexual attractions). Nevertheless, the author performed exploratory factor analyses and Cronbach's α on all scales, and most had acceptable factor structure and above sufficient reliability scores when edited.

Third, this study's cross-sectional, retrospective design cannot warrant any causal attributions between any variables. Also, error in human memory recall may be selective and highly biased due to the controversial nature of the questions. The APA (2009) has eloquently established that retrospective questions about SOCE can be prone to many biases. The data, especially in terms of pre-SOCE Kinsey attraction may be prone to recall bias, change expectancy, and effort justification to name a few.

Despite these limitations, this study is one of the more rigorous ones that have explored SOCE with its mixed-method nature introducing new, possibly highly relevant quantitative variables and providing in-depth qualitative details on etiological opinions and positive and negative outcomes and experiences. Future research should aim toward taking more time in seeking out SOCE providers via stratified or multistage sampling methods. Also, utilization of a psychometric study on SSA-identity congruence, attitudes, and shame about attractions would be critical to more reliably and validly understanding this community. Future qualitative studies should conduct in-depth focus groups and interviews with people on why they sought SOCE, what their perceived causes of SSA were, and if that has any relationship with motivations for SOCE. The possibilities are widespread due to the scarcity of research in this subject.

Concluding Remarks

For some individuals, SOCE could have been damaging, inducing shame and self-blame. Consequently, it is recommended to be wary of SOCE, especially when proponents offer strong promises of sexual orientation change that may not be fulfilled. At the same time, however, certain SOCE could have been quite therapeutic, fostering personal growth, or as promoting fulfilling and protective factors in peoples' lives. A minority of practices may be deserving of a label change to "attraction reframing processes" (ARP) because the attractions were not suppressed nor forced to adapt into heteronormative "rules"; instead the attractions were non-judgmentally accepted and explored in relation to one's identity. These ARP seemed to allow people to decide whether their attractions would be internalized as an integral part of an identity, or not (e.g., a perceived result of family or social issues). Culture ontogeny (Milstein & Manierre, 2012) has plenty to offer in terms of values and spirituality being an integral part of the brain and identity. There should be room for anyone to decipher the meaning of their attractions. This project brought new variables and insights to light and hopefully

broadened and complexified the SOCE topic for further study.

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APPENDIX: MULTIPLE-ITEM SCALES

The scales and their items were as follows. An asterisk (*) indicates a recoded item.

Attitudes Towards Change Efforts (7-item, 5-point Likert, [1] Strongly disagree – [5] Strongly agree)

How much do you agree with the following statements?

In my experience, trying to change my same-sex attraction was…

Something I regret. *
A fulfilling process.

Psychologically harmful. *
Eye-opening or enlightening.
Shame-inducing. *
A positive experience.
A negative experience. *

Attitudes Towards Change Efforts (three 6-point semantic differential items [0-6])

Trying to change my same-sex attraction was

Unproductive (0) – Productive (5)
Worthless (0) – Worthwhile (5)
Meaningless (0) – Meaningful (5)

SSA-Identity Congruence Scale (10-item, 5-poing Likert; [1] Does not describe me – [5] Describes me extremely well)

Think about yourself or your identity. How well would these statements describe you?

When I think about myself, my attraction to the same sex immediately comes to mind.
I might be attracted to the same sex, but I don't identify as LGBTQ+. *
Because of my same-sex attraction, I am an LGBTQ+ person.
There is a strong connection between my same-sex attraction and identity.
I feel uncomfortable when others try to label my identity as LGBTQ+. *
I feel uncomfortable when others tell me I can change my LGBTQ+ identity.
My attraction to the same sex is an insignificant part of who I am. *
My same-sex attraction is a central part of my identity.
To understand who I am as a person, you have to know that I am attracted to the same sex.
Being attracted to the same sex is an important part of me.

SSA Shame (8-item, 5-poing Likert; [1] Strongly disagree – [5] Strongly agree)

How much do you agree with the following statements?

I feel inferior because of my attraction to the same sex.
I feel like people who are attracted to the opposite sex are superior to me.
I feel like my attraction to the same sex is a personal shortcoming for me.
I feel alienated from myself because of my same-sex attraction.
I often feel ashamed about my attraction to the same sex.
I worry that people perceive me as a person who is attracted to the same sex.
I feel like I am a disappointment because of my attraction to the same sex.
I would be a much more lovable person if my attraction to the same sex went away.

External Motivations Toward Change Efforts (7-item, 7-point Likert scale; [1] Strongly disagree – [7] Strongly agree)

What motivated you to start trying to change or manage your same-sex attraction?

I was being bullied for being a sexual minority.
My family pressured me to change.
My friends pressured me to change.
My pastor or religious/spiritual leader pressured me to change.
I felt social or cultural pressure to change.
I felt religious pressure to change.
I was self-motivated to change. *

Sexual Orientation Differences Between Children of Same-Sex Parents and Children of Heterosexual Parents: A Brief Report Using a Meta-Analysis

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While it has been debated whether parental and children's sexual orientations are associated, no meta-analyses have yet been reported, using data with older children, comparison groups of heterosexual families, and larger samples. The apparent scientific consensus has been that parental and children's sexual

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orientations are unrelated. In contrast to previous research, here six studies are analyzed through three meta-analyses, with the result found that children from same-sex parent families are significantly more likely to be nonheterosexual (gay, lesbian, or bisexual; questioning; to engage in same-sex sexual relationships, or report same-sex sexual attraction) than are children from heterosexual parent families. Further research and more detailed social science theories are needed to explain possible pathways from parental sexual orientation to the development of sexual orientations in children.

Keywords: same-sex parents, sexual orientation of children, family theory, meta-analysis, gender of children

As described in far greater detail elsewhere (Schumm, 2018; Schumm & Crawford, 2019; Stacey and Biblarz, 2001) there has been considerable controversy regarding the possible association of the sexual orientation of children and of their parents. In particular, Stacey and Biblarz (2001) stated that "Virtually all of the published research claims to find no differences in the sexuality of children reared by lesbigay parents and those raised by nongay parents. . . . Yet it is difficult to conceive of a credible theory of sexual development that would not expect the adult children of lesbigay parents to display a somewhat higher incidence of homoerotic desire, behavior, or identity than children of heterosexual parents" (p. 163). However, they and others (see Schumm, 2013, p. 273) since have been severely criticized for and/or have been extremely cautious about maintaining such a possibility (Rosky, 2013), regardless of any theoretical merit.

For example, Ball (2003) went so far as to call Stacey and Biblarz's conclusion not only essentially unfounded but "both useless and dangerous" (p. 703). Likewise, Ronner (2010) stated that ". . . There are people who believe, despite reliable studies to the contrary, that children raised by gay and lesbian parents are more likely to become homosexuals themselves" (pp. 22–23), which Ronner had included as one of many "delusional belief[s] about gay and lesbian parents" (p. 5). Furthermore, as many as 160 scholars and various authors have argued that lesbian, gay, and bisexual parents were not more likely to raise children who would grow up to be nonheterosexuals themselves (Schumm, 2013, p. 267).

It would be fair to say that many scholars considered the idea that gay or lesbian parents would be more likely to raise children who would become lesbian, gay, or bisexual was a mere "myth." Schumm (2020a, b) has provided a literature update on the issue, but no one has yet performed a meta-analysis on relevant data. Schumm and Crawford (2021) found evidence that research studies that found in favor of our alternative hypothesis (that LGB parents would tend to have children who would grow up to be LGB) tended to be cited significantly less often than studies that asserted they had found evidence in favor of the null hypothesis (that their children would not tend to grow up to be LGB), a tendency which has clouded the literature and obscured a great deal of research evidence (Schumm & Crawford, 2019).

Research Hypotheses

Our general hypothesis involved comparing the percentages of nonheterosexuality for children as a function of their parents' sexual orientations. We expected that the children of same-sex parents would be more likely to report nonheterosexual attractions, questioning of their sexual orientation identity, nonheterosexual sexual behaviors, or nonheterosexual sexual orientation identities than would children of comparison groups with heterosexual parents. Thus, our main hypothesis was:

H_0. There will be no significant differences in children's reports of their own sexual orientation(s), in terms of sexual attraction, identity, behavior, and questioning of their sexual orientation, as a function of their parent's sexual orientations.

H_1. Children of nonheterosexual or same-sex parents will more often report higher levels of nonheterosexual sexual orientations, in terms of sexual attraction, identity, behavior, and questioning of their sexual orientation, compared to the children of heterosexual or mixed-gender parents.

Methods

Sample

We had located 59 studies that measured some aspect of children's sexual orientation, defined in terms of sexual attraction, sexual behavior, as described in detail elsewhere (Schumm, 2018; Schumm & Crawford, 2021, Appendix, pp. 27–28). To the best of our knowledge, those 59 studies represent all studies, published between 1978 and 2019, that assessed the sexual orientation, in some way, in terms of percentages, of the children of same-sex parents. Six studies also had comparison groups of the children of heterosexual parents. We did not include those without control groups (e.g., Easterbrook, 2019; Saffron, 1998). We did not include studies published more than 40 years ago (i.e., before 1980) or which primarily involved children under the age of 15 (e.g., Javaid, 1993). Studies that reported having studied similar variables but that did not report their results in terms of percentages were not included in our sample of studies (see also, Schumm, 2018, pp. 113–138). We also did not include studies if the number of children of same-sex parents was less than 20 (e.g., Canning, 2005).

Thus, the studies included were Tasker & Golombok (1995, 1997); Sirota (1997); Kunin (1998); Zweig (1999); Murray and McClintock (2005), and Swank et al. (2013). Regnerus's (2012) research was not included, even though it would have favored our alternative hypothesis, because of numerous problems noted with it (Cheng & Powell, 2015) and because of variations in how parental sexual orientation was measured. Gartrell, Bos, and Koh's (2019) research would have been a logical inclusion except they did not explain in detail how they weighted the cases involving children of heterosexual parents; furthermore, depending on how one defined sexual orientation across sons and daughters of same-sex parents, the percentages ranged between 5.6% (Bos, Carone, Rothblum, Koh, & Gartrell, 2021) and approximately 70% (Gartrell, Bos, & Koh, 2019). Although Sirota (1997) was a dissertation, parts were later published as a refereed journal article (Sirota, 2009). Thus, two of our six studies have remained as unpublished dissertations (Kunin, 1998; Zweig, 1999).

Measures

Same-sex sexual orientation has been measured in terms of same-sex attraction or questioning of one's sexual orientation as a child, same-sex sexual behavior, and same-sex sexual identity. We followed that line of reasoning in the selection of measures in our six studies.

Selected Studies

Tasker and Golombok (1995, 1997) studied 25 children of lesbian mothers in England, of whom 9/25 (36%) reported same-sex attraction, 6/25 (24%) reported same-sex behavior, and 2/25 (8%) reported a lesbian identity, compared to 4, 0, and 0, respectively, for 20 children of heterosexual

parents. Notably, 14/25 (56.0%) had reported that their parent(s) had wanted them to become involved in LGB relationships or had no preference (Schumm, 2018, p. 128).

Sirota (1997, 2009) found that 23/67 (34.33%) of daughters of gay fathers identified as lesbian or bisexual while 30/43 (69.77%) of heterosexual daughters of gay fathers had questioned their sexual orientation previously. If one counted questioners and lesbian/bisexual daughters together, the total percentage would have been higher (53/67, 79.1%). The daughters of heterosexual fathers reported 2/67 (3.0%) reported being lesbian or bisexual while 14/60 (23.3%) of the heterosexual daughters reported having questioned their sexual orientation.

Kunin (1998) surveyed 21 sons and 26 daughters (ages 12 to 17) of lesbian mothers and found that 21/47 (44.68%) of them reported having questioned their sexual orientation and 4/47 reported being LGB with another six reporting "unknown." Among the children of heterosexual parents, the comparable rates were 1/47 (2.1%) and 10/47 (21.3%).

Zweig (1999) found that 3/154 (1.9%) adult children of heterosexual parents were LGB compared to 20/80 (25.0%) of the children of LGB parents; in terms of not being exclusively heterosexual, the parallel rates were 3.9% (6/154) and 57.5% (46/80), respectively.

Murray and McClintock (2005; also see Ross & Dobinson, 2013) reported in their study that 43% (3/7) of the adult children of bisexual parents were LGB while 38% (11/29) of the adult children of gay or lesbian parents were LGB, compared to 0/63 children with heterosexual parents. Thus 14/36 (38.9%) of the children of LGB parents were LGB compared to none of the children of heterosexual parents.

Swank, Woodford, and Lim (2013) gathered data on the sexual orientation of college students and their immediate family members. Of those with an immediate family member who was LGBT, 31% (52/168) were LGBT compared to 15.5% (289/1870) of those who did not have an immediate family member who was LGBT.

Analysis

Most meta-analyses present a PRISMA chart detailing how articles were excluded or included. In our case, we had already performed a literature review of studies that included children's sexual orientation as a variable (Schumm, 2018; Schumm & Crawford, 2021). We used the Cochrane Collaboration's free meta-analysis program Review Manager (Rev Man 5.4.1, 2020) for our calculations to compare the rates for the six studies. Because the studies measured different aspects of homosexuality (questioning, attraction, behavior, and identity) we performed three meta-analyses. First, we assessed differences in identity, then changed the data from Tasker and Golombok from identity to behavior and ran a second meta-analysis. Third, we used data on attraction or questioning from Tasker and Golombok, Sirota, and Kunin only to assess differences in attraction/questioning for those three studies.

Limitations

Because we used single items, no reliability or validity data were available. Our literature search did not yield any studies published after 2013 that met our eligibility criteria. The sample sizes in our studies ranged from small to fairly large. Some of the studies included younger children for whom sexual orientation might have been less relevant. Our data was limited to that from only six studies, but we excluded at least two studies that would probably have increased support even further for our alternative hypothesis. The free meta-analysis program we used did not calculate bias measures.

