No. 21-35815

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIAN TINGLEY,
Plaintiff-Appellant,
v.
ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; UMAIR A. SHAH, in his official capacity as Secretary of Health for the State of Washington; KRISTIN PETERSON, in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,
Defendants-Appellees,

EQUAL RIGHTS WASHINGTON,
Intervenor-Defendant-Appellee.

On Appeal from the United States District Court for the Western District of Washington
Case No. 3:21-cv-05359-RJB, Hon. Robert J. Bryan

BRIEF OF AMICI CURIAE THE TREVOR PROJECT, INC., AMERICAN FOUNDATION FOR SUICIDE PREVENTION, AND AMERICAN ASSOCIATION OF SUICIDOLOGY, IN SUPPORT OF DEFENDANT-APPELLEES AND AFFIRMANCE

J. Denise Diskin
denise@qlawfoundation.org
QLAW FOUNDATION OF WASHINGTON
101 Yesler Way #300
Seattle, WA 98104
Telephone: (206) 483-2725

Shireen A. Barday
sbarday@gibsondunn.com
GIBSON, DUNN & CRUTCHER LLP
200 Park Avenue
New York, NY 10166
Telephone: (213) 351-4000

Isaac Ruiz
iruiz@ruizandsmart.com
RUIZ & SMART PLLC
1200 Fifth Avenue, Suite 1220
Seattle, WA 98101
Telephone: (206) 203-9100

Attorneys for Amici Curiae The Trevor Project, Inc., American Foundation for Suicide Prevention, and American Association of Suicidology

CORPORATE DISCLOSURE STATEMENT

Under Federal Rule of Appellate Procedure 26.1, Amicus Curiae The Trevor Project, Inc. certifies that it is a non-profit crisis services, advocacy, and research organization that has no publicly held corporate parents, affiliates, and/or subsidiaries.

Under Federal Rule of Appellate Procedure 26.1, Amicus Curiae American Foundation for Suicide Prevention certifies that it is a non-profit health, research, education, and advocacy organization that has no publicly held corporate parents, affiliates, and/or subsidiaries.

Under Federal Rule of Appellate Procedure 26.1, Amicus Curiae American Association of Suicidology certifies that it is a non-profit health, research, education, and advocacy organization that has no publicly held corporate parents, affiliates, and/or subsidiaries.

Dated: January 21, 2022

s/ Shireen A. Barday
Shireen A. Barday

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

TABLE OF AUTHORITIES (*continued*)

Page(s)

OTHER AUTHORITIES

TABLE OF AUTHORITIES (*continued*)

Page(s)

TABLE OF AUTHORITIES (*continued*)

Page(s)

IDENTITY AND INTEREST OF AMICI CURIAE AND SOURCE OF THEIR AUTHORITY TO FILE THIS BRIEF

The Trevor Project, Inc. is the world's largest suicide prevention and crisis intervention organization for lesbian, gay, bisexual, transgender, queer & questioning ("LGBTQ") young people. The Trevor Project offers the only accredited, free, and confidential phone, instant message, and text messaging crisis intervention services for LGBTQ youth, which are used by thousands of youth each month. Through analyzing data derived from these services and national surveys, The Trevor Project produces innovative research that brings new knowledge, with clinical implications, to issues affecting LGBTQ youth.

The American Foundation for Suicide Prevention ("AFSP") is dedicated to saving lives and bringing hope to those affected by suicide. In carrying out its mission, AFSP funds scientific research, educates the public about mental health and suicide prevention, advocates for public policies in mental health and suicide prevention, and supports survivors of suicide loss and those affected by suicide.

The American Association of Suicidology ("AAS") is a nationally recognized organization comprised of public health and mental health professionals, researchers, suicide prevention and crisis intervention centers, survivors of suicide loss, attempt survivors, and others, that promotes the prevention of suicide through research, public awareness programs, education, and training. In addition to advancing suicidology as a science—developing and disseminating scholarly

research on suicidology and suicide behaviors—AAS promotes public education and training for professionals and volunteers on suicide prevention and intervention. AAS is also an accrediting body for crisis services providers.

Amici have a special interest in this litigation as well as familiarity and knowledge of the significant harms that LGBTQ youth endure as a result of conversion therapy. Amici are deeply concerned that issuance of a preliminary injunction in this case will place minors at an increased and substantial risk of suicidality, a scientifically proven risk inherent in conversion therapy. The Trevor Project works firsthand with LGBTQ youth who have endured these harmful practices—and understands the devastating effects that these therapies inflict, including an increased risk of suicide. Due to the increased and substantial risks of suicidality, The Trevor Project, AFSP, and AAS advocate to end the practice of conversion therapy against minors through public policy advocacy. For these reasons, The Trevor Project, AFSP, and AAS have a substantial interest in supporting the enforcement of laws prohibiting the practice of conversion therapy against minors.

Amici have obtained consent to file this brief from both parties and therefore may file it pursuant to Federal Rule of Appellate Procedure 29(a)(2).

Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), *Amici* state that no party's counsel authored this brief in whole or in part; no party or party's counsel

contributed money intended to fund preparing or submitting this brief; and no person, other than *amici*, its members or counsel, contributed money intended to fund preparing or submitting this brief.

INTRODUCTION

Substantial evidence shows youth subjected to conversion therapy are at risk of great harm, including a significantly increased risk of suicide, which has resulted in an overwhelming medical consensus that minor patients must not be subjected to conversion therapy under the imprimatur of the mental health profession. For this reason, it is a matter of well-settled law as pronounced by this Court and the United States Supreme Court that state and local governments may regulate unsafe medical treatments and protect minor children from medical treatments that put minors at an increased risk of suicidality and other serious harms.[1] In arguing to the contrary, Plaintiff-Appellant/Cross-Appellee (hereafter "Plaintiff") Brian Tingley ignores decades of binding case law, and falsely claimed below that "[t]here is no statistically valid evidence that counseling of the type that [he] provides is harmful or ineffective." *See Tingley v. Ferguson et al.*, No. 21-cv-5359 (W.D. Wash. May 13, 2021), ECF No. 2 at 12. As demonstrated below, the medical consensus that conversion therapy is harmful to minors is based on extensive evidence and rigorous, peer-reviewed studies. The relief Plaintiff seeks would place minors in this state at risk of serious and potentially life-threatening harms. *Amici* urge this Court to affirm

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[1] *See, e.g.*, *Nat'l Inst. of Family and Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) ("*NIFLA*"); *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992); *Welch v. Brown*, 834 F.3d 1041 (9th Cir. 2016); *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014).

the district court's decision and recognize the state's authority (indeed, responsibility) to protect children from being subjected to this dangerous abuse by state-licensed mental health professionals.