Results

Sexual Orientation Identity

Here we had data from 423 children of LGB parents or relatives and data from 2,221 children with heterosexual parents, across the six studies. The weights assigned to the six studies were 9.4%, 18.9%, 13.8%, 20.8%, 10.4%, and 26.6% for Tasker and Golombok, Sirota, Kunin, Zweig, Murray and McClintock, and Swank et al., respectively. We used a random effects model. The respective odds ratios were 0.23 (95% CI, 0.01 to 5.06), 0.06 (0.01 to 0.26), 0.23 (0.03 to 2.17), 0.06 (0.02 to 0.21), 0.01 (0.00 to 0.21), and 0.41 (0.29 to 0.58) where the odds ratios predicted lower odds for children of heterosexual parents reporting an LGB sexual orientation identity. The overall odds ratio was 0.12 (95% CI, 0.04 to 0.37) with an overall z test = 3.60 (p = .0003). In terms of heterogeneity, tau = 1.32, with a chi-square (df = 5) of 18.79 (p = .002), and I^2 = 73%, indicating some heterogeneity of results across the studies, a result that supports the use of a random effects model in meta-analyses. The odds ratio for predicting greater likelihood of the children of same-sex parents growing up to be lesbian, gay, or bisexual in terms of sexual orientation identity would be 8.3 (i.e., 1/.12), roughly equivalent to a Cohen's d of 4.57.

Sexual Orientation Behavior or Identity

Here we had the same data, except for using behavior as the outcome measure for Tasker and Golombok's research, as in the previous meta-analysis, from 423 children of LGB parents or relatives and data from 2,221 children with heterosexual parents, across the six studies. The weights assigned to the six studies were 10.2%, 18.8%, 13.8%, 20.6%, 10.5%, and 26.1% for Tasker and Golombok, Sirota, Kunin, Zweig, Murray and McClintock, and Swank et al., respectively. We used a random effects model. The respective odds ratios were 0.07 (95% CI, 0.00 to 1.39), 0.06 (0.01 to 0.26), 0.23 (0.03 to 2.17), 0.06 (0.02 to 0.21), 0.01 (0.00 to 0.21), and 0.41 (0.29 to 0.58) where the odds ratios predicted lower odds for children of heterosexual parents reporting an LGB sexual orientation identity or behavior. The overall odds ratio was 0.10 (95% CI, 0.03 to 0.34) with an overall z test = 3.74 (p = .0002). In terms of heterogeneity, tau = 1.39, with a chi-square (df = 5) of 19.67 (p = .001), and I^2 = 75%, indicating some heterogeneity across the studies, again supporting the use of a random effects model. The equivalent odds ratio for predicting greater chances for children of same-sex parents growing up to engage in same-sex sexual behavior or report a lesbian, gay, or bisexual sexual orientation identity would be 10.0, roughly equivalent to a Cohen's d of 5.5.

Sexual Orientation Attraction or Questioning

With data from only three studies, the data set included data from 127 children of LGB parents or relatives and data from 115 children with heterosexual parents. The weights assigned to the three studies were 21.9%, 39.6%, and 38.5% for Tasker and Golombok, Sirota, and Kunin, respectively. We used a random effects model. The respective odds ratios were 0.44 (95% CI, 0.11 to 1.74), 0.13 (0.05 to 0.32), and 0.33 (0.14 to 0.83) where the odds ratios predicted lower odds for children of heterosexual parents reporting nonheterosexual sexual attraction or questioning of their sexual orientation. The overall odds ratio was 0.25 (95% CI, 0.12 to 0.51) with an overall z test = 3.78 (p = .0002). In terms of heterogeneity, tau = 0.14, with a chi-square (df = 2) of 3.06 (p = 0.22), and I^2 = 35%, indicating relatively low heterogeneity across the three studies. The equivalent odds ratio for predicting higher rates of same-sex sexual attraction/questioning for children of same-

sex parents would be 4.0, roughly equivalent to a Cohen's *d* of 2.2.

In none of the meta-analyses were the funnel plots unusual.

Discussion

In what we think are the first meta-analyses of data relating to a differential risk of the children of same-sex parents being more likely to report nonheterosexual sexual orientation identities, behavior, or attractions/questioning, compared to the children of heterosexual parents, we found strong evidence rejecting the null hypothesis of no differences, and in favor of the alternative hypothesis. The *z* tests for all of our three meta-analyses were significant ($p < .001$). The overall odds ratios ranged between 0.10 and 0.25, which would have been between 4 and 10 if reversed to indicate the increased odds of the children of LGB parents growing up to report LGB identity, behavior, attraction, or questioning. The Cohen's *d* measure of effect sizes for the three meta-analyses was more than large in all three tests (0.80 or more is considered "large"). Using a $z = 3.00$ as an average for the meta-analyses, the fail-safe number of studies supporting the null hypothesis required to overturn our findings would be approximately 114 (Rosenthal, 1979). It is doubtful that even 100 studies have been conducted in this area, suggesting it would take a considerable number of future studies that supported the null hypothesis, to overturn our findings here. If there has been a "myth" about the association between parental and children's sexual orientations, it would appear now that the myth was the null hypothesis about that association.

A point to consider for future research is that the effect size for attraction/questioning was lower than those for behavior and identity. That result may not fit the "born again" hypothesis, that genetic factors from the parents predict same-sex attraction. Elsewhere, it has been noted that in the Tasker and Golombok (1995) study, some of the children of their lesbian mothers reported same-sex sexual behavior in the absence of same-sex sexual attraction (Schumm, 2018, pp. 121–122). Specifically, if there was same-sex attraction reported, the children of the lesbian mothers were significantly more likely to act on that attraction (6/9) compared to the children of heterosexual mothers (0/5), with a Cohen's *d* of 1.57 ($p < .05$). However, at least five of the children of the lesbian mothers were considering or had engaged in a same-sex sexual relationship even without experiencing same-sex sexual attraction. Such results suggest modeling of parents as a factor in children's behavioral decisions.

More work needs to be done in terms of research, seeking for mediating variables between same-sex parenting and child sexual orientation outcomes (Schumm, 2020a); likewise, more work needs to be done in theory development to anticipate which factors might be most likely to account for pathways from parental sexual orientation to children's sexual orientations (Schumm, 2020b). Other scholars might want to try to replicate our meta-analytic results with different samples, perhaps relaxing some of our choices for exclusions, or using different meta-analytic programs.

Conclusion

Despite over 90% of literature reviews between 2001 and 2017 concluding that the children of same-sex parents were not more likely to grow up to be lesbian, gay, or bisexual (Schumm & Crawford, 2019), our results differ and indicate that same-sex parents are more likely to have children who grow up to be nonheterosexual in their sexual attractions, questionings, behavior, and identity. The effect sizes found in our study were all well beyond the "large" effect size,

indicating that our results were not merely significant statistically but were also very substantial. This represents an important and substantial reversal of "common knowledge" among social scientists, even though more than twenty years ago Stacey and Biblarz (2001) argued that most social science theories would have predicted what we have reported here.

Our results would suggest that environmental factors, or perhaps genetic ones, are important predictors of adult sexual orientation, in contrast to the conventional idea that lesbian, gay, or bisexual persons are "born" that way. Even Gartrell et al. (2019) adopted environmental theory as one way to explain the high rates of nonheterosexuality they found among their sons and daughters of lesbian mothers. Some results suggest that parental modeling may influence children's sexual behaviors, above and beyond any degree of sexual orientation attraction. One might wonder how long it will take to turn this ship of science around—literature reviews in recent years have continued to argue in favor of the no difference hypothesis on this issue in spite of increasing evidence to the contrary (see Schumm, 2020a, b for citations).

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Differences Between Acceptance of Sexual Diversity and Nonheterosexual Sexual Orientation Among Children of Same-Sex Parents

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The possible effects of same-sex parenting on children's sexual attitudes and sexual orientation have been controversial. Some scholars have argued that parental influence might be greater for their children's sexual attitudes, such as greater acceptance of sexual diversity, than for their children's sexual orientations. Our review of the literature yielded nine studies of the children of same-sex parents in which both types of measures were included in measurable formats. We compared the reported percentages of both factors, using weighted and unweighted data, as well as by the use of meta-analysis. Both types of measures were positively associated ($r > .85$) across the studies while a significantly higher percentage of children reported greater

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acceptance of sexual diversity than they did for their own nonheterosexual sexual orientation. Effect sizes were substantial (> 3.0). Future research should test whether greater acceptance of sexual diversity or nontraditional gender role orientations may predispose children, especially adolescents and emerging adults, with same-sex parents, to consider, experiment with, or identify with nonheterosexual sexual orientations. Same-sex parenting may influence acceptance of sexual diversity more than sexual orientation among the children of lesbian, gay, or bisexual parents, even though the two factors were strongly correlated across our studies. More complex theories about same-sex parenting need to be developed and tested in future research.

Keywords: Same-sex parents, acceptance of sexual diversity, sexual orientation of children, family theory, meta-analysis

Stacey and Biblarz (2001) stated that "Virtually all of the published research claims to find no differences in the sexuality of children reared by lesbigay parents and those raised by nongay parents. . . . Yet it is difficult to conceive of a credible theory of sexual development that would not expect the adult children of lesbigay parents to display a somewhat higher incidence of homoerotic desire, behavior, or identity than children of heterosexual parents" (p. 163). Yet, they noted that "ideological pressures constrain intellectual development in this field" (p. 160) and that "the ideological 'family values' of scholars play a greater part than usual" (p. 161) in research. Subsequently, they were severely criticized by other scholars for that suggestion (Ball, 2003; Golombok et al., 2003; Hequembourg, 2007; Hicks, 2005). Ball (2003) went so far as to call Stacey and Biblarz's conclusion not only essentially unfounded but "both useless and dangerous" (p. 703).

However, Rosky (2013), for example, noted that "it still seems plausible that an openly LGBT teacher" [or parent] "could facilitate a student's becoming *queer* in the broader sense—for example, in the sense of admitting, accepting, and safely exploring one's homosexual desires and variance from traditional gender roles" (p. 675). Rosky (2013, p. 678) further indicated some uncertainties about the issue even though he didn't think there was enough evidence to reject the null hypothesis. Most scholars have sided with the null hypothesis, as explained in more detail elsewhere (Schumm & Crawford, 2021a; Schumm & Crawford, 2019; Schumm, 2020a), although a recent meta-analysis of six studies found that children of same-sex parents were more likely to report lesbian, gay, or bisexual attractions, behaviors, or identities than were children of heterosexual parents (Schumm & Crawford, 2021b).

If there is no expected association between two variables, then theory development may seem less needed and may be less likely to occur. Schumm (2018, p. 134) suggested linkages might exist or develop among variables such as greater acceptance of sexual diversity and the development of sexual orientation. From our perspective, common sense might suggest that if you accept greater sexual diversity in sexual orientations in general or for others, you might be more accepting of it for yourself—and the reverse might occur as well, leading to a substantial correlation between two such variables, even at the level of group data. Since it might be easier to accept greater sexual diversity for others than for yourself, we might expect a higher rate of approval for sexual diversity in general than for a nonheterosexual sexual orientation for oneself, at both the individual level and the group level. While Stacey and Biblarz (2001) expressed their view that almost all social-psychological theories would support a somewhat higher level of nonheterosexual sexual orientation among the children of same-sex parents, other scholars have suggested that social learning theory and social constructionist theory (Goldberg et al.,

2012) or genetic and environmental theories (Gartrell et al., 2019) as specific sociological/psychological theories that would explain how parents might influence their children in the development of gender roles or sexual orientation.

Our approach would use social learning theory and environmental theory to formally explain how modeling and effects of one's environment in the home and family might influence a child's social development, including the development of their greater acceptance of sexual diversity and of their own sexual orientation. While we think both those theories would predict higher rates of those two factors that is not the key research question here. Rather, our key question here is whether/how those two factors might differ from each other in magnitude, in terms of relative percentages. It might also be reasonable to expect differences between those two variables among the children of heterosexual parents, but that is not within the scope of this report. We also expected a positive correlation between the two variables across our studies.

Research Hypotheses

Our general hypothesis involved comparing the percentages for acceptance of sexual diversity versus the percentages for nonheterosexual orientation across different studies. We expected that the children of same-sex parents would be more likely to accept greater sexual diversity than to identify as nonheterosexual, even if those two variables were positively correlated across our studies. Thus, our two hypotheses were:

H_1. Reports of greater openness to sexual diversity will be greater/higher than reports of nonheterosexual sexual orientation among children of same-sex parents across studies that report data on both variables.

H_2. Reports of greater openness to sexual diversity and reports of nonheterosexual sexual orientations will be positively correlated across our studies.

Methods

Sample

We located 59 studies that measured some aspect of children's sexual orientation, defined in terms of sexual attraction, sexual behavior, as described in detail elsewhere (Schumm & Crawford, 2021, Appendix, pp. 27–28). To the best of our knowledge, those 59 studies represent all studies, published between 1978 and 2019, that assessed the sexual orientation, in some way, in terms of percentages, of the children of same-sex parents. Nine studies, of the 59, also assessed their acceptance of greater sexual diversity, openness, or questioning in themselves or others (Paul, 1986; Javaid, 1993; Tasker & Golombok, 1995; Saffron, 1996; Sirota, 1997; Kunin, 1998; Jedzinak, 2004; Canning, 2005; Goldberg, 2007a). In three cases, the same results were reported in other sources (Golombok & Tasker, 1996; Saffron, 1998; Goldberg, 2007b), but the two publications were deemed as one research report for purposes of our analyses. Although Sirota (1997) was a dissertation, parts were later published as a refereed journal article (Sirota, 2009). Thus, only four of our nine studies have remained as unpublished dissertations. We conducted a search of Google Scholar to try to find other sources that had assessed both of our key variables for the same participants, but we did not find any additional such studies. Studies that reported having studied similar variables but that did not report their results in terms of percentages were not included in our sample of studies (see also, Schumm, 2018, pp. 113–138).

Measures

Since our first hypothesis involved comparing scores for two variables and since we expected to find significant differences, we developed our measures so as to minimize our chances of rejecting the null hypothesis, so that our approach to measurement would not bias our results in our expected direction, but rather contrarily to it. That approach meant that we attempted to maximize the percentage of LGB children, reduce the percentage of children open to sexual diversity, and to reduce sample sizes, all of which would reduce the chances of rejecting the null hypothesis of no difference between the two variables across our nine studies. For example, if daughters of same-sex parents reported higher levels of nonheterosexual sexual orientation than did sons of same-sex parents, we would use the smaller sample of daughters and their higher level of nonheterosexual sexual orientation rather than using a larger sample of both genders. One-sample Kolmogorov-Smirnow tests of normality for our two variables yielded no significant deviations from normality ($p \geq .200$).

Study Descriptions

The data for our report are presented in Table 1, but each study is described in more detail, as follows, each study in chronological order of publication date.

Table 1

Data from Nine Studies of the Children of Same-Sex Parents

Authors	Date	N	Minimum Age	Percent Daughters	Percent LGB	Percent Open
Paul	1986	34	18	55.88	68.42	84.21
Javaid	1993	26	6	42.31	27.27	63.64
Golombok & Tasker	1995	25	23	68.00	36.00	56.00
Saffron	1996	15	17	73.33	46.67	75.00
Sirota	1997	67	18	100.00	34.33	69.77
Kunin	1998	47	12	51.06	21.28	44.68
Jedzinak	2004	7	18	100.00	42.86	71.43
Canning	2005	11	12	0.00	10.00	36.36
Goldberg	2007a	42	19	83.33	17.14	50.00

Paul (1986) surveyed 15 sons and 19 daughters between the ages of 18 and 28 who had LGB parents. In terms of describing their own sexual fluidity, 27/34 (79.41%) agreed that they had the potential to experience a change in their sexual orientation, a result stronger for the daughters (84.21%) than for sons (73.33%). In terms of having ever questioned their own sexual orientation, 21/34 (61.76%) agreed, more for daughters (73.68%) than for sons (46.67%). Only 8/34 (23.53%) currently defined their sexual identity as LGB, slightly higher for sons (26.67%) than for daughters (21.05%). However, five of the daughters also reported previous same-sex sexual behavior and four others reported strong same-sex sexual attractions (p. 68). Counting those additions,

the nonheterosexual attraction rate for the daughters might have been as high as 68.42% and for the entire sample 50.00%. Paul did not report the correlation between questioning and sexual orientation but said it was minimal (p. 65).

Javaid (1993) interviewed 13 lesbian mothers who had 15 sons and 11 daughters. He also interviewed 15 divorced heterosexual mothers who had 13 sons and 15 daughters. Seven of the thirteen (53.85%) lesbian mothers expressed their acceptance (not preference) if their children became LGB adults. Of the daughters of the lesbian mothers 3 of 11 (27.27%) described themselves as nonheterosexual (i.e., asexual), compared to 1/15 (6.67%) of sons; of the 28 children of heterosexual mothers, all of them described themselves as heterosexuals. In terms of homosexual fantasies, seven of eleven (63.64%) daughters of lesbian mothers had lesbian, bisexual, or asexual fantasies with one other's response as unknown, compared to 7/15 (46.67%) of the daughters of heterosexual mothers. Using all of the children of lesbian mothers as the denominator, the percentages of nonheterosexual children and those with homosexual fantasies were 15.38 and 26.92, respectively. In addition, seven of eleven daughters of lesbian mothers were open to a diversity of gender roles in their own lives. The daughters of heterosexual mothers were 1.4 years older (14.9) on average than the daughters (13.5) of the lesbian mothers; since Javaid (1993) did not provide standard deviations for age, it was not possible to compare that difference statistically.

Tasker and Golombok (1995; Golombok & Tasker, 1996) studied 25 children of lesbian mothers in England, of whom 9/25 (36%) reported same-sex attraction compared to 14/25 (56.0%) who had reported that their parent(s) had wanted them to become involved in LGB relationships or had no preference (Schumm, 2018, p. 128). Only two of the 24 (8.33%) children identified as lesbian, so we used the more conservative report of 36% to reduce our chance of rejecting the null hypothesis.

Saffron (1996, 1998) interviewed 20 children of LGB parents (3 gay fathers, 14 lesbian mothers, 3 with both gay fathers and lesbian mothers), seven sons and thirteen daughters. However, three sons (Josh, Kieron, Lawrence) and two daughters (Alice, Gretel) were under the age of 16 and their sexual diversity outcomes were not reported. All of the remaining 15 children were at least 17 years old. Among the 11 older daughters, one was heterosexual (Rachel, age 20), one was lesbian (Emily, 21), and two were bisexual (Zoe, 24; Rosie, 20) or mostly heterosexual (Jane, 25) while several appeared to be heterosexual but either had or were questioning their sexual orientation (i.e., open to diversity in their sexual orientation; Kate, 24; Mary, 20; Fiona, 19; Claire, 33; Mandy, 24; Katrina, 17). Of the four older sons, one was heterosexual (Nicholas, 66) and three were gay (Stephen, 23; Rikki, 34; Mark, 29). Thus, for the 15 older children, 7/15 (46.67%) were nonheterosexuals (lesbian, gay, bisexual, mostly heterosexual) with another six questioning (86.67%, questioning or nonheterosexual). However, if we follow Sirota's (1997) approach of basing the questioning percentage on the number of heterosexuals, then we would find 6/8 (75%). To be conservative in our testing, we will use 75% as our measure of sexual openness or diversity. As fits other research (Goldberg, 2007a, 2007b; Golombok & Tasker, 1996), there appeared to be greater sexual fluidity among the daughters (five categories of sexual orientation) than among the sons (two categories).

Sirota (1997, 2009) found that 23/67 (34.33%) of daughters of gay fathers identified as lesbian or bisexual while 30/43 (69.77%) of heterosexual daughters of gay

fathers had questioned their sexual orientation previously. If one counted questioners and lesbian/bisexual daughters together, the total percentage would have been higher (53/67, 79.1%). Our method used the more conservative 69.77% value.

Kunin (1998) surveyed 21 sons and 26 daughters (ages 12 to 17) of lesbian mothers and found that 21/47 (44.68%) of them reported having questioned their sexual orientation and 4/47 reported being LGB with another six reporting "unknown," so the maximum nonheterosexual orientation rate was 10/47 (21.28%), used to make our analysis more conservative with respect to rejecting the null hypothesis. The Pearson zero-order correlation for children of both the lesbian mothers and a group of 47 children of heterosexual mothers in Kunin's (1998) study, between degree of questioning and reported sexual orientation was .417 ($p <$ .001; Spearman rho was .487, $p < .001$), even including one homosexual child who had never questioned their sexual orientation.

Jedzinak (2004) interviewed seven daughters, ages 18–27, who had lesbian mothers, finding that 42.86% identified as lesbian or bisexual while 57% had engaged in same-sex sexual behavior, with 71.43% having been open to exploring options other than heterosexuality while growing up. Furthermore, 86% defined sexual orientation as a fluid phenomenon (Schumm, 2018, p. 127). To use the most conservative data with respect to testing the null hypothesis, we used 42.86% and 71.43% for our measures of LGB identity and of openness to sexual diversity.

Canning (2005) surveyed eleven sons, of at least 12 years of age, of gay fathers and found 10% (1/10, one missing value) were nonheterosexual while 4/11 (36.36%) had questioned their sexual orientation at some point.

Goldberg (2007a, 2007b) surveyed adult children, ages 19 to 50, of LGB parents. There are differences between her two articles. In Goldberg (2007a) there were 42 interviews, of 35 daughters and 7 sons; in Goldberg (2007b) there were 46 interviews, of 36 daughters and 10 sons. In Goldberg (2007a) there were six lesbian or bisexual daughters; in Goldberg (2007b) there were seven. For our analyses, we used 6/35 (17.14%) for sexual orientation identity to be more conservative with respect to testing our null hypothesis. In Goldberg (2007a) it was reported that 21/42 (50.00%) of the children (48.57% of daughters, 57.14% of sons) felt intergenerational pride about their parents' sexual orientation, which we will treat as a measure of openness to sexual diversity.

In summary, we had data from nine empirical studies in which both openness to sexual diversity and the sexual orientation of the children of same-sex parents were available as variables. The dates of the studies ranged from 1986 to 2007, with sample sizes from 7 to 67. The minimum ages of the children ranged from 6 to 23, while the percentage of daughters ranged from zero to 100 percent. The percent of LGB children ranged from 10% to 68.42% while the percent open to sexual diversity ranged from 36.36% to 84.21%. Descriptive data for the nine studies are presented in Table 1.

Analysis

Statistics are useful for comparing numerical values obtained from individuals or groups, usually in terms of rejecting or not rejecting a null hypothesis. In our study, we were concerned with results from group data. We took two approaches for our statistical analyses. First, we used paired samples *t*-tests to compare the relative percentages for our two key variables, using weighted and unweighted data (by sample size). Because our two measures did not diverge significantly from normal distributions, were ratio variables, and were positively correlated, we did not feel uncomfortable using paired samples *t*-tests to evaluate the

null hypothesis. At the same time, some reviewers suggested the use of meta-analysis as a better alternative. Therefore, we invited a meta-analysis expert to perform a meta-analysis for us, and we also used statsdirect.com to perform two further meta-analyses, using one more conservative approach (Table 1) and a less conservative approach (explained below). Most meta-analyses present a PRISMA chart detailing how articles were excluded or included. In our case, we had already performed a literature review of studies that included children's sexual orientation as a variable (Schumm, 2018) and one that also included studies that included openness to sexual diversity as another variable (Schumm & Crawford, 2021). Our requirement that studies include both variables in their data reduced the available studies to the nine we have described. Studies that did not report both of our variables in terms of percentages were not included, as explained elsewhere (Schumm & Crawford, 2021).

Results

T-tests

Tables 2 and 3 present the unweighted and weighted results from our t-test analyses. For both weighted and unweighted data, reports of openness to sexual diversity were greater than reports of nonheterosexual sexual orientation, even though we selected our data to minimize the chances of rejecting the null hypothesis of no difference between the two variables. With respect to our second hypothesis, the reports for the two variables were substantially and significantly correlated. Effect sizes for the difference between the two variables were substantial, as well as statistically significant, greater than 3.50 in both analyses.

Table 2

Comparing Percentages of Children of Same-Sex Parents Reporting Greater Acceptance of Sexual Diversity in Themselves or Others versus Those Reporting Some Degree of Nonheterosexuality across Nine Studies Using Unweighted Data

	Mean	SD	*r*	*t*	*df*	*p*	*d*
Greater Acceptance of Sexual Diversity	61.23	15.6	0.921				
			($p < .001$)	11.89	8	< .001	3.91
Nonheterosexuality	33.77	17.7					

Table 3

Comparing Percentages of Children of Same-Sex Parents Reporting Greater Acceptance of Sexual Diversity in Themselves or Others versus Those Reporting Some Degree of Nonheterosexuality across Nine Studies Using Weighted Data

	Mean	SD	*r*	*t*	*df*	*p*	*d*
Greater Acceptance of Sexual Diversity	61.38	14.6	0.894				
			($p < .001$)	11.12	8	< .001	3.62
Nonheterosexuality	33.09	17.0					

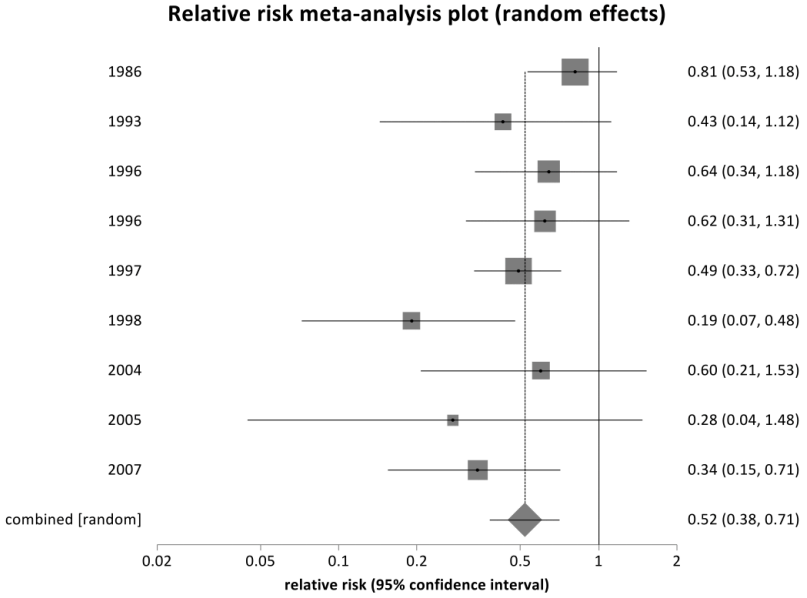
Meta-Analyses

First, we requested assistance from Dr. Chelsea Spencer, who has published several articles using meta-analyses (Kimmes et al., 2019; Love et al., 2018; Spencer & Stith, 2020; Spencer, Stith, & Cafferky, 2019; Spencer, Anders et al., 2020; Spencer, Topham, & King, 2020; Spencer, Keilholtz et al., 2020), for running a meta-analysis on the data from Table 1 using a repeated measures approach. I^2 was 70.74%, high enough to indicate that a random effects model should be used, in which the mean for nonheterosexuality was 33.2% (95% CI, 23.9 to 44.0); while for diversity it was 59.6% (95% CI, 48.3 to 70.0), with a Q statistic for non-combinability of 10.93 ($df = 1$), $p < .001$. The pooled result was 46.1% (22.7% to 71.3%). By her analysis, the results were similar to the *t*-test results, with a significant difference between the two variables.