Amici are three non-profit organizations that have particular familiarity and knowledge of the significant harms that LGBTQ youth endure as a result of conversion therapy. As representatives advocating on behalf of the interests of impacted minors, *amici* believe their perspective—developed through decades of work studying mental health and suicide and addressing suicidality in LGBTQ youth—will be useful to the Court as it adjudicates Plaintiff's appeal from the district court's dismissal of Plaintiff's lawsuit.[2] Indeed, as the largest crisis service provider for LGBTQ youth, The Trevor Project, Inc. ("The Trevor Project") has unique insight into the harmful role conversion therapy plays in the mental health of LGBTQ youth; the American Foundation for Suicide Prevention ("AFSP") is a leading organization funding research on and educating the public about suicide; and the American Association of Suicidology ("AAS") is focused on advancing

[2] *See Cmty. Ass'n for Restoration of Env't (CARE) v. DeRuyter Bros. Dairy*, 54 F. Supp. 2d 974, 975 (E.D. Wash. 1999) ("An amicus brief should normally be allowed when a party is not represented competently or is not represented at all, . . . or when the amicus has unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide"); *see, e.g.*, *Castaneda Juarez v. Asher,* No. C20-0700JLR-MLP, 2020 WL 3104919, at *1 (W.D. Wash. June 11, 2020) (granting leave to file amicus where proposed amici had "unique information or perspective that can help the court").

suicidology as a science and developing scholarship and information surrounding suicide and suicidal behaviors to increase public awareness. These organizations now respectfully offer the following summary of the evidence linking conversion therapy to a significantly heightened risk of suicidality and other serious harms, including an important new study published by The Trevor Project in 2020, which has further corroborated the overwhelming evidence that these practices are extraordinarily dangerous for youth.

ARGUMENT

I. Washington's Statute Redresses Significant Harms to the Health and Safety of Minors.

The statute challenged by Plaintiff, SB 5722, regulates the practice of conversion therapy, a practice through which professional therapists seek to impose a predetermined outcome with respect to a person's sexual orientation or gender identity under color of a Washington-issued license to practice.[3] Notably, in addition to the Washington law clearly serving the public interest, the balance of equities weighs heavily in favor of the statute as it seeks to protect children from the grave harms of conversion therapy, which can be a matter of life and death. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20, 26, 32 (2008) (emphasizing "the

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[3] *See* RCW 18.130.020 (defining conversion therapy as "a regime that seeks to change an individual's sexual orientation or gender identity . . . includ[ing] efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.").

importance of assessing the balance of equities and the public interest" in determining the propriety of injunctive relief). Numerous rigorous, peer-reviewed studies have shown that conversion therapy is closely correlated with a dramatically increased risk of suicide in minors, as well as with other serious harms. The baseline scientific principle that a treatment "is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit," *United States v. Rutherford*, 442 U.S. 544, 556 (1979), deems conversion therapy unsafe. This is why the statute at issue was enacted,[4] and why every leading medical and mental health organization has issued policy statements over the past 20 years, cautioning therapists and parents that conversion therapy is unsafe and should not be performed on minors.

A. Social Science Overwhelmingly Confirms the Significant Harm of Conversion Therapy to LGBTQ Youth.

The Trevor Project offers free and confidential crisis intervention services for LGBTQ youth, which are used by thousands of young people each month, and counselors record anonymized data about the cases that come before them. In over 1,100 crisis contacts in 2020—an average of more than three per day—LGBTQ

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[4] Washington Governor Jay Inslee signed SB 5722 into law, noting that "conversion therapy is not so much therapy; it's abuse." Human Rights Campaign, Facebook (Mar. 28, 2018, 1:20), https://www.facebook.com/watch/?v=10156295724678281&t=80.

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youth seeking help through these crisis services proactively raised conversion therapy as a topic in their discussions with crisis counselors.[5] These contacts came from almost every state, including multiple contacts from youth in Washington. When raised, conversion therapy was discussed in various contexts, including dealing with experiences of conversion therapy, facing threats of conversion therapy, looking for help getting out of conversion therapy, and expressing relief that conversion therapy is illegal where they live. This data shows that conversion therapy is a serious issue for LGBTQ youth in crisis, who are estimated to attempt suicide at a rate of 1 every 45 seconds in the United States.[6]

Recent peer-reviewed retrospective case-control studies confirm the devastating harms that conversion therapy inflicts upon LGBTQ youth. Conversion therapy harms LGBTQ youth "by invoking feelings of rejection, guilt, confusion, and shame, which in turn can contribute to decreased self-esteem, substance abuse,

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[5] This information is derived from anonymized data that The Trevor Project has collected from its platforms, compiled, and reviewed. In order to protect the privacy of the youth using its services, The Trevor Project does not make the underlying sources of this data publicly available.

[6] The Trevor Project, *Estimate of How Often LGBTQ Youth Attempt Suicide in the U.S.* (Mar. 11, 2021), https://www.thetrevorproject.org/2021/03/11/estimate-of-how-often-lgbtq-youth-attempt-suicide-in-the-u-s/.

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social withdrawal, depression, and anxiety."[7] The Trevor Project documented these harmful results and others in its 2020 peer-reviewed article in the *American Journal of Public Health* (AJPH), reporting that LGBTQ youth who underwent conversion therapy were "***more than twice* as likely to report having attempted suicide**" and more than 2.5 times as likely to report multiple suicide attempts in the past year compared to those who did not.[8] In 2021, The Trevor Project released the results of a cross-sectional survey with nearly 35,000 LGBTQ individuals between the ages of 13 and 24 across the United States.[9] Thirteen percent of these youth reported undergoing conversion therapy, a staggering proportion of whom were subjected to it as minors (83%).[10]

The results of this study are consistent with a substantial body of other rigorous, peer-reviewed research on the detrimental impact of conversion therapy on

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[7] Am. Found. for Suicide Prevention, *State Laws: Banning Conversion Therapy Practices* 2 (2020), https://www.datocms-assets.com/12810/1592504833-conversion-therapy-issue-brief-6-18-20.pdf.

[8] Amy E. Green et al., *Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018*, 110 Am. J. Pub. Health 1221, 1224 (2020) (emphases added).

[9] The Trevor Project, *National Survey on LGBTQ Youth Mental Health* (2021), https://www.thetrevorproject.org/survey-2021/?section=ConversionTherapy.