Second, we tried a risk difference meta-analysis on our own, using StatDirect's programming. For our nine studies, in chronological order, from Table 1, the relative risks and 95% confidence intervals were, respectively, 0.813 (0.53 to 1.18), 0.429 (0.14 to 1.12), 0.643 (0.335 to 1.18), 0.622 (0.31 to 1.31), 0.492 (0.33 to 0.72), 0.190 (0.07 to 0.48), 0.600 (0.21 to 1.53), 0.275 (0.04 to 1.48), and 0.343 (0.15 to 0.71), as illustrated in a forest plot, Figure 1, the relative risk meta-analysis plot (random effects).

Figure 1

Forest Plot of Effect Sizes (Random Effects Model) for Each Study and for the Overall Meta-Analysis.

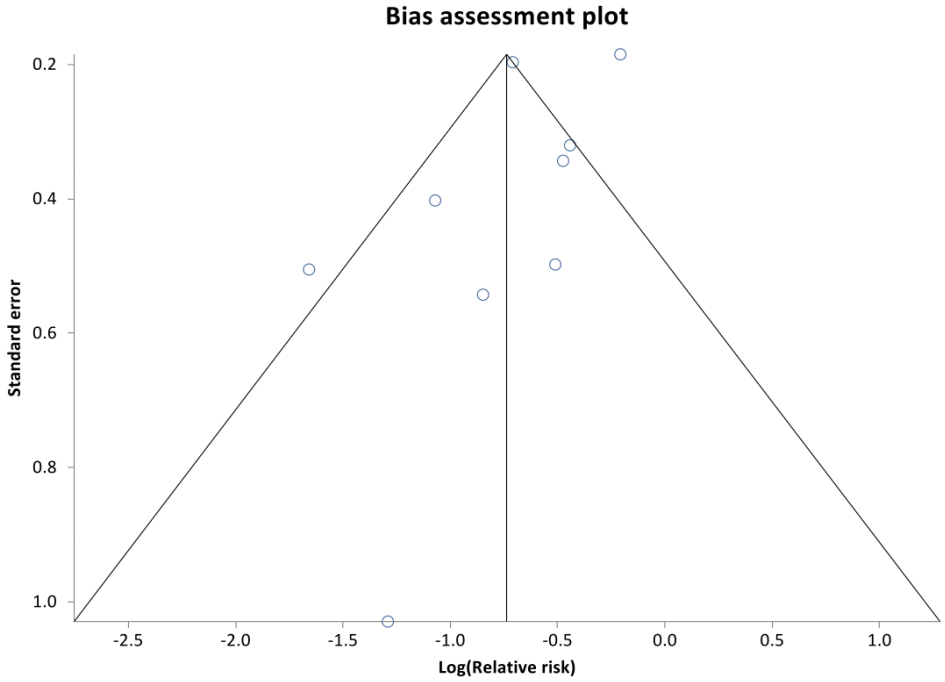


Note: The relative weight used for each study is reflected in the area of the squares for each study while the diamond indicates the mean of the overall effect size. The solid vertical line over 1.0 represents no significant effect size while the horizontal lines represent the 95% confidence intervals for each study or the overall effect size. The vertical line at 0.52 shows the overall effect size compared to the effect size for each of the individual studies.

The weights assigned to the nine studies, respectively, were 20.86, 6.55, 13.25, 12.25, 20.10, 7.30, 7.47, 2.17, and 10.06. The standardized effect sizes determined for the nine studies, respectively, were -.21, -.85, -.44, -.47, -.71, -1.66, -.51, -1.29, and -1.07. For the data in Table 1, we obtained an I^2 = 43.5% (95% CI, 0.0% to 72.3%), and we used the random effects result (DerSimonian-Laird) with a pooled relative risk of 52.0 (95% CI, 38.2 to 70.9). A chi-square test that the relative risks differed was 17.17 (df = 1), $p < .0001$. None of the three bias indicators (Begg-Mazumdar, Egger, Harbord-Egger) were significant ($p > .05$). A funnel plot (Figure 2) showed a nearly equal distribution of results (4/5) and a L'Abbe plot (Figure 3) showed that sample sizes were not related to relative risk.

Figure 2

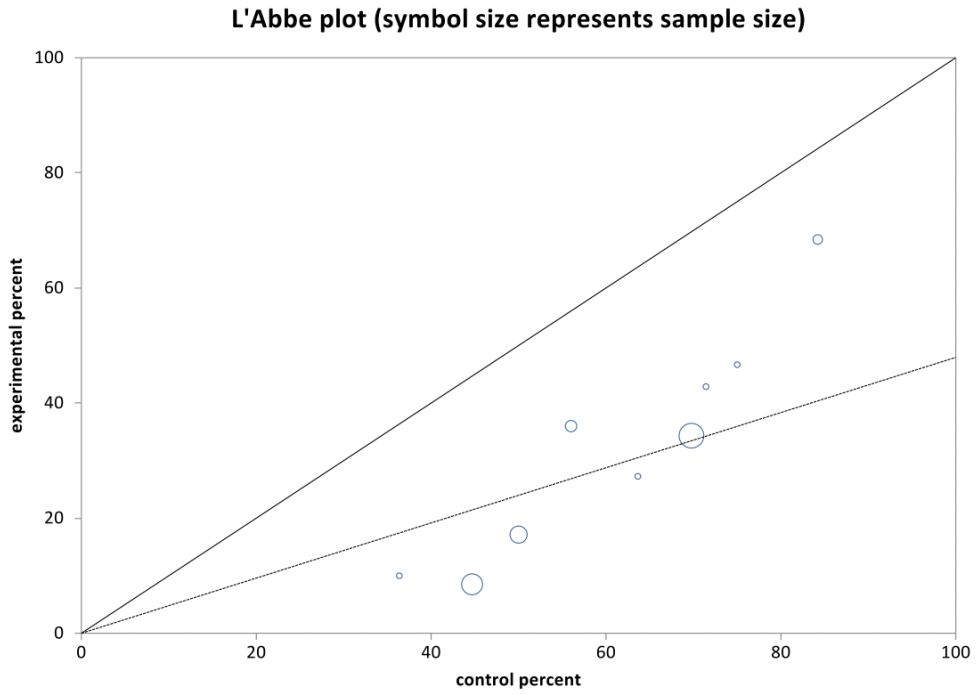
Funnel Plot/Bias Assessment Plot



Note: Funnel plots compare measures of effect size against sample size or standard error (standard errors decrease with larger sample sizes) to detect bias from omission of non-significant smaller samples due to publication or availability bias, as well as other sources of bias such as low methodological quality. In general, smaller samples will yield larger standard errors. Bias is indicated if the pattern of study results are not evenly distributed around the center line for smaller samples/larger standard errors. Little bias appears to be present in this figure.

Figure 3

L'Abbe Plot



Note: The equal line (45-degree angle) represents no effect. The line below the no effect line represents the average effect in the study. The horizontal axis reflects the percent of those open to sexual diversity while the vertical axis represents those children who are lesbian, gay, or bisexual (LGB). The area of each study's circle is proportional to the same size of the study. The results show that in each study, the percent open is higher than the percent LGB. Differences appear to be slightly larger for larger samples.

To respond to critics who might argue that we overestimated nonheterosexuality rates for our first three sources (Paul, 1986; Javaid, 1993; Tasker & Golombok, 1995) we tried using larger sample sizes and more strict definitions of nonheterosexuality, that led to lower rates of nonheterosexuality (8/34, 4/26, 2/24), respectively for those three studies. With this second analysis, $I^2 = 21.3\%$ but we still used the random effects approach, with a pooled relative risk of 40.2 (95% CI, 29.7 to 54.3) and a chi-square test of 35.31, $p < .0001$. The three bias indicators remained non-significant. Even though our relative risk analyses did not assume repeated measures, making our analyses more conservative with respect to rejecting the null hypothesis of no differences, we retained our significant results by the final two meta-analyses.

Limitations

Because we used single items, no reliability or validity data were available. Our literature search did not yield any studies published after 2007 that included data for both of our key variables. The sample sizes in our studies were small, less than 70 cases. Some of the studies included younger children for whom sexual orientation might have been less

relevant. The studies were not consistent in how they measured sexual orientation or sexual diversity. Our data was limited to that from only nine studies. Because our goal for this study was not to compare the children of heterosexual versus those with same-sex parents, we did not analyze data from children of heterosexual parents. Because of these important limitations, our results should be considered exploratory rather than definitive.

Discussion

Recent research suggests that some children of same-sex parents grow up to report same-sex attractions, to experiment with same-sex sexual behavior, or to identify as nonheterosexual (Gartrell et al., 2019; Saffron, 1996, 1998; Sirota, 1997; Easterbrook, 2019; Zweig, 1999; Schumm, 2018, 2020; Schumm & Crawford, 2021b).[3] The specific pathways for their sexual orientation development are not yet known. However, one possibility is that growing up in an environment in which parental or child same-sex sexuality is at least accepted and often celebrated (i.e., acceptance of greater sexual diversity) may give children greater freedom to accept any same-sex sexual attractions they might experience, to explore same-sex sexual behaviors, or to eventually identify as LGBT with less risk of ostracism from their own family compared to a situation of being raised by heterosexual parents.

While the children of same-sex parents may experience adverse situations related to their own or their parents' sexual orientations, they may also experience many positives, as have been detailed elsewhere (Riggle et al., 2011; Riggle et al., 2008; Rostosky et al., 2010; Saffron, 1998; Schumm, 2020b; Titlestad & Robinson, 2019). Rather than merely hearing about such positives from others, such children may appreciate them by direct and immediate observation. If same-sex attractions are experienced, children of same-sex parents may be more likely to accept those feelings as legitimate and healthy. If such feelings are legitimate, why not engage in same-sex behaviors that would mirror one's own autonomous, authentic self? If such feelings endure, same-sex sexual behaviors are found to be rewarding and fulfilling, a child's identity as LGBTQ+ may be affirmed internally and externally by parents and others.

Our results do not prove any of the suggested pathways, but the high correlations found between our two key variables are consistent with acceptance of greater sexual diversity being a possible mediating variable between having same-sex parents and growing up to be LGBTQ+. Other mediating variables might include perceptions of the positive or negative aspects of LGBT identity, acceptance of same-sex sexual attractions as legitimate feelings, or the child's sense of parental acceptance for the child's sexual orientation (regardless of its nature) or interest in exploring a diversity of sexual partners in terms of partner sexual orientation. Research should also include parallel measures of parental values and attitudes about their children's sexual orientation attractions, interests,

[3] Bos, Carone, Rothblum, Koh, & Gartrell (2021) have recently reported that only 5.6% of their children of lesbian parents identified as lesbian or gay and only another 15.2% identified as bisexual. While technically correct, their analysis omits four sons who had been included in previous analyses (e.g., Gartrell, Bos, & Koh, 2019) and overlooks results for same-sex sexual attraction (e.g., approximately 70% for daughters) and same-sex sexual behavior, as well as a rate of nonheterosexual (lesbian and bisexual) sexual identification of nearly 30% for daughters (11/37) and 11.4% (4/35) for sons, a difference nearly significant (one-sided Fisher Exact Test, $p = .051$; odds ratio of 3.28, two-tailed test, $p = .064$).

explorations, behavior, and identity. Future theory development should take such pathways into account (Schumm, 2020b). Ideally, future research would assess changes in these variables across the lifetimes of children of same-sex and heterosexual parents in order to identity various longitudinal patterns, which may be diverse, across individual children.

Conclusion

Among the nine studies in which both acceptance of sexual diversity and sexual orientation of the children of same-sex parents were measured, significantly higher percentages of acceptance of sexual diversity were found than for nonheterosexual sexual orientation, although the two measures were strongly correlated for both weighted and unweighted analyses. The results suggest that children of same-sex parents may be more likely to adopt a greater acceptance of sexual diversity than to identify as lesbian, gay, or bisexual. The strong correlation across the two variables may suggest that greater acceptance of sexual diversity might be one of several possible mediating variables between same-sex parenting and a child's later development of an LGB identity. More complex theoretical pathways, with a greater variety of variables, need to be studied in future research with same-sex parents and their children, as well as for heterosexual parents and their children.

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The Relationship Between Father Involvement and Father-Role Confidence for Fathers of Gay Sons

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This nonexperimental quantitative study of 70 participants explored how father involvement during their gay sons' childhood and adolescence was impacted by their levels of father-role confidence (FRC) and past father involvement experiences (PFIE). As hypothesized, the results indicated that participants' past involvement with their fathers, and reported levels of father-role confidence, predicted father-gay son involvement (FGSI). Participants in this study predominately exhibited indirect, non-nurturing, or low-engagement types of father involvement activities with their gay sons rather than direct, nurturing, or high-engagement activities. Implications from the results of this study may be used to inform existing therapeutic approaches for fathers of gay sons, increase father-gay son engagement, and promote relationship reconciliation efforts between adult gay men and their fathers.

Keywords: gay sons, father involvement, parents, sexual minority, homosexuality

Introduction

Over the past two decades, social acceptance of homosexuality steadily increased in most countries (Pew Research Center, 2020). A Pew Research Center (2017) study reported that 70% of Americans believe homosexuality should be accepted compared with only 46% in 1994. Despite the increase in social acceptance of homosexuality, there is a rising trend by researchers in counseling literature to focus on parental acceptance of their sexual minority children (Conley, 2011; D'Augelli et al., 2008; Grafsky, 2014; LaSala, 2010, 2013; Rostosky et al., 2021; Ryan et al. 2010).

Research on parental reactions to a child's "coming out" experiences has been based predominately on the child's recollections (Cramer & Roach, 1988; D'Augelli et al., 2008; Savin-Williams & Dube, 1998; Willoughby et al., 2006). The seminal work by Savin-Williams (2001) documented how families negotiate

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relationships with gay and lesbian youth after their sexuality disclosures. Savin-Williams's work continues to be cited in counseling literature (e.g., Glennon, 2012; Grafsky, 2014; Horn & Wong, 2014; Shpigel et al., 2013) to inform family counseling approaches. LaSala's (2010) study on the coming out experiences of gay and lesbian youth included interviews with sexual minority youth and only some of their parents. Studies are now available that explore the parents' perspectives and the challenges they face in dealing with their sexual minority children beyond the coming out phase. For example, topics in the research include parents resolving uncomfortable memories of their sexual minority child's history (Aveline, 2006), talking about their child's sexual orientation in existing social circles (Glennon, 2012), adjusting to their new identity as parents of a sexual minority child (Goodrich, 2009; Grafsky, 2014; Lee & Lee, 2006), and finding social support options (Saltzburg, 2004, 2009). Although fathers of gay sons were among the participants in several studies (e.g., Aveline, 2006; Glennon, 2012; Goodrich, 2009; Grafsky, 2014; Lee & Lee, 2006; and Saltzburg, 2004, 2009) the father-gay son relationship was not specifically addressed.

The counseling approaches recommended for use with parents of sexual minority children are based on studies where fathers are underrepresented (LaSala, 2010, 2013; Horn & Wong, 2014, 2016). The experiences of fathers of gay sons are rarely documented in studies on parents of sexual minority children (Glennon, 2012; Jadwin-Cakmak et al., 2015). Jadwin-Cakmak et al. caution that studies on sexual minority children that oversample mothers may wrongly inform counselors to anticipate fathers' responses that are not reflective of actual societal experiences. In Grafsky's (2014) study, the two fathers who participated reported low levels of closeness with their gay sons; however, each father indicated that they were not bothered by their son's sexual orientation disclosure. The finding in Grafsky's study contradicts the belief that fathers of gay sons would be less close after sexual orientation disclosure because they are not accepting of homosexuality or that they experience some level of homophobia (LaSala, 2010, 2013).

The available research on parents of sexual minority children does not adequately look at the unique concerns of fathers of gay sons (Gottlieb, 2000; Horn & Wong, 2014, 2016; Jadwin-Cakmak et al., 2015; LaSala, 2013). Counseling approaches specific to the fathers' needs have not been evaluated in the literature on gay sons (Horn & Wong, 2014, 2016). The therapeutic goal in family therapy case studies that include fathers of gay sons is the acceptance of the gay son's sexual orientation (Diamond & Shpigel, 2014; LaSala, 2013) without accounting for relational deficits or emotional health of their fathers. Research on factors that impede or promote father-gay son involvement is necessary to better inform existing counseling approaches with gay men and their fathers.

Background

A common theme in research on the father-gay son relationship is how the unmet need for a father is an enduring factor impacting gay men's social and emotional health (Koritar, 2013, McAndrew & Warne, 2010; Rose, 2005). In counseling literature, gay men are presented with disproportionally high incidences of having distant (Seutter & Rover, 2004) or harsh fathers (Rose, 2005; McAndrew & Warne, 2010; Koritar, 2013). Openly gay psychotherapist Rose (2005, 2007) expressed his surprise that the father wounds of his adult gay male clients represented greater therapeutic impasses than dealing with social stigma, homophobia, or

discrimination. Rose (2005) suggested that therapists avoid focusing on the father-gay son relationship because psychoanalytical theorists use it to explain male homosexuality development (Bieber et al., 1962; Isay, 1989; Nicolosi, 1991; Socarides, 1978). Rose (2005) confirms that exploring the father-gay son relationship is a therapeutic tool for addressing the presenting symptoms in gay male clients.

Through an exhaustive search of the literature, only three studies were discovered that focused on the father-gay son relationship from the father's perspective, however, none of the studies focused specifically on father-gay son involvement. First, a qualitative study was completed by psychotherapist Gottlieb (2000) consisting of narrative accounts from 12 fathers about their gay sons. Second, a mixed-method study by Bucher (2014), using both surveys (n = 50) and interviews (n = 25), explored the relationship between homophobia and masculinity for fathers of gay sons. Third, a qualitative study by Horn and Wong (2016) of five heterosexual fathers looked at the positive experiences of fathers with gay sons. Gottlieb (2000), Bucher (2014), Horn and Wong (2016) did not specifically focus on father involvement in their studies, but they did highlight the need for counseling approaches centered on improving a father's connection with his gay son.

In making recommendations for counseling professionals, Horn and Wong (2014, 2016) acknowledged the lack of literature to support clinical approaches that address the relational needs of fathers with gay sons. Horn and Wong (2014, 2016) indicated that fathers of gay sons have unique challenges or barriers that prevent many of them from engaging with their gay sons. These barriers included the disappointment fathers feel about their gay sons not meeting their expectations of masculine norms and the concerns they experience about the health and safety of their gay sons (Horn & Wong, 2014). Additionally, men who do not experience strong emotional connections from their fathers may have difficulties connecting emotionally with gay sons (Horn & Wong, 2014).

Theoretical Framework and Variables

To study father involvement for fathers of gay sons, two predominant theories associated with father involvement in the literature were selected: social learning theory (Bandura, 1971; Lamb & Lewis, 2013) and self-efficacy theory (Bandura, 1977; Sevigny & Loutzenhiser, 2010). According to social learning theory (Bandura, 1971), a person learns behavior through observation within a social context. Social learning theory (Bandura, 1971) guides the research design for this study. For example, a man learns how to be a father by observing his father, a family friend, or relative (Bouchard, 2012). Additionally, self-efficacy theory (Bandura, 1986), or the degree a person believes they will be successful in performing a behavior, is applied to fathers of gay sons as a predictor of their involvement with their gay son.

This study explores father-gay son involvement by examining fathers' recollections of past involvement with their gay sons. The rationale for selecting "father-role confidence" and "past father involvement experiences" as independent (predictor) variables for "father-gay son involvement" dependent (criterion) variable in this study, was found by reviewing existing father involvement literature (Hofferth et al., 2013; Lamb & Tamis-LeMonda, 2004; Pleck, 1997). Kwok, Ling, Leung, and Li (2013) determined that the level of parenting efficacy predicted father involvement, and a lack of involvement with children was found among fathers with low parenting efficacy. Hofferth et al.'s (2012)

longitudinal study of 409 men documented that a consistent pattern of positive parenting styles was passed from father to son, confirming that a man's involvement with his father predicts his future parenting behavior. Bouchard's (2012) study indicated that fathers who demonstrated lower levels of engagement with young children had received less involvement from parents in their childhood.

Father-Gay Son Involvement

Father involvement is shown to impact the development of children, both positively and negatively, depending on the quality and amount of engagement with children (Lamb, 2000; Long et al. 2014). Fathers influence their sons in unique ways compared to daughters that determine self-esteem (Dick & Bronson, 2005), gender identity (Galenson, 2015), and masculinity (Hammer & Good, 2010). The variety of ways fathers are involved with children is shown to be both direct (e.g., engaging emotionally and spending time doing activities) and indirect (e.g., providing financially and planning for their children's futures) (Hawkins et al., 2002). The criterion variable for this study, father-gay son involvement (FGSI), was reviewed in relationship to the two predictor variables: past father involvement experiences and father-role confidence.

Past Father Involvement Experiences

For this study, the past father involvement experiences (PFIE) variable includes the participants' activities with a biological father, adoptive father, stepfather or father figure. Research suggests that the primary learning mechanism for fathering behaviors is being fathered (Forste et al., 2009), which is consistent with social learning theories (Bandura, 1971). Intergenerational transmission of parenting behaviors, both positive and negative, is well documented in existing research (e.g., Belsky et al., 2005; Bouchard, 2012; Chen et al., 2008; Conger et al., 2003). Past father involvement experiences predicted future father-son involvement in previous research on family populations in the U.S. (Guzzo, 2011); Turkey (Ünlü-Çetin & Olgan, 2012); and a Jewish kibbutz (Gaunt & Bassi, 2012).

Father-Role Confidence

Father-role confidence in this study is the beliefs a man has about fatherhood, his identity as a father, and his fathering efficacy (Ohan et al., 2000). For fathers of gay sons, the impact of father-role confidence on father involvement has not been considered in the current literature. Existing research suggests that fathers of gay sons may have low fathering efficacy, meaning that they may lack the knowledge or confidence in being a father, regardless of whether their son is gay (Aveline, 2006; Gottlieb, 2000). Jacobs and Kelley (2006) found in their study of paternal involvement that "the more confident fathers felt in the parenting role, the more involved they were in their children's lives" (p. 33). Bouchard et al. (2007) found that men's perceptions of parenting competence provided motivation to participate in childcare activities, especially if they had the support of the mother. In the Kwok et al. (2013) study, fathers with high fathering self-efficacy were involved in a greater number of activities with their children than fathers with low fathering self-efficacy.

Method

Participants and Procedures

Participants (n = 70) were recruited over 18 months across the US using convenience and snowball sampling methods. As shown in Table 1, the age span of participants ranged from 40 to 79. The predominant race/ethnicity of the population was White/Caucasian (87%, n = 61). The race/ethnicity of the remaining participants

consisted of African American (7.1%, *n* = 5), Hispanic/Latino (4.3%, *n* = 3), and Asian American (1.4%, *n* = 1). Most of the ages of the participants' gay sons at the time of the survey ranged from age 18 to 40, with 7.1% (*n* = 5) ranging in age from 15 to 17, and 7.1% (*n* = 5) ranging from age 41 to 50. The highest number of participants (*n* = 62) reported they first learned their son was gay when he was between the ages of 18 to 25. Only six fathers (8.6%) reported that their sons were below the age of 15 when they learned he was gay. Two fathers (2.9%) reported the age when they learned their son was gay as between ages 26 to 30.

The data set for this study was obtained through an online survey, consisting of a brief demographic questionnaire and a series of pre-existing instruments representing the study variables. The demographic questionnaire was designed to collect minimal information regarding the father's age, the father's race, the current age of the gay son, and the timing of when the father learned his son was gay. The remaining portion of the survey was comprised of three different pre-existing instruments to represent the three study variables.

Table 1

Frequencies: Sample Demographics (N = 70)

Fathers of Gay Sons		n	%
Age of Father			
40 – 49		9	13%
50 – 59		35	50.0%
60 – 69		21	30.0%
70 – 79		5	7%
	Total	70	100%
Race/Ethnicity			
White/Caucasian		61	87.1%
African American		5	7.1%
Hispanic/Latino		3	4.3%
Asian American		1	1.4%
	Total	70	100%
Current Age of Gay Son			
15 – 17		5	7.1%
18 – 20		13	18.6%
21 – 25		18	25.7%
26 – 30		13	18.6%
31 – 40		16	22.9%
41 – 50		5	7.1%
	Total	70	100%
Age of Gay Son When Father Learned He Was Gay			
Under 15		6	8.6%
15 – 17		24	34.3%
18 – 20		20	28.6%
21 – 25		18	25.7%
26 – 30		2	2.9%
	Total	70	100%

One interfaith nonprofit organization that provided resources and workshops focused on healing between parents and gay children, agreed to recruit participants for the study. The organization recruited participants by advertising the online survey link in their online newsletter, making direct contacts with potential participants, and emailing survey information to their father healing weekend event attendees. For a limited time,

some participants from the recruitment site were offered a $5.00 virtual Amazon gift card as an incentive to complete the online survey. In addition to the main recruitment site, information about the study was shared through the following methods: personal contacts, personal referrals by participants or those close to participants, social media posts, flyers, and advertisements.

Measures

Father-Gay Son Involvement (FGSI)

The Inventory of Father Involvement (IFI) (Hawkins et al., 2002) was used to measure the type of involvement participants recalled having with their gay sons from infancy through adolescence. The instrument contains 26 items in a Likert scale format, ranging from 1 = never to 7 = always. Higher scores indicate higher levels of father involvement. The IFI (Hawkins et al., 2002) was developed to expand the concept of father involvement to include multidimensional ways fathers are involved with their children. The dimensions of father involvement are measured by the nine IFI subscales: discipline and teaching responsibility, praise and affection, mother support, school encouragement, providing, attentiveness, time and talking together, reading and homework support, and development talents and future concerns.

Validity. Hawkins et al. (2002) demonstrated face validity by use of a focus group of fathers who gave their feedback about the accuracy of the items included in the IFI. Construct validity was determined by analyzing intercorrelations between items in the scale (Hawkins et al., 2002). Comparisons of the *t*-test's means from the surveys of married resident and nonresident father populations were performed to confirm construct validity (Hawkins et al., 2002).

Reliability. Internal consistency reliability testing of the IFI reported a global Cronbach's alpha of .94, with the subscales ranging from .69 to .87 (Hawkins et al., 2002). Reliability of the IFI is demonstrated in numerous other studies, where good psychometric properties were reported when using the IFI with different populations of fathers (Bradford & Hawkins, 2006; Flouri, 2004; Fong & Lam, 2007; Kwok et al., 2013). Similar global Cronbach's alphas (.92 to .96) were reported in a recent study that used the IFI (Kwok et al., 2013). The global Cronbach's alpha for this sample is .95, and subscale alphas range from .71 to .89.