[10] *Id.*

(Cont'd on next page)

LGBTQ youth.[11] A 2020 study found that exposure to conversion therapy ***doubled*** the odds of lifetime suicidal ideation, increased the odds of planning to attempt suicide by 75%, and increased the odds of a suicide attempt by 88% as compared with those who had not undergone conversion therapy.[12] A November 2018 study found that the rates of attempted suicide by LGBTQ young adults whose parents tried to change their sexual orientation during adolescence were ***more than double*** (48%) the rate of LGBTQ young adults who reported no conversion therapy experience (22%).[13] The study also found that these rates were nearly ***triple*** for LGBTQ youth who reported both home-based efforts to change their sexual orientation by parents and intervention efforts by therapists and religious leaders

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[11] *See, e.g.*, Am. Ass'n of Suicidology, *Suicidal Behavior Among Lesbian, Gay, Bisexual, and Transgender Youth Fact Sheet* (2019), https://suicidology.org/wp-content/uploads/2019/07/Updated-LGBT-Fact-Sheet.pdf ("[Y]outh who have undergone conversion therapy [are] more than twice as likely to attempt suicide as those who did not.").

[12] John R. Blosnich et al., *Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016–2018*, 110 Am. J. Pub. Health 1024, 1027 (2020), https://dworakpeck.usc.edu/sites/default/files/2020-10/Blosnich%20Henderson%20Coulter_0.pdf.

[13] Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*, J. Homosexuality, 10 (Nov. 2018), https://www.utah.gov/pmn/files/513643.pdf.

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(63%).[14] More recent data shows the same increased risk: "Around 28 percent of U.S. LGBTQ youth who had experienced conversion therapy had attempted suicide within the previous 12 months as of 2020, compared to 12 percent of LGBTQ youth who had not experienced conversion therapy."[15]

B. Every Major Medical and Mental Health Organization Has Rejected Conversion Therapy as Scientifically Unsound, Harmful to the Patient, and Ineffective at Changing Sexual Orientation, Gender Identity, or Gender Expression.

Every major medical and mental health organization has uniformly rejected conversion therapy as unsafe for minors. AFSP has stated that "conversion therapy efforts are inappropriate and harmful therapeutic interventions" and "urges states to prohibit this discredited practice and protect LGBTQ youth."[16] As the federal Substance Abuse and Mental Health Services Administration has cautioned, there is a "professional consensus that conversion therapy efforts are inappropriate" and that "none of the existing research supports the premise that mental or behavioral health

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[14] *Id.*

[15] Statista Research Dep't, *U.S. LGBTQ Youth Who Experienced Conversion Therapy and Attempted Suicide 2020*, Statista (May 10, 2021), https://www.statista.com/statistics/1053024/lgbtq-youth-in-us-attempted-suicide-conversion-therapy-experience/.

[16] Am. Found. for Suicide Prevention, *Conversion Therapy Bans*, https://afsp.org/conversion-therapy-bans (listing other professional medical organizations with similar policies).

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interventions can alter gender identity or sexual orientation."[17] The U.S. Surgeon General has similarly warned that "[c]onversion therapy is not sound medical practice."[18]

The American Psychological Association ("APA") recently published a review of sexual orientation change efforts, including conversion therapy.[19] It found that "[p]articipation in [conversion therapy] is associated with numerous negative effects, including depression, suicidality, decreased self-esteem, and self-hatred . . . as well as negative views of homosexuality, internalized homonegativity, sexual dysfunction, impaired familial and romantic relationships . . . and decreased overall sexual attraction."[20]

In 2021, the APA published updated policy statements on sexual orientation and gender identity change efforts, condemning conversion therapy, and reaffirming

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[17] Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 3, 11 (2015), https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4928.pdf.

[18] Sunnivie Brydum, *WATCH: U.S. Surgeon General Opposes Conversion Therapy* (Apr. 10, 2015), https://www.advocate.com/ex-gay-therapy/2015/04/10/watch-us-surgeon-general-opposes-conversion-therapy.

[19] Amy Przeworski, et al., *A Systematic Review of the Efficacy, Harmful Effects, and Ethical Issues Related to Sexual Orientation Change Efforts*, 28 Clinical Psychol. Sci. & Prac. 81 (2020).

[20] *Id.* at 90 (internal citations omitted).

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that "sexual minority youth and adults who have undergone" efforts to change their sexual orientation "are significantly more likely to experience suicidality and depression than those who have not," and that "minors who have been subjected to [this practice] have reported more suicide attempts than those who have not."[21] But the professional consensus rejecting conversion therapy has been well established for over two decades. In 1993, the American Academy of Pediatrics took the position that "[t]herapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."[22] Since 1998, the American Psychiatric Association has "opposed any psychiatric treatment, such as 'reparative' or conversion therapy."[23] And in 2009, an APA task force found "no research demonstrating that providing [conversion therapy] to children or adolescents has an

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[21] Am. Psychol. Ass'n, *APA Resolution on Sexual Orientation Change Efforts*, at 5, 7 (Feb. 2021), https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf; Am. Psychol. Ass'n, *APA Resolution on Gender Identity Change Efforts*, at 3 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[22] Am. Acad. Pediatrics, *Homosexuality and Adolescence*, 92 Pediatrics 631, 633 (1993).

[23] Am. Psychiatric Ass'n, *Position Statement on Conversion Therapy and LGBTQ Patients* (Dec. 2018), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Conversion-Therapy.pdf.

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impact on adult sexual orientation" and significant evidence that it "has the potential to be harmful."[24]

C. Uninterrupted Enforcement of Washington's Law Is Crucial to Preventing this Significant Harm to LGBTQ Youth.

Washington's law is plainly within the public interest as it protects Washington's minors and saves lives by stopping a practice that results in increased suicide and suicidality among LGBTQ youth. A preliminary injunction would, at minimum, disrupt enforcement of the statute, allowing conversion therapy practitioners to continue harming Washington's young people. Other federal courts considering similar bans on the administration of conversion therapy have denied preliminary injunctions precisely for this reason, noting that "conversion therapy is likely harmful to minors." *Doyle v. Hogan*, 411 F. Supp. 3d 337, 346–47 (D. Md. 2019) (highlighting "negative effects on minors" and noting that "[r]eparative therapy (for minors, in particular) . . . has been proven harmful to minors,[ ] and that there is no scientific evidence supporting the success of these interventions[.]") (internal quotation mark omitted), *rev'd and vacated on other grounds*, 2021 WL 2424800 (4th Cir. Jun. 15, 2021); *see King v. Governor of the State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014) (finding that "substantial evidence" supports

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[24] Am. Psychol. Ass'n, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, at 4, 6 (2009), https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf.

finding that "[conversion therapy] is ineffective" and that law banning it "advances . . . [the state's] interest in protecting minor citizens from harmful professional practices"). Indeed, given the life-saving impact of Washington's law, the balance of equities lies in favor of continued enforcement of Washington's law given the significant harms from which the law protects children. *See Sierra Club v. Trump*, 963 F.3d 874, 895 (9th Cir.), *cert. granted*, 141 S. Ct. 618 (2020); *see also San Francisco Veteran Police Officers Ass'n v. City & Cty. Of San Francisco*, 18 F. Supp. 3d 997, 1005 (N.D. Cal. 2014) (in assessing balance of equities, court denied injunction of law that would prevent "frequent and documented" instances of death and serious harm). This Court should not prevent Washington from protecting the mental and physical wellbeing of its LGBTQ youth.

CONCLUSION

For the foregoing reasons, this Court should affirm the District Court's opinion.

Dated: January 21, 2022 Respectfully submitted,

/s/ Shireen A. Barday

SHIREEN A. BARDAY
GIBSON, DUNN & CRUTCHER LLP
200 Park Avenue
New York, NY 10166
Telephone: (213) 351-4000
sbarday@gibsondunn.com

J. DENISE DISKIN
QLAW FOUNDATION OF WASHINGTON
WSBA No. 41425
101 Yesler Way #300
Seattle, WA 98104
Telephone: (206) 483-2725
denise@qlawfoundation.org

ISAAC RUIZ
RUIZ & SMART PLLC
WSBA No. 35237
1200 Fifth Avenue, Suite 1220
Seattle, WA 98101
Telephone: (206) 203-9100
iruiz@ruizandsmart.com

CERTIFICATE OF COMPLIANCE

I certify that pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the foregoing Brief of The Trevor Project, Inc., American Foundation for Suicide Prevention, and American Association of Suicidology as *Amicus Curiae* in Support of Appellees Seeking Affirmance is proportionately spaced, has a typeface of 14 points, and contains 2,547 words, excluding the portions excepted by Fed. R. App. P. 32(a)(7)(B)(iii), according to the word count feature of Microsoft Word used to generate this brief.

Dated: January 21, 2022

s/ Shireen A. Barday
Shireen A. Barday

CERTIFICATE OF SERVICE

I hereby certify that on January 21, 2022, I filed the foregoing Brief of The Trevor Project, Inc., American Foundation for Suicide Prevention, and American Association of Suicidology as *Amicus Curiae* in Support of Appellees Seeking Affirmance with the Clerk of Court for the United States Court of Appeals for the Ninth Circuit using the Court's CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

Dated: January 21, 2022

s/ Shireen A. Barday
Shireen A. Barday

ADDENDUM: HARD-TO-FIND AUTHORITIES

For the convenience of the Court, *amici curiae* have included the following hard-to-find sources that are cited in the proposed brief.

Amy E. Green et al., Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018, 110 Am. J. Pub. Health 1221, 1224 (2020)

Amy Przeworski, et al., American Psychological Association, A Systematic Review of the Efficacy, Harmful Effects, and Ethical Issues Related to Sexual Orientation Change Efforts, 28 Clinical Psychology: Science and Practice 1, 81-100 (2021)

ADDENDUM

Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018

Amy E. Green, PhD, Myeshia Price-Feeney, PhD, Samuel H. Dorison, MSc, LLM, and Casey J. Pick, JD

Objectives. To explore associations between undergoing sexual orientation or gender identity conversion efforts (SOGICE) and suicidality among young LGBTQ (lesbian, gay, bisexual, transgender, and queer or questioning) individuals.

Methods. Data were derived from a 2018 online cross-sectional study of young LGBTQ individuals (13–24 years of age) residing in the United States. Multivariate logistic regression was used to determine the relative odds of suicidality among young LGBTQ individuals who experienced SOGICE (in comparison with those who did not) after adjustment for age, race/ethnicity, geography, parents' use of religion to say negative things about being LGBTQ, sexual orientation, gender identity, discrimination because of sexual orientation or gender identity, and physical threats or harm because of sexual orientation or gender identity.

Results. Relative to young people who had not experienced SOGICE, those who reported undergoing SOGICE were more than twice as likely to report having attempted suicide and having multiple suicide attempts.

Conclusions. The elevated odds of suicidality observed among young LGBTQ individuals exposed to SOGICE underscore the detrimental effects of this unethical practice in a population that already experiences significantly greater risks for suicidality. (*Am J Public Health.* 2020;110:1221–1227. doi:10.2105/AJPH.2020.305701)

See also Fish and Russell, p. 1113.

Sexual orientation and gender identity change efforts (SOGICE), also known as "conversion therapy," are pervasive despite a lack of credible evidence of their effectiveness.[1,2] SOGICE involves attempts by licensed professionals (e.g., psychologists or counselors) or practices by religious leaders to alter sexual attractions and behaviors (to make one straight or heterosexual), gender expression (to align with gender expectations for the sex assigned at birth), or gender identity (to make one cisgender).[3] SOGICE can include the use of aversive stimuli, individual talk therapy, group therapy, and residential programs.[2,4] SOGICE lacks scientific merit and has uniformly been declared dangerous by leading professional associations such as the World Psychiatric Association,[5] the American Medical Association,[4] and the American Psychological Association,[6] among others.[7–9]

A recent examination of SOGICE documented that it fit definitions of adverse childhood experiences and would be considered abusive if it occurred outside of a treatment context.[10] However, SOGICE is still legal in the majority of US states.[2] A report by the Williams Institute estimated that approximately 700 000 lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) adults in the US have undergone SOGICE at some point in their lives, including about 350 000 who received treatment as adolescents.[2] The report further estimated that 20 000 LGBTQ youths between 13 and 17 years old will receive SOGICE from a licensed health care professional before they reach the age of 18 years, a total that does not include youths who undergo SOGICE led by religious leaders not covered in new regulations. Furthermore, a recent analysis revealed that 13.5% of transgender people in the United States reported lifetime exposure to conversion efforts.[11]

Concerns about the harms of SOGICE among LGBTQ youths are especially warranted as this population has been found to report suicide attempts at more than 4 times the rate of non-LGBTQ youths.[12,13] Emotional and physical abuse and neglect, which may occur as part of SOGICE, increase suicidality risks.[10,14]

Furthermore, according to the minority stress model, mental health disparities found among LGBTQ individuals (relative to those who are straight, heterosexual, or cisgender) are the result of chronic stressors stemming from the marginalized social status of these individuals rather than a function of their identity itself. Among lesbian, gay, and bisexual youths, sexuality-based discrimination and victimization have consistently been related to greater suicidality.[15–17] Support for the minority stress model has also been found among transgender and nonbinary individuals, with increased suicidality related to internalized transphobia and expectations of rejection.[18] Thus, SOGICE, which can encompass emotional and physical abuse in addition to rejection based on sexual orientation and gender identity (designed to produce internalized LGBTQ stigma), would be expected to be strongly associated with suicidality outcomes.