Father-Role Confidence (FRC)

The 8-item Efficacy Subscale of the Parenting Sense of Competence (PSOC) (Johnston & Mash, 1989) instrument measures a parent's perceptions or beliefs about their parenting abilities (Johnston & Mash, 1989; Ohan et al., 2000). The measuring of father-role confidence levels of the participants in this study was related only to the parenting of their gay son. The PSOC Efficacy Subscale was among the instruments positively reviewed for measuring parenting confidence (Črnčec et al., 2010).

Validity. Researchers' testing of the PSOC have provided evidence of internal consistency, divergent, and convergent validity through factor analysis and partial correlation testing (Ohan et al., 2000). Problems of internal validity remain with the instrument's Satisfaction subscale, which is often used separately from the Efficacy subscale (Črnčec et al., 2010; Kwok et al., 2013). Stronger psychometric properties are associated with the Efficacy subscale than with the Satisfaction subscale (Ohan et al., 2000).

Past Father Involvement Experiences (PFIE)

To measure participants' retrospective involvement with their fathers during

childhood and adolescence, the 64-item Fatherhood Scale (FS) (Dick, 2004) was selected. The FS was designed to measure adult men's positive and negative memories of activities, direct or indirect, their fathers did with them or for them. Participants who were not raised by a father, stepfather, or adoptive father were instructed not to complete this portion of the survey. The FS consists of the following nine subscales: positive engagement, positive emotional responsiveness, negative engagement, moral father role, good provider role, gender role model, androgynous role, accessible father, and the responsible father. A total score above 256 indicates a positively engaged father, and a total score lower than 128 would indicate a negatively engaged father (Dick, 2004). The FS has been used along with the IFI (Hawkins et al., 2002) in researching the intergenerational transmission of father involvement in large populations of fathers (e.g., Ünlü-Çetin & Olgan, 2012).

Validity. Content or face validity was determined by reviews from psychology experts in fatherhood research who confirmed the accuracy of the content or recommended changes to wording more consistent with real experiences in father-child relationships (Dick, 2004). Construct validity is confirmed through theoretically based correlations reflected in the instrument items and subscales (Corchran & Fischer, 2013).

Reliability. The FS subscales are significantly intercorrelated and have substantial construct validity with an overall Cronbach's alpha of .98, and the subscale alphas ranged from .80 to .96 (Dick, 2004). The reliability of the FS was demonstrated in subsequent research (e.g., Dick & Bronson, 2005; Rizvi, 2015; Ünlü-Çetin & Olgan, 2012), where the psychometric properties were consistent with the original tests. The global Cronbach's alpha for this sample is .87, and subscales ranged from the lowest at .69 (Negative Paternal Engagement) to the highest at .93 (Positive Paternal Emotional Responsiveness).

Hypotheses

A series of three hypotheses were used to answer the primary research question: What relationship do father-role confidence and past father involvement experiences have with father-gay son involvement? The first research question (RQ) served to determine a statistically significant relationship between the predictor variables. The second and third research questions consider each predictor variable's relationship with the criterion variable.

RQ1: Is there a statistically significant relationship between father-role confidence and past father involvement experiences for fathers of gay sons?
$H1_0$: There is no statistically significant relationship between father-role confidence and past father involvement experiences for fathers of gay sons.
$H1_a$: There is a statistically significant relationship between father-role confidence and past father involvement experiences for fathers of gay sons.

RQ2: Do past father involvement experiences predict father-gay son involvement?
$H2_0$: Past father involvement experiences do not predict father-gay son involvement.
$H2_a$: Past father involvement experiences do predict father-gay son involvement.

RQ3: Does father-role confidence predict father-gay son involvement?
$H3_0$: Father-role confidence does not predict father-gay son involvement.
$H3_a$: Father-role confidence does predict father-gay son involvement.

Data Analysis

The data analysis phase had several steps that were prioritized both by the research questions and theoretical principles. First, the raw survey dataset was imported into an Excel file to enable scoring and formatting of the dataset. Next, the Excel file was imported into IBM SPSS Statistics, Version 23, for analysis. The following steps were performed in SPSS: (a) demographic data (e.g., age, race, etc.) categorical analysis, (b) tests for frequencies and descriptive statistics on all survey instrument responses, (c) computation of variables, (d) computation of Cronbach's alphas for all survey instruments and subscales, (e) Pearson's *r* correlation tests for variables and subscales, (f) graphical and plot tests were performed to verify statistical assumptions, (g) hypothesis testing with ANOVA, and (h) multiple linear regression analysis.

Results

The descriptive statistic results for the criterion variable and predictor variables are found in Table 2. The instrument scores per variable are listed by means, standard deviations, minimum and maximum scores for the overall instrument, and scores individually by subscale. The Cronbach's Alpha for each instrument and subscale, demonstrating reliability for the population in this study, is listed in Table 2. The Pearson *r* correlation test for the IFI, PSOC-Efficacy, and FS subscales are found in Table 3.

Table 2

Descriptive Statistics for Variable Instruments and Subscales

Instruments and Subscales	*M* (*SD*)	Min	Max	Alpha
Father-Gay Son Involvement (IFI, *n* = 70)	152.08 (20.64)	71	182	.95
IFI Providing	13.60 (1.36)	4	14	.89
IFI School Encouragement	18.91 (2.56)	7	21	.77
IFI Praise/Affection	18.49 (2.66)	11	21	.73
IFI Developing Talents/Future Concerns	17.97 (3.08)	8	21	.73
IFI Mother Support	17.69 (3.38)	7	21	.88
IFI Attentiveness	17.21 (2.81)	6	21	.73
IFI Discipline/Teaching	17.06 (3.12)	10	21	.77
IFI Time/Talking Together	15.61 (3.28)	9	21	.75
IFI Reading/Homework Support	15.49 (3.76)	3	21	.83
Father-Role Confidence (PSOC-Efficacy, *n* = 70)	34.04 (7.93)	17	48	.84
Past Father Involvement Experience (FS, *n* = 60)	215.52 (38.07)	135	303	.96
FS Good Provider Role	19.00 (2.59)	10	20	.77
FS Negative Paternal Engagement	47.05 (5.55)	21	54	.78
FS Moral Father Role	16.63 (4.90)	7	25	.78
FS Positive Emotional Responsiveness	41.15 (10.84)	20	60	.93
FS Positive Engagement	15.70 (4.53)	8	25	.88
FS Gender Role Model	17.52 (5.19)	7	27	.78
FS Androgynous Role	20.20 (4.93)	12	32	.69
FS Accessible Father	11.67 (3.91)	5	20	.80
FS Responsible Paternal Engagement	22.67 (8.15)	8	40	.90

Table 3

IFI, FS, PSOC Subscale Correlations

Subscales	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. IFI Discipline	--	.65**	.69**	.13	.53**	.47**	.35**	.49**	.53**	.34**	.28*	.22	.27*	.24	.27*	.17	.19	.04	.42**
2. IFI School		--	.71**	.51**	.60**	.65**	.65**	.62**	.68**	.31*	.25	.20	.29*	.37**	.28*	.29*	.15	.16	.43**
3. IFI Mother Support			--	.40**	.49**	.62**	.51**	.60**	.63**	.44**	.40**	.24	.37**	.40**	.44**	.39**	.27*	.26*	.50**
4. IFI Providing				--	.19	.22	.43**	.34**	.49**	.17	.04	.01	.12	.25	.06	.22	.02	.28*	.09
5. IFI Time/Talking					--	.74**	.67**	.77**	.68**	.53**	.49**	.56**	.55**	.54**	.46**	.20	.26*	-.01	.67**
6. IFI Praise/ Affection						--	.55**	.69**	.60**	.38**	.37**	.36**	.35**	.44**	.42**	.27*	.12	.16	.47**
7. IFI Talent/Future							--	.66**	.70**	.40**	.32*	.34**	.34**	.44**	.34**	.30*	.20	.23	.46**
8. IFI Reading								--	.70**	.48**	.37**	.41**	.38**	.39**	.31*	.21	.14	.12	.48**
9. IFI Attentiveness									--	.37**	.26*	.30*	.34**	.34**	.25	.29*	.08	.15	.56**
10. FSRPE.										--	.75**	.80**	.72**	.70**	.68**	.40**	.43**	.11	.54**
11. FSAF											--	.79**	.70**	.78**	.81**	.37**	.34**	.06	.46**
12. FSPE.												--	.75**	.78**	.69**	.32*	.30*	.10	.47**
13. FSAR													--	.78**	.72**	.23	.25	.10	.55**
14. FSPPER														--	.80**	.35**	.28*	.26*	.43**
15. FSGRM															--	.49**	.35**	.08	.47**
16. FSMFR																--	.38**	.03	.42**
17. FSGPR																	--	.05	.38**
18. FSNPE																		--	.05
19. PSOC Efficacy																			--

Note. *$p < .05$, two-tailed. **$p < .01$, two-tailed. FSRPE = Fatherhood Scale Responsible Paternal Engagement, FSAF = Fatherhood Scale Accessible Father, FSPE = Fatherhood Scale Positive Engagement, FSAR = Fatherhood Scale Androgynous Role. FSPPER = Fatherhood Scale Positive Paternal Engagement Responsiveness, FSGRM = Fatherhood Scale Gender Role Model, FSMFR = Fatherhood Scale Moral Father Role, FSGPR = Good Provider Role, FSNPE = Fatherhood Scale Negative Paternal Engagement

Father-Gay Son Involvement (FGSI) Variable

The maximum score for the IFI (Hawkins et al., 2002) was 186, which means that a father responded "always" to the frequency he spent in the fathering activities listed in the instrument. The IFI subscales are listed individually to indicate the multiple ways fathers recalled being involved with their gay sons in this study. The mean score was 152 for the fathers in this study (n = 70), with the highest scores for the "providing" subscale (M = 13.60, SD = 1.36). The lowest scores for the "time and talking together" subscale (M = 15.61, SD = 3.28) and "reading/homework support" subscale (M = 15.49, SD = 3.76).

Past Father Involvement Experiences (PFIE) Variable

In Table 2, the nine FS (Dick, 2004) scales were listed individually to show the types of involvement each study participant recalled having with his father. Total instrument scores between 128 and 256 are linked to low to moderate levels of positive paternal engagement. Of the participants in this study, only seven participants (10%) scored above 256. The mean score for the population in this study was 215 (n = 60). In the FS scoring, 10 participants could not complete the questionnaire because they did not have a father or father figure.

Father-Role Confidence (FRC) Variable

The mean score for father-role confidence measured by PSOC Efficacy Subscale (Johnston & Mash, 1989) was 34.04 (SD = 7.39). As shown in Table 2, the lowest score was 17 and the highest score was 48, which was the maximum possible score. The ranges of father-role confidence scores are depicted in more detail in Table 4.

Table 4

Father-Role Confidence Scores

	Score Range	*N*	%	Cumulative %
Low	17–32	26	37%	37%
Moderate	33–40	27	38%	75%
Moderate-High	41–45	11	17%	92%
High	46–48	6	8%	100%

Note: Father-Role Confidence scores measured by the PSOC Efficacy subscale

Hypothesis Testing

Prior to testing the hypotheses, a series of underlying assumptions should be confirmed through statistical checks (Hair et al., 2010). The variables were checked for the following conditions: normality, linearity, multicollinearity, homoscedasticity, and the presence of outliers. The tests performed included the use of histograms, residual scatter plots, normal p-p plots, and residual scores for Cook's distance < .5 for outlier inclusion decisions. After it was determined the statistical assumptions had been met, the statistical testing of the hypotheses was undertaken.

Hypothesis One

The relationship between the FRC and PFIE variables was determined through statistical tests in SPSS. The PSOC efficacy

subscale, used to measure the FRC variable, was moderately, positively, and significantly correlated with the FS subscales, used to measure the PFIE variable, except for the negative paternal engagement subscale (see Table 2). The Pearson *r* correlation results for the PFIE and FRC variables were positive and significant at .559 ($p < .01$). As Table 5 shows, the PFIE variable was found to be a significant contributor to the FRC variable ($F(1, 58) = 26.33, p < .000$). The null hypothesis was rejected with a confidence interval alpha of 95%. Additionally, the regression analysis results confirm that PFIE predicts FRC, with 31.2% of the variance in the FRC variable explained by the PFIE variable.

Table 5

Regression Analysis Summary for PFIE Predicting FRC

Variable	*B*	*SE B*	*β*	R^2	*F*	*df*	*p*
Constant	9.386	4.878					.059
PFIE	.114	.022	.559	.312	26.33	1, 58	.000

Dependent Variable: Father-Role Confidence (Constant)

Hypothesis Two

The second hypothesis, that the PFIE variable would predict the FGSI variable, was confirmed through step one of the two-step multiple regression analyses performed in SPSS as shown in Table 6. The PFIE variable accounted for 27.7% of the variance in FGSI scores. Total scores for the PFIE variable were entered as an independent or predictor variable in Step One. The PFIE variable was found to have a statistically significant relationship with the FGSI variable through the ANOVA test results ($F(1, 58) = 22.186, p < .000$). The null hypothesis was rejected at an alpha level of 95%. In Step One of Table 6, the PFIE variable was shown to be a statistically significant predictor of the FGSI variable ($\beta = .526$, $t = 4.710$, $p = .001$). This result is expected based on Bandura's (1962, 1971) social learning theory; however, other circumstances known to impact father involvement, such as being a residential father versus a non-residential father, the marital relationship, the father's employment, or whether the father suffered from mental and physical illness (Pleck, 1997), were not measured.