There is little empirical research on the effects of SOGICE on children and adolescents. A 2018 study involving 245 LGBT young adults (21–25 years) provided the first data on the association of sexual orientation change efforts with outcomes.[19] Those who

ABOUT THE AUTHORS

The authors are with The Trevor Project, West Hollywood, CA.

Correspondence should be sent to Amy E. Green, PhD, The Trevor Project, PO Box 69232, West Hollywood, CA 90069 (e-mail: amy.green@thetrevorproject.org). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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reported both parent-initiated attempts to convince them to change and formal sexual orientation conversion efforts by others (e.g., therapists or clergy) were 5 times more likely to report suicide attempts than those who reported no sexual orientation change attempts or conversion efforts. The findings of another study, involving data from more than 27 000 transgender adults participating in the 2015 US Transgender Survey, showed that undergoing gender identity change efforts doubled the adjusted odds of a lifetime suicide attempt, with change efforts before the age of 10 years resulting in more than 4-fold adjusted odds of an attempt.[1]

In our study, we sought to contribute to the empirical knowledge base on SOGICE by examining its association with suicidality among LGBTQ young people (13 to 24 years) living in the United States. Specifically, we hypothesized that SOGICE would be positively and significantly related to suicidality after adjustment for other related characteristics including age, race/ethnicity, geographic region, sexual orientation, gender identity, parents' use of religion to make negative statements about being LGBTQ, discrimination because of sexual orientation or gender identity, and physical harm because of sexual orientation or gender identity.

METHODS

Young people between the ages of 13 and 24 years were recruited for a cross-sectional online survey conducted by The Trevor Project, a suicide prevention and crisis intervention organization for LGBTQ youths younger than 25 years, between February and September 2018. Recruitment was conducted through targeted advertisements placed on 2 social media platforms: Facebook and Instagram. The advertisements targeted those who interacted with material deemed to be relevant to the LGBTQ community. No recruitment was conducted through any Trevor-branded social media channels or Web sites. Eligible participants resided in the United States, were between 13 and 24 years of age, identified as LGBTQ, and were able to read and understand English.

Respondents completed a secure, anonymous questionnaire that included a maximum of 110 questions depending on skip logic (i.e., branching of survey questions depending on how a respondent answered a particular question). A statement was included before questions specific to youth mental health and suicidality that directed participants to call The Trevor Project's 24-hour-a-day crisis intervention lifeline if at any time they needed to talk to someone about their mental health or thoughts of suicide. Individuals who completed the survey were eligible to be entered into a drawing for a $50 Amazon gift card by providing their e-mail address after being routed to a separate survey. All participants provide informed consent to participate in the study.

Analytic Sample

A total of 34 808 young people consented to complete the online survey. Excluded from the analytic sample were 475 young people who lived outside of the United States and 294 who identified as both straight/heterosexual and cisgender. A filter was applied such that any young people who completed fewer than half of the survey items or reached the end of the survey within 3 minutes (n = 8091) were eliminated. An additional 52 young people who provided highly unlikely answers (e.g., selecting all possible religious affiliations and race/ethnicity categories) or included obvious hate speech directed toward LGBTQ populations in the open-response options were also eliminated.

Finally, 105 young people were excluded who responded no to the questions asking whether someone attempted to convince them to change their gender identity and whether someone attempted to convince them to change their sexual orientation but responded yes to having undergone "conversion or reparative therapy." It was assumed that these young people may not have understood the intended meaning of conversion or reparative therapy.

Measures

Questions aligned with practices identified by the Williams Institute were used to assess gender identity.[20] Young people were asked "What sex were you assigned at birth? (meaning the sex showing on your original birth certificate)," with options of male and female. Next, they were asked "What is your gender identity? Please select all that apply," with the following options: man, woman, trans male/trans man, trans female/trans woman, gender queer/gender nonconforming, and different identity (please state). For the purposes of the current analyses, gender identity was coded as (1) transgender and nonbinary (for those whose assigned sex at birth did not fully match their current gender identity) or (0) cisgender (for those whose assigned sex at birth was consistent with their current gender identity).

Sexual orientation was assessed via a question from the National Center for Health Statistics[21]: "Do you think of yourself as?" with the options gay/lesbian, straight (that is, not gay or lesbian), bisexual, something else, and don't know. Young people who selected "something else" were asked a follow-up question that allowed them to respond with another sexual orientation (e.g., queer, omnisexual, pansexual, trisexual), that they did not use labels, or that they were unsure of their sexual orientation. Although a diversity of identities emerged, sexual orientation was coded as (1) gay/lesbian, (2) bisexual, and (3) something else (which also included transgender and nonbinary young people who identified as straight and those who were questioning or unsure).

To assess ethnicity, young people were asked "Do you consider yourself to be Hispanic or Latino?" Race was separately assessed by asking young people "What race or races do you consider yourself to be?" Mutually exclusive groups were created, as follows:

1. non-Hispanic White,
2. Hispanic/Latinx,
3. Black/African America,
4. Asian American/Pacific Islander,
5. American Indian/Alaska Native, and
6. 2 or more races/ethnicities.

Respondents were asked to report their age using whole numbers between 13 and 24. Response options were categorized into those who were aged 17 years or younger (1) and those who were aged 18 years or older (0). Given that legislative efforts to end "conversion therapy" focus primarily on minors, responses were dichotomized as those of minors versus those of individuals aged 18 years or older.

Young people were asked to indicate the state in which they lived. State-level data

were aggregated into 1 of 4 US Census regions: Northeast, South, Midwest, or West.

In accordance with practices commonly used in examining socioeconomic status among youth populations,[22,23] an assessment of free or reduced-price lunches was used as a proxy for family income. Respondents were asked either "Are you eligible for free or reduced-price lunch at school?" (if they were enrolled in school) or "Were you eligible for free or reduced-price lunch when you were in school?" (if they were not currently enrolled). A variable was created to reflect young people who were eligible for free or reduced-price lunch (1) and those who were not (0).

Negative family religious beliefs about being LGBTQ were examined as a possible characteristic related to suicidality and experiencing conversion therapy. Young people were asked to respond to a statement that read "I have heard my parents (or guardians) use religion to say negative things about being LGBTQ." Those who responded with strongly agree or agree (1) were compared with those who responded strongly disagree, disagree, or neither agree nor disagree (0).

Respondents' lifetime experiences with discrimination based on their sexual orientation were assessed by asking "Do you feel that you have ever been the subject of discrimination because of your sexual orientation?" A parallel question was used to assess discrimination based on gender identity. A variable was created to reflect young people who had experienced discrimination based on their sexual orientation or gender identity (1) and those who had not (0).

Young people were asked "In the past 12 months, have you felt physically threatened or been physically abused because of your sexual orientation or gender identity?" to assess their experiences with being physically threatened or harmed in the preceding 12 months. A variable was created to reflect young people who were physically threatened or harmed as a result of their sexual orientation or gender identity (1) and those who were not (0).

As a means of assessing lifetime experiences of SOGICE, young people were asked "Have you ever undergone reparative therapy or conversion therapy?" Before being asked this question, young people responded to a pair of items asking them more broadly whether anyone had ever attempted to convince them to change their sexual orientation or gender identity. Only those who responded affirmatively that someone had attempted to convince them to change their orientation or identity were included in our analyses, which eliminated 0.4% of young people whose responses were inconsistent. A variable was created to reflect young people who reported experiencing SOGICE (1) and those who did not (0).

Outcome Variables

An item derived from the Youth Risk Behavior Surveillance System survey was used to assess whether young people had seriously considered suicide in the preceding 12 months.[12] Respondents were asked "During the past 12 months, did you ever seriously consider attempting suicide?" A variable was created to reflect young people who reported seriously considering suicide (1) and those who did not (0).

An item derived from the Youth Risk Behavior Surveillance System survey was also used to assess past-year attempted suicide.[12] Young people who reported having considered suicide were asked "During the past 12 months, how many times did you actually attempt suicide?" Response options were as follows:

1. 0 times,
2. 1 time,
3. 2 or 3 times,
4. 4 or 5 times, and
5. 6 or more times.

Young people's responses were dichotomized to compare those with 1 or more suicide attempts in the preceding 12 months (1) and those with no suicide attempts in the preceding 12 months (0). Those who reported that they had not seriously considered suicide (and were thus skipped out of the question) were coded as 0 (no attempt). A separate dichotomous variable was created to indicate the presence of multiple suicide attempts in the past year, with those who reported 2 or more attempts coded as 1 and those who reported 1 or no attempts coded as 0.

Data Analysis

SPSS version 25 was used in conducting all of our analyses.[24] With the exception of suicidality outcome variables, we addressed missing data using multiple imputation; the final analytic sample consisted of 22 462 respondents. The significance level of findings from analyses performed with imputed data did not differ from that of findings from analyses performed with missing data. We used the χ^2 test of independence to examine the proportion of young people reporting SOGICE by each study variable with the exception of race/ethnicity, which we examined via a Fisher's exact test. After adjustment for related variables, multivariate logistic regression was used to determine the relative odds of suicidality among LGBTQ respondents who underwent SOGICE in comparison with those who did not.

RESULTS

Higher proportions of Hispanic/Latinx respondents, those from low-income families, and those from the South were found among those who underwent SOGICE (Table 1). More than three quarters of young people who underwent SOGICE reported hearing their parents or caregivers use religion to say negative things about being LGBTQ, as compared with just under half of those who did not undergo SOGICE. In addition, greater proportions of young people who identified as gay or lesbian (relative to bisexual or "something else") and who identified as transgender or nonbinary (relative to cisgender) were found among those who underwent SOGICE. Lifetime reports of discrimination because of sexual orientation or gender identity, as well as reports of having been physically threatened or harmed because of sexual orientation or gender identity in the preceding year, were also more common among LGBTQ respondents who underwent SOGICE than among those who did not.

An assessment of suicidality (Table 2) showed that more young people who underwent SOGICE than those who did not reported having seriously considered suicide in the preceding year (62.6% vs 37.6%). In addition, the percentage of young people reporting a suicide attempt was more than twice as high among those underwent SOGICE than among those who did not (43.6% vs 17.3%). Finally, young people who underwent SOGICE were more than 3 times

TABLE 1—Characteristics of Young LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning) Individuals Who Underwent Sexual Orientation and Gender Identity Change Efforts (SOGICE) and Those Who Did Not: United States, 2018

Characteristic	All Respondents (n = 25 791), % (No.)	Respondents Who Underwent SOGICE (n = 1 088), % (No.)	Respondents Who Did Not Undergo SOGICE (n = 24 703), % (No.)
Age, y			
13–17	50.9 (13 130)	62.0 (675)	50.4 (12 455)
18–24	49.1 (12 661)	38.0 (413)	49.6 (12 248)
Race/ethnicity[a]			
White	72.2 (18 611)	66.7 (726)	72.4 (17 865)
Hispanic/Latinx	14.3 (3 686)	20.0 (218)	14.0 (3 468)
Black/African American	2.6 (681)	3.1 (34)	2.6 (647)
Asian American/Pacific Islander	3.1 (807)	2.1 (23)	3.2 (784)
American Indian/Alaska Native	0.7 (172)	1.0 (11)	0.7 (161)
Multiple	7.1 (1 834)	7.0 (76)	7.1 (1 758)
Census region			
Northeast	18.5 (4 781)	12.3 (134)	18.8 (4 647)
South	30.0 (7 739)	35.4 (385)	29.8 (7 354)
Midwest	27.9 (7 199)	29.2 (318)	27.9 (6 811)
West	23.5 (6 072)	23.1 (251)	23.6 (5 821)
Family income status			
Free/reduced-price lunch	36.7 (9 467)	55.9 (608)	35.9 (8 859)
Paid lunch	63.4 (16 324)	44.1 (480)	64.1 (15 844)
Family use of religion to say negative things about being LGBTQ	48.5 (12 506)	75.5 (821)	47.3 (11 685)
Sexual orientation			
Gay/lesbian	45.1 (11 635)	48.9 (532)	44.9 (11 103)
Bisexual	32.8 (8 468)	27.8 (302)	33.1 (8 166)
Straight[b] or something else	22.1 (5 688)	23.3 (254)	22.0 (5 434)
Gender identity			
Transgender/nonbinary	33.0 (8 521)	41.5 (451)	32.7 (8 070)
Cisgender	67.0 (17 270)	58.5 (637)	67.3 (16 633)
Discrimination because of sexual orientation or gender identity	70.9 (18 298)	89.7 (976)	70.1 (17 322)
Physical threats or harm because of sexual orientation or gender identity	20.8 (5 352)	48.0 (522)	18.7 (4 830)

Note. All analyses were significant at $P < .001$.

[a]Racial categories are non-Hispanic.

[b]All respondents who identified as straight were transgender or nonbinary.

as likely as those who did not to report multiple suicide attempts (29.0% vs 8.3%).