Table 6

Two-Step Regression Analysis Summary for Variables Predicting Father-Gay Son Involvement

Step and Predictor Variable	*B*	*SE B*	*β*	R^2	ΔR^2	*p*	*t*
Step One:							
PFIE	.285	.061	.526	.277	.277	.000	4.710
Step Two:							
PFIE	.149	.066	.275	.277	.277	.028	2.253
FRC	1.189	.323	.449	.415	.139	.001	3.677

Hypothesis Three

In Step Two of the multiple regression analysis, the hypothesis for question three was confirmed, with the FRC variable (β = .449, $p < .001$) accounting for an additional 13.9% of the variance in the FGSI variable. At an alpha level of 95%, the ANOVA test confirmed the rejection of the null hypothesis. A statistically significant relationship was confirmed between the predictor variables and the criterion variable, FGSI (F (2,57) = 20.245, $p < .000$).

The combined PFIE and FRC predictor variables accounted for 41.5% of the variance of the FGSI variable. This means that participants' interactions with their gay sons were significantly influenced both by their past experiences being fathered and their level of confidence as a father. The finding that the FRC variable had a stronger beta weight than the PFIE variable as an influence on the FGSI variable was not expected, based on the theoretical framework.

Discussion

The father-gay son involvement is best understood by reviewing the nine IFI subscales. The five subscales measuring indirect father involvement (providing, praise and affection, developing talents and future concerns, school encouragement, and mother support) are comprised of activities that do not require the physical presence of the father. For example, praise and affection is a measure of verbal comments (e.g., praising your child for being good or doing the right thing, telling your child you love them) and not a measure of physical affection between a father and his child. The four subscales measuring indirect father involvement (discipline and teaching responsibility, time and talking together, reading and homework support) are comprised of activities requiring the physical presence and time investment of the father with the child.

This population scored highest for indirect involvement subscales, such as the "providing" subscale (M = 13.60, SD = 1.36). The highest score means that 83% (n = 58) of the participants responded that they recalled "always" providing financially for their gay son. The providing subscale was followed in order by the other four indirect, less physical engagement subscales where fathers responded that they recalled "always" performing these activities: school encouragement 34% (n = 24), praise and affection 33% (n = 23), mother support 31% (n = 22), and developing talents and future concerns 29% (n = 20).

The lowest level of father involvement the participants recalled having with their gay sons was in direct physical engagement activities, such as the reading and homework support subscale (M = 15.49, SD = 3.76) and the time and talking together subscale (M = 15.61, SD = 3.28). The time and talking together subscale included items like "I was a pal or friend to my son" or "I spent time just talking with my son when he wanted to talk about something." The reading and homework support subscale included items such as "I read to my son" and "I helped my son with homework." Only eight fathers (11%) had the highest score (21/21) for time and talking together subscale, meaning that they recalled "always" engaging in the behaviors. Six fathers (8%) had the highest score (21/21) for the reading and homework support subscale.

Regarding the participants' high scores in the IFI (Hawkins et al., 2002) providing subscale, there are some limitations in making a unique interpretation for fathers of gay sons. Financial provision is the primary father involvement activity with other father populations as well (e.g., Kwok et al., 2013; Ünlü-Çetin & Olgan, 2012). The IFI (Hawkins et al.) providing subscale in this study was not significantly correlated with the PSOC efficacy subscale (Johnston &

Mash, 1989) or FS (Dick, 2004) scores. The participants in this study were not asked about their relationship with the gay sons' mothers nor if they were residential or non-residential fathers. The participants' higher levels of indirect, non-physically engaged father involvement in this study may be indicative of being a non-residential father, however, that information was not included in the demographic data collected. Financial provision may be imposed in the form of court-ordered child support, making this form of indirect father involvement unrelated to the FRC or PFIE variables by maternal relationship barriers (Fagan & Barnett, 2003).

Father-role confidence can be influenced by other factors not measured in this study, such as marital satisfaction (Kwok et al., 2013; Murdock, 2013; Sevigny & Loutzenhiser, 2010; Sevigny et al., 2016). The results should be interpreted with caution since the moderation is slight, but research indicates that a positive relationship with the child's mother as a co-parent improves parenting self-efficacy (Murdock, 2013; Sevigny et al., 2016) and acts as a buffer for transmission of negative generational parenting in men (Lunkenheimer et al., 2006). Research indicates that the behavioral outcomes of children are a predictor of parenting self-efficacy for mothers, but not fathers (Murdock, 2013; Sevigny et al., 2016), which is an important factor to consider when interpreting the results of this study. According to Bandura's (1977) self-efficacy theory, even with parenting instruction or a desire not to repeat negative parenting behavior, men must have obstacle-free opportunities to perform successfully and established coping skills when met with adversity to engage with their children confidently (Schofield et al., 2014).

The indication that parenting efficacy is predicted by past experiences with a man's father is consistent with Bandura's (1982) self-efficacy theory; however, this theoretical application is not consistently considered when recommending counseling interventions with fathers of gay sons. One reason for this overlooked consideration for fathers of gay sons is that research into fathers' parenting self-efficacy separate from mothers' parenting self-efficacy is relatively a new area of study (Sevigny et al., 2016). Another strong predictor of men's parenting self-efficacy is his co-parenting marital relationship with the child's mother, which may buffer the negative impact of a man's lack of experiences with his father (Sevigny et al., 2016).

A high percentage (89%) of the participants did not have a highly involved nurturing father of their own. In comparison, only 16% of the participants (fathers of heterosexual children) in the Long et al. (2014) study reported not having a close relationship with their fathers. The results of this study are mirrored in Gottlieb's (2000) qualitative work on fathers of gay sons, where the fathers without nurturing fathers struggled to connect with their gay sons. Gottlieb observed from his research that fathers of gay sons who grew up without an involved nurturing father were likely to play the breadwinner role as their primary father involvement when becoming a parent themselves.

Participants' overall scores on involvement with their gay sons were higher if they reported having a nurturing, highly involved father of their own. Other parenting research shows that only certain types of father involvement, direct physical engagement, promote feelings of father-child connection (Finley & Swartz, 2004). Previous studies on father involvement indicate that the strongest predictor of father-child connectedness is regular participation with the child in recreational activities or play (Brotherson et al., Goodsell et al., 2011). Participants with low PFIE scores, also

scored lower in regular participation with the direct physical engagement activities on the IFI (Hawkins et al., 2002) subscales, indicating a weak father-gay son connection for the participants in this study.

The FS (Dick, 2004) scores were consistent with the IFI (Hawkins et al. 2002) scores, where only 11% of participants reported having a nurturing relationship with their fathers. The smaller percentage of fathers that were involved in direct ways with their gay sons had the highest PCOS efficacy subscale scores and the highest FS subscale scores. These results do not imply that having a gay son represents causation for low father-role confidence, rather the father's confidence as a parent was influenced by past experiences with his father and not by having a son who eventually identified as gay.

Limitations

The limitations are discussed in terms of what could be improved to enhance the study's results if a similar study is conducted in the future. The limitations of this study include the scope of inquiry, the instruments used, the online data collection process, and sample size. Certain inquiries not included in this study, or delimiters, are discussed in terms of how their inclusion could improve or expand upon the results of this study.

Scope of inquiry. This study was limited by means of the topic selected, which was English-speaking fathers of gay sons living in the U.S. Other cultures may experience fathering a gay son differently or need adjustments to the language of the instruments used. There may be a population of fathers of gay sons living in the U.S. who do not speak English, that could have been included in this study.

Instrumentation. To measure levels of father involvement with a gay son, father-role confidence, and own father's involvement, the data collected was limited by the choices offered on the IFI (Hawkins et al., 2002), the FS (Dick, 2004), and the PSOC Efficacy subscale (Johnston & Mash, 1998). The order and number of instruments may have been a limitation. The order of instruments included in the survey was considered carefully to promote completion. Completion of the IFI first would allow participants to think about numerous positive ways they contributed to their sons' lives prior to asking about their thoughts or beliefs about fatherhood in the PSOC Efficacy subscale. The FS instrument, which was inserted as the final instrument, could only be completed by participants who were raised by a father.

Data collection limitations. The data collection process was challenging because of the hard-to-reach population. Random sampling is not a reasonable option for such a specifically defined and hidden population like fathers of gay sons. Snowball sampling—or using others to recruit known fathers of gay sons—worked better than advertising. The challenges of using an online survey include having limited control over the identity of the participant taking the online survey recruited through snowball sampling.

Sample limitations. The original goal of this study was to obtain a sample size of at least 96 to obtain optimal statistical power determined by the Raosoft calculator. While the sample size of this study on fathers of gay sons is considered large compared to previous studies, it was still too small to conduct group comparisons within the sample. With a larger sample size, the participants who did not indicate having a father-figure raise them (n = 10) could have been compared to those that did (n = 60).

Future Research

What was not covered by the scope of this study was the father's relationship with the gay son's mother and the current health of the father-gay son relationship. Future studies could expand the collection of demographic

information on fathers of gay sons because they may play a role in father involvement. For example, no information was collected as to the religious affiliations, the level of education, the employment status, or the marital status of the fathers in this study. Previous studies on father involvement have included these demographic variables such as age and marital satisfaction as factors that impact father involvement (Kwok et al., 2013).

Researchers could examine more details of the father-gay son relationship related to father involvement. What is also not known in this study is how learning of the son's sexual orientation impacted father involvement for younger gay sons still living in the home with the father. Future research could include either a qualitative or quantitative element to explore the current health of the father-gay son relationship and whether counseling approaches with fathers of gay sons improve the future health of the relationship from both the father and gay son's perspectives.

Conclusions

Correlational research is suitable to inform counseling interventions when combined with experimental research literature of clinical interventions and their outcomes with specific populations (Thompson et al., 2005). Conclusions from this study raise three areas of concern in counseling practice. First, the father-gay son relationship was explored from the father's perspective instead of the son's expands the understanding of the relational deficits of gay men's fathers. Based on the literature reviewed on fathers of gay sons and the results of this study, counselors may need to consider the wounds and relational deficits fathers have (Miller, 2010) when including fathers in interventions focused on the gay son's healing. The fathers with their own father wounds possibly lack the relationship skills necessary to father their sons in nurturing ways. Fathers may have challenges with being emotionally available to their gay sons, based on the lack of their own father's involvement or not having close non-sexual relationships with other men themselves (Horn & Wong, 2016).

Second, there is a connection between low father-role confidence and the types of father involvement activities men perform. The social learning (Bandura, 1962, 1971) and self-efficacy (Bandura, 1983, 1986) theoretical framework is confirmed in the results of this study. The results indicate that fathers' involvement with their gay sons may be limited due to low father-role confidence and not having learned positive fathering behavior from their family of origin. Based on the results of this study, fathers may need help improving their relationship with their sons because they have neither learned positive fathering skills nor possessed the confidence as fathers to connect with their sons on an emotional level. As both Gottlieb (2000) and Bucher (2014) indicated, fathers of gay sons often have unresolved mental health issues and relational wounds to confront before working on the relationship with their gay son.

Third, relational deficits in the fathers-gay son relationship may have more to do with a lack of involvement men have with their fathers than with the sexual orientation of their sons. According to social learning theory, new behaviors can be learned, but behavioral reinforcement through social support must exist for lasting behavioral changes to occur (Bouchard, 2012). Fathers of gay sons will benefit from developing relationships with other fathers in social organizations where they could learn through modeling the behavior of fathers who experience close father-son relationships. Counseling sessions heavily concentrated on the therapist providing psychoeducational information about accepting a gay son are

unlikely to promote changes in the father's behaviors, attitudes, or relational skills if social supports are missing.

Counselors ought not dismiss fathers' expressions of regret over their parenting choices with their gay sons but use these expressions of regret as motivation to improve relationships with their gay sons. Fathers of gay sons could benefit from knowing what types of involvement are perceived as nurturing by their gay sons. By exploring the father's relational deficits from not having a nurturing relationship with another man, fathers may be encouraged to adopt more nurturing approaches when parenting their children. Adopting a problem-solving approach that is tailored to the father's relational history promotes a therapeutic alliance and helps prevent early termination of the counseling process.

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A Brief Review of *Homosexuality, Aids, and the CDC*

By The Millennium First Initiative[1]

Reviewed by

Keith Vennum, M.D.[2]

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This monograph of 89 pages describes itself as a collection of peer-reviewed studies and book excerpts on the Aids Epidemic and Homosexuality in the American Culture. This comprises the majority of the presentation, but not incidentally, other items are included such as news articles, non-peer-reviewed books, media awards, surveys, photos and other material to flesh out the narrative.

Historians, politicians, medical workers, and researchers looking at issues related to homosexuality would find this book most useful. Researchers looking for recent studies would find it lacking as only six studies are cited for the years 2000 and 2001. The bulk of 78 of the 169 citations fall between 1980 and 2000. That being said the citations used are of the highest order and most useful to the topic presented. Those interested would capture the leaders and most solid researchers and clinicians of the past.

Many topics are covered including promiscuity, pedophilia, disease control, research practices, psychotherapy, marriage, physical and mental health, and substance abuse. Appendix A discusses Reparative Therapy, Appendix B examines Genetic Theories of Sexual Orientation, and Appendix C presents A comparison of 12-month and lifetime disorders between heterosexual, gay/lesbian, and bisexual populations.

One is reminded of *Successful Outcomes of Sexual Orientation Change Efforts* (2014) by James Phelan, which is a similar monograph with citations directed toward similar issues.

[1] The Millennium First Initiative is an Ohio-based think tank that focuses on providing novel solutions to long-standing social problems, and is the author of a book entitled *Homosexuality, Aids and the CDC*, which deals with the failure of the CDC to control the Aids virus, and the impact the drive to normalize homosexuality is having on American culture.