In adjusted models (Table 3), the strongest predictors of suicidality included younger age, parents or caregivers using religion to say negative things about being LGBTQ, self-identification as transgender or nonbinary, discrimination because of sexual orientation or gender identity, physical threats or harm because of sexual orientation or gender identity, and SOGICE. LGBTQ respondents who underwent SOGICE were significantly more likely than those who did not to report seriously considering suicide in the preceding 12 months (adjusted odds ratio [OR] = 1.76; 95% confidence interval [CI] = 1.52, 2.04; $P < .001$). In addition, LGBTQ respondents who underwent SOGICE were more than twice as likely to report having attempted suicide (adjusted OR = 2.23; 95% CI = 1.93, 2.59; $P < .001$) and having multiple suicide attempts (adjusted OR = 2.54; 95% CI = 2.16, 2.99; $P < .001$) in the preceding year.

DISCUSSION

Young LGBTQ respondents who had undergone SOGICE experienced dramatically higher levels of suicidality than their LGBTQ peers not exposed to such experiences. SOGICE was the strongest predictor of multiple suicide attempts, even after adjustment for other known risk factors. Young LGBTQ individuals reporting suicidality after having undergone SOGICE represent an extremely vulnerable population that would benefit from additional protections and support.

Our data also highlight characteristics among young LGBTQ individuals that relate to greater reports of experiencing SOGICE. Specifically, young people with lower family incomes, from the South, whose parents use religion to say negative things about being

TABLE 2—Suicidality Among Young LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning) Individuals Who Underwent Sexual Orientation and Gender Identity Change Efforts (SOGICE) and Those Who Did Not: United States, 2018

Suicidality	All Respondents (n = 22 462), % (No.)	Respondents Who Underwent SOGICE (n = 951), % (No.)	Respondents Who Did Not Undergo SOGICE (n = 21 511), % (No.)
Seriously considered suicide	38.6 (8 681)	62.6 (594)	37.6 (8 087)
At least 1 suicide attempt	18.4 (4 137)	43.6 (415)	17.3 (3 722)
Multiple suicide attempts	9.5 (2 131)	29.0 (277)	8.3 (1 854)

Note. All analyses were significant at $P < .001$.

LGBTQ, who are Hispanic/Latinx, and who are transgender or nonbinary were overrepresented in reports of SOGICE. Our family income findings align with previous results indicating that higher family incomes are associated with fewer parent-initiated change attempts and conversion efforts.[19] In addition, overrepresentation of Hispanic/Latinx young people has been observed in adult studies of gender identity change efforts.[1] Furthermore, our elevated reports of SOGICE among transgender or nonbinary young people extend previous findings showing that young adults who report greater gender nonconformity during adolescence are more likely to experience SOGICE.[19]

Previous research has also revealed that greater levels of family religiosity are associated with SOGICE, supporting our finding that three quarters of young people who underwent SOGICE reported having parents or caregivers who used religion to say negative things about being LGBTQ.[19] Such data highlight that young people who report undergoing SOGICE are not a homogeneous population and that efforts to address this issue must be inclusive in terms of the diversity of identities affected. Future research can advance this work by developing a deeper understanding of why these young people are more likely to experience SOGICE, including how familial and cultural beliefs around sexual and gender identity affect the risk of undergoing SOGICE.

Limitations

Although noteworthy, our findings involve limitations that should be considered. For example, our data were cross sectional; thus, temporality cannot be determined. However, previous longitudinal research has supported the prediction of suicidality based on prior experiences of minority stress.[15] The percentage of lesbian, gay, and bisexual young people who reported having attempted suicide in the preceding 12 months in the Youth Risk Behavior Surveillance System survey (24%)[12] and the percentage of age-matched LGBTQ respondents in our study (23%) are comparable; however, in both studies a lack of responses on sensitive topics such as suicide attempts may have underestimated the extent of the problem. In regard to age, our study focused only on young people above the age of 13 years. Although some scholars debate whether gender identity change efforts can be effective among prepubescent children, few would argue that such efforts are appropriate for youths after puberty begins,[25] with existing research underscoring the importance of gender-affirming care.[26]

Our study is also limited by the language of the item used to measure SOGICE. Many young people may have undergone experiences that would be considered SOGICE but would not endorse the words "conversion or reparative therapy." Our additional questions examining attempts to convince young people to change their sexual orientation and gender identity were endorsed by two thirds of respondents[27]; however, these questions were too broad to be operationalized as formal SOGICE. Using questions that more comprehensively explain and address SOGICE will likely expand the rate at which young people report such experiences.

There is also a need to separately examine the associations of sexual orientation change efforts and gender identity change efforts with suicidality among young LGBTQ individuals. Although our question did not allow us to examine these differences, segmentation of our adjusted logistic regression models by gender identity did not reveal any significant differences. To more clearly describe youth experiences, future studies should attempt to refine how SOGICE is measured, including how experiences differ between sexual orientation change attempts and gender identity change attempts, how age at exposure relates to outcomes, and how experiences differ according to the type of individual (e.g., licensed therapist or religious leader) conducting the efforts.

Finally, our data did not allow us to attend to the impact of parental acceptance on the relationship between conversion therapy and suicidality. In the current data set, young people were asked whether they had disclosed their sexual orientation and gender identity to a parent, and if so they were asked about whether they were accepted. Thus, acceptance data were available for less than two thirds of the sample. In this limited sample, although parental acceptance was significantly associated with reduced suicidality, our SOGICE variable was still significantly positively related to each of the suicidality outcomes (Appendix A, available as a supplement to the online version of this article at http://www.ajph.org).

Public Health Implications

Our findings add empirical data to support the professional consensus that SOGICE is inappropriate and harmful. Our data can be used to inform policies related to the protection of young LGBTQ individuals, as implementation of policies that support these young people has been related to reductions in suicide attempts.[28,29] Currently, only a minority of US states have policies addressing SOGICE efforts targeting minors. Our findings echo those of other recent studies establishing a significant positive association between exposure to change attempts and suicidality among young people.[1,19] Cumulatively, the lack of evidence of SOGICE effectiveness combined with evidence of associated suicidality supports efforts to end SOGICE through policy implementation.