Correspondence regarding the book should be directed to The Millennium First Initiative at TMFI@startmail.com

[2] Keith Vennum MD, LMHC, is Past-President of the Alliance for Therapeutic Choice and practices mental health counseling part-time in Orlando, Florida, where he is licensed and in good standing as a mental health counselor.

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Review of Maria Keffler's[1] *Desist, Detrans, & Detox: Getting Your Child Out of the Gender*

Reviewed by

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The author of *Desist, Detrans & Detox: Getting Your Child Out of the Gender Cult*, Maria Keffler, is the co-founder of Partners for Ethical Care, a grassroots non-profit organization that works to "raise awareness and support efforts to stop the unethical treatment of children by schools, hospitals, and mental and medical healthcare providers under the duplicitous banner of gender identity affirmation" (Partners for Ethical Care, 2021). Understanding the content of the book begins with defining the words in the title. For example, the word "desist" means to accept your birth gender after formerly identifying as transgender. To "detrans" means to transition back to your birth gender after having gone through some degree of gender transition through outward appearance alterations, drugs, and/or surgery. The author uses the word "detox" to compare the process of rejecting the toxic, false gender ideology to that of as going through a drug detox program (Partners for Ethical Care).

Keffler wrote the book in response to the exponentially high increase of transgender identification in children and young adolescence, particularly girls. She refers to the over 5000% increase in gender dysphoria for girls and almost 1500% increase for boys at the Tavistock Clinic in the UK over the last 10 years (Transgender Trend, 2020). The book is intended to provide strategies for parents to utilize with transgender identifying children; however, no evidence is provided that these strategies are universally successful in every case. Keffler's strategies are based on information on cults, brainwashing techniques, education, psychology, and child development. Stories and comments from people that

[1] Maria Keffler is a co-founder of Partners for Ethical Care. She is an author, teacher, and public speaker. Keffler has a background in educational psychology and resides in Arlington, VA.

[2] Sheri Golden, PhD, practices as a licensed professional counselor in Illinois. She serves as the Director of The Steeple Institute of Research, Counseling, and Education, in Arlington Heights, IL. She serves as a member of the research committee for the Alliance of Therapeutic Choice and Scientific Integrity.

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detransitioned in Appendix B provide anecdotal support for parents to apply the techniques and approaches given in this book.

The target audience for the book is conservative Christian parents rather than academic or counseling professionals. Although the book is not overtly full of Christian content, there is a section discussing theological principles about gender from the Bible. The author's discussion of gender ideology (i.e., sex is binary) and expressed views on organizations like Planned Parenthood, follows along politically conservative party lines. The book also refers to family therapy theory, setting boundaries, and motivational theory, which are interventions often utilized by professional counselors. Keffler provides guidance for parents seeking a counselor or mental health therapist that is "non-affirming" of gender ideology.

The book contains two main sections: 1) Seven chapters covering a complete range of topics related to gender ideology and current social constructs; and 2) Appendixes (A, B, C). Appendix A contains quoted statements from de-transitioned individuals. Appendix B presents the results from 2021 survey of "detransitioners" or "desisters" conducted by Partners for Ethical Care. Appendix C provides an example of a letter parents can use to opt out of mandatory sex education programs in schools. Since there are several new words created by the gender identity social movement, a helpful glossary is included in the back of the book.

The book does not have a consistent flow from one chapter to the next. Chapters one, two, three, and seven focus on aspects of the gender cult in society that may or may not be influencing every child. In these chapters, examples from websites, news articles, social media, and books are provided to explain how the current trends in transgender ideology are like a cult. Chapters three, five, and six are dedicated to family dynamics and relationship-building skills. In these chapters, the author explores family of origin issues, relationship deficits, and parenting styles that contribute to the problem as well as to the solution.

I. Gender Ideology Is a Cult

Chapter one describes how the gender identity social activists behave like a cult. Keffler discusses eight steps that cult groups use to gather and indoctrinate followers based on an article in the *New Zealand Herald* (Norman, 2017). Keffler indicates that cults entrap vulnerable people into their organization through a process of identity engineering (Edge, 2015). The use of the term "deadnaming"—when a transgender identifying person's name given at birth is rejected as if that part of themselves no longer exists—demonstrates an identity engineering technique. The goal is to "kill off" all aspects of who the person was in favor of the identity the cult wants the person to have.

Chapter four continues to discuss the cult-like experience of young people de-transitioning back to their biological gender. They require a processing of deprogramming, which is described in detail. To begin the process, Keffler suggests: 1) find out exactly what happened and what is really happening with the child; 2) determine which influences in the child's life are pro- or anti-transgender ideology; 3) initiate a campaign to undo brainwashing of the child. The end of the chapter provides a complete summary of steps to take and the expected goals of each step.

Chapter seven addresses what parents can do to keep their child from regressing or being pulled back into the cult. Keffler indicates that after leaving the transgender cult, a child may experience fear of those outside the cult, adulthood, their sexuality, being a victim, lacking control, etc. Keffler provides examples of how the transgender

movement uses fear as a motivator to keep members from leaving. With a trustworthy professional counselor, talk therapy interventions that are helpful to a detransitioning child's healing from post-cult fears include exposure therapy, cognitive behavioral therapy, and mindfulness therapy (Stanborough, 2020).

II. Healthy Family Relationships Are Necessary

Chapter three explores how parents cope with their transgender child, beginning with young children, under the age of 12. Keffler cites the work of Dr. Michelle Cretella (2020) with a young boy mistakenly believing he needed to be a girl like his special needs sister to get attention and be loved. With the help of a therapist, the parents were able to explore the beliefs of their son and offer the needed reassurance he was missing. He subsequently abandoned his notion that he was a girl and went back to being a boy.

For pre-teen, teens, and adult children who identify as transgender, Keffler offers suggestions to improve communication. If talking does not work with a pre-teen/teen, using a shared note pad to communicate information back and forth can facilitate a more thoughtful conversation that avoids elevated tones or yelling. Keffler gives five relationship-improving tips for parents to use with transgender identifying children: 1) make all interactions positive; 2) use open-ended questions; 3) listen 80/ speak 20; 4) praise things they do, not who they are; and 5) in crisis ask what they need, not tell them what to do (pp. 73–74). Keffler does offer encouragement for parents with children 18 years and older to keep things positive and to not let oneself be manipulated.

Chapter five, "Unfailing Love," contains information about maintaining love not only for your child who has left home and joined the gender cult but for the parents themselves. Parents often feel a sense of guilt or failure that how their child turned out is their own fault or that they did not do enough to prevent the influences on their child early enough. Keffler stresses the need for parents of being in charge of boundaries with tough love, guiding the gender identity formation of their children, and being parents rather than friends with their children.

In chapter six, "the rest of the family," Keffler advises for families dealing with a transgender child on self-care and seeking additional help. Parents consumed by the identity confusion of their child often forget to care for their marriage or consistently parent their other children if they have them. Keffler gives details on how to find a trustworthy therapist for family counseling by giving a series of questions to ask before the first counseling session. She tells readers that there are excellent therapists who will explore a child's medical, psychological, and social history. An excellent therapist will provide evidence-based therapy, without giving a desired gender dysphoria diagnosis after one meeting or engaging in an unproven treatment approach. According to Keffler, one question to ask a potential therapist before scheduling an appointment is: "What is your opinion on transgenderism/gender ideology with respect to co-occurring issues like autism, anxiety, self-harm, prior trauma, substance abuse, and eating disorders?" (p. 139).

III. Results from the 2021 Desister/Detransitioner Survey

Partners for Ethical Care conducted an informal, non-randomized survey of 60 people, desisters/detransitioners and parents, during February of 2021. The participants were comprised of the following: 1) desisters—individuals who either stopped insisting they were some other genders than their birth genders, 2) detransitioners—individuals who reversed the process of transitioning to the opposite sex by changing

their appearance outwardly, and 3) parents of a transgender-identified child. The option was given to complete the survey anonymously although half of the participants included contact information. Most of the survey participants (71.7%) were desisters/detransitioners and female (78.3%). Keffler stipulates that the survey results must be considered with caution. The survey was informal, the sample was small, and no official authentication of the results could be performed.

The most significant question asked was the one related to the mental health of the child. For example, Question 22 of the survey asked for the following information: "Does the child have any diagnosed or suspected health, psychological, or neurological issues?" (Keffler, 2021, p. 193) Participants could respond to more than one answer. Of the issues selected, 75.9% had depression, 50% had suicide ideation, 46.6% had trauma, 37.9% had autism, and 22.4% had at least one suicide attempt. The results of Question 22 demonstrate the importance of addressing mental health issues in people struggling with their gender identity.

IV. Final Thoughts

Keffler's book can be a useful tool for therapists to share with parents who lack understanding of what new world their child has entered. By using the cult analogy, parents have a clearer picture of how difficult the battle is. More help is needed for the child than just a conversation or a visit to a therapist. While there are no standard approaches to use in every situation, Keffler combines techniques to try that are validated in parenting, psychology, and educational research. More research is needed to determine the best approach for those detransitioning. The push to deny the existence of desisters and detransitioners persists and inhibits the publishing of this information (Shirer, 2020).

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A Review of the Documentary *Pray Away*

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"If one more person who was never involved in Exodus speaks for what Exodus did and believed, I may just lose it. The *Pray Away* film has got everyone sharing their uniformed opinion," wrote Brenna, a former Exodus International director.

Exodus International, the widely known ex-gay Christian organization, has recently been taken to task by the 2021 Netflix film *Pray Away*. Directed by Kristine Stolakis, the film features the testimonies of a few former Exodus International leaders who use emotional appeal to claim that the goal of leaving homosexual behavior or practice caused trauma for those who later embraced gay relationships and identity.

It is not surprising so many reviews of the Netflix film *Pray Away* lambaste the organization that used to be Exodus International. After all, since it was shut down in 2013, Exodus has become a convenient tool to use as a scapegoat. But if scapegoating is allowed to continue, it will end up being a useful tool to demonize those who hold to biblical sexuality.

What's perhaps most distressing is that those doing the denigrating have absolutely no connection with the organization about which they write, nor the people featured in the documentary. Becket Cook, for example, who reviewed *Pray Away* for The Gospel Coalition, had no concept of what Exodus was or was not. "Exodus International was missing the forest through the trees, setting people up for failure," Cook wrote. It would have been helpful if he knew of what he wrote.

I, on the other hand, have a long history with Exodus starting in 1988. I personally received help from a local Exodus ministry in northern California and then gave back help and hope to others seeking to walk faithfully

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with Jesus and leave behind old identities and behaviors. I helped in women's ministry at my local church in the San Francisco Bay Area; led women's ministry in Portland, Oregon; served on the board of a local ministry; taught routinely at the Exodus annual conference; and served on the Exodus board of directors for several years. The film also includes my ex-husband, who re-entered gay identity and relationships that ended our 21-year marriage.

While the *Boy Erased* movie was pure fiction, *Pray Away* is an emotive weapon that has some semblance of reality. Semblance is not the whole picture, nor even an accurate picture, taken from those who have renounced Jesus's call, "If anyone wishes to come after Me, he must deny himself, and take up his cross daily and follow Me" (Luke 9:23).

In the earliest days of Exodus, Frank Worthen—a co-founder of Exodus—said that if the organization no longer pursued holiness, it would no longer exist. In the end, the final leaders had compromised personally and theologically, capitulating to cultural ideals about sexuality rather than to the Author of the Gospel.

The movie has roused sympathy for the five souls who thought they could leave LGBT, conceive of an identity outside of their sexual feelings, and live set apart from homosexual identity and behavior—only to abandon that pursuit in various ways. The movie has not—of course—roused sympathy for those who have left LGBT and remain faithful to Christ and biblical teaching contained in Scripture. It also did not give an accurate picture of what Exodus was, what it promised (or rather, what it did *not* promise), and mis-characterized Exodus as a pseudo-psychological organization. It conflated psychology with Christian discipleship.

The sympathetic characters in the documentary were actually the ones who added confusion during their leadership roles in Exodus's later years. Alan Chambers and Randy Thomas popularized the message, "Change is possible!" with ad campaigns that did not spell out exactly what change meant. John Paulk[2] denied the truth that he continued to have same-sex attraction while representing Exodus in media. Yvette Schneider is likely the one who brought Exodus into political action because of her past in policy. I find it ironic that the charges of dishonesty and toxic counsel are leveled by them toward the rest of us who continue to follow Jesus out of our LGBT pasts. Amazing!

So, let's correct the record: Exodus International did not promise a removal of homosexual feelings; instead, it offered help to walk faithfully with Jesus away from homosexuality. Exodus also offered support for those who did not see their sexual feelings as a moral imperative to embrace. That perspective, filmmaker Stolakis stated clearly in *Newsweek,* "creates self-hatred in the deepest and darkest of ways while self-harm is such a part of this movement."

Stolakis did not affirm her uncle's choice to not live according to his sexual feelings, yet it is a person's right to live according to their highest values—whether it be gay feelings or biblical beliefs. Some people go back into gay relationships, some continue to deal with residual same-sex attraction of one degree or another, some no longer deal with same-sex attraction on a regular basis, if at all. Why not accept that all of these are potentials and that there is honor before God in not embracing sexual immorality? Why should others be allowed to judge those of us who have abandoned our pasts for the One who loves us more? Where is the tolerance of those of us who walk out of LGBT because

[2] Additional insights on John's return to a gay identity can be found in a piece written by Joseph Nicolosi, Sr. at https://www.josephnicolosi.com/my-old-friend-john-paulk

of the incredible love of Jesus and have faithfully lived this experience with joy?

Scapegoating what Exodus truly was, not the cartoon it is made out to be in *Pray Away*, will only serve to offer a tool to those who wish to despise the Gospel and those who hold to scriptural beliefs.