Our data are also valuable in providing education to parents and family members regarding how to support youths in ways that do not compound experiences of minority stress marked by victimization, rejection,

TABLE 3—Adjusted Odds of Experiencing Suicidality Among Young LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning) Individuals Who Underwent Sexual Orientation and Gender Identity Change Efforts (SOGICE) and Those Who Did Not: United States, 2018

Variable	Seriously Considered Suicide (n = 22 462), AOR (95% CI)	Attempted Suicide (n = 22 462), AOR (95% CI)	Multiple Suicide Attempts (n = 22 462), AOR (95% CI)
Age, y (Ref = 13–17)	0.58 (0.55, 0.61)	0.44 (0.41, 0.48)	0.40 (0.36, 0.44)
Race/ethnicity[a]			
White (Ref)	1	1	1
Hispanic/Latinx	0.90 (0.82, 0.98)	1.10 (0.99, 1.22)	1.15 (1.00, 1.31)
Black/African American	0.82 (0.69, 0.99)	1.09 (0.87, 1.36)	0.96 (0.71, 1.29)
Asian American/Pacific Islander	0.88 (0.74, 1.04)	0.95 (0.78, 1.20)	1.07 (0.79, 1.44)
American Indian/Alaska Native	1.24 (0.87, 1.76)	1.87 (1.28, 2.74)	1.87 (1.20, 2.91)
Multiple	1.14 (1.02, 1.28)	1.27 (1.11, 1.45)	1.31 (1.11, 1.54)
Census region			
Northeast (Ref)	1	1	1
South	1.01 (0.92, 1.10)	1.02 (0.91, 1.14)	1.03 (0.88, 1.19)
Midwest	1.15 (1.05, 1.26)	1.22 (1.09, 1.36)	1.19 (1.03, 1.39)
West	1.12 (1.03, 1.23)	1.16 (1.03, 1.30)	1.06 (0.91, 1.24)
Family use of religion to say negative things about being LGBTQ	1.61 (1.51, 1.70)	1.62 (1.50, 1.75)	1.66 (1.50, 1.84)
Low family income	1.33 (1.25, 1.42)	1.57 (1.46, 1.70)	1.62 (1.47, 1.80)
Sexual orientation			
Gay or lesbian (Ref)	1	1	1
Bisexual	1.53 (1.43, 1.64)	1.37 (1.26, 1.49)	1.32 (1.18, 1.48)
Straight or something else	1.38 (1.27, 1.50)	1.16 (1.05, 1.28)	1.21 (1.06, 1.38)
Transgender/nonbinary	1.94 (1.82, 2.08)	1.87 (1.72, 2.02)	1.78 (1.60, 1.97)
Discrimination because of sexual orientation or gender identity	1.45 (1.36, 1.56)	1.62 (1.47, 1.79)	1.55 (1.35, 1.78)
Physical threats or harm because of sexual orientation or gender identity	2.13 (1.98, 2.29)	2.28 (2.10, 2.47)	2.19 (1.97, 2.42)
SOGICE	1.76 (1.52, 2.04)	2.23 (1.93, 2.59)	2.54 (2.16, 2.99)

Note. AOR = adjusted odds ratio; CI = confidence interval.
[a]Racial categories are non-Hispanic.

and internalized stigma.[30] For example, the Family Acceptance Project provides psychoeducation to ethnically and religiously diverse families to help them understand how their reactions to their LGBTQ child, including rejecting and accepting behaviors, can influence their child's well-being.[31] In addition, given the potential adverse experiences associated with SOGICE, including physical and psychological harm, our results highlight the need for practitioners to screen LGBTQ youths for exposure to SOGICE. Those providing care to LGBTQ youths who have undergone SOGICE should be aware of the higher rates of suicidality in this population and should work to ensure that youths are safe and supported. To best address the risk of SOGICE among LGBTQ youths, interventions must take place at the policy, family, and provider levels. AJPH

CONTRIBUTORS

A. E. Green conceptualized the study, conducted primary analyses, and created the initial draft. M. Price-Feeney conducted additional analyses and contributed to writing and revision of the article. S. H. Dorison oversaw data collection and study design and contributed to the drafting of the article. C. J. Pick served as a content expert, drafted text related to legal implications, and contributed to writing and revision of the final article. All of the authors reviewed the final version of the article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

This study was reviewed and approved by Solutions IRB, an independent institutional review board. A waiver of signed consent was obtained. All participants completed an online consent form that required them to select "yes" to a question inquiring about whether they understood the contents of the consent form and "yes" to a question asking them whether they would like to consent to complete the survey.

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LITERATURE REVIEW

A Systematic Review of the Efficacy, Harmful Effects, and Ethical Issues Related to Sexual Orientation Change Efforts

Amy Przeworski, Emily Peterson, and Alexandra Piedra
Department of Psychological Sciences, Case Western Reserve University, Cleveland, OH, USA

Sexual orientation change efforts (SOCE) are practices intended to eliminate same-sex attraction. We systematically review the literature on the efficacy of SOCE and discuss ways in which SOCE violate ethical guidelines for working with LGBQ clients. Existing literature indicates that SOCE are not efficacious in altering sexual orientation. Studies concluding otherwise often contain methodological limitations, such as biased recruitment or a retrospective design, that weaken the validity or prevent the generalizability of results. Many studies report negative outcomes associated with SOCE, such as depression, relationship dysfunction, and increased homonegativity. SOCE-oriented therapies also violate the American Psychological Association's (APA) ethical guidelines for working with LGBQ populations. In contrast, affirming therapies are efficacious, consistent with APA guidelines, and are associated with positive outcomes for LGBQ clients.

Public Health Significance Statement
Therapies promoting attempts to alter sexual orientation are unlikely to be successful and, in many cases, may cause significant harm to participants. Such therapies also violate the American Psychological Association's (APA) ethical guidelines for working with LGBQ clients. Individuals who experience conflict between their sexual orientation and other identities should instead seek affirming therapy to learn how to integrate these identities.

Keywords: affirming therapy, conversion therapy, LGBTQ therapy, reorientation therapy, reparative therapy, sexual orientation change efforts

Introduction

Sexual orientation change efforts (SOCE), including the practices of "conversion," "reparative," or "reorientation" therapies, are methods of therapy that attempt to eliminate same-sex attraction (American Psychological Association [APA], 2009; Drescher, 1998; Haldeman, 2001; Nicolosi, 1991). Many traditionally religious LGBQ individuals, motivated by societal pressures to conform to a heterosexual lifestyle, may seek such methods of altering their sexual orientation (Maccio,2010). Others report seeking SOCE due to pressure from families or religious organizations, under threat of rejection if they do not pursue change (Shidlo & Schroeder, 2002). However, countless studies, including a thorough review conducted by the American Psychological Association (APA), have concluded that the practice of SOCE is ineffective and often harmful (APA, 2009; Haldeman, 2002; Serovich et al., 2008; Shidlo & Schroeder, 2002). Further, many SOCE are inconsistent with the APA's current ethical standards for psychological treatment of LGBQ individuals.

Due to the potential for negative outcomes and the core ethical guideline of "do no harm" that underlies most professional service organizations, many groups have adopted policies in opposition to SOCE. Some such organizations include the American Academy of Pediatrics (1993), APA (1998, 2009), American Psychiatric Association (2000), National Association of Social Workers (2000), American Medical Association (Davis et al., 1996), American Counseling Association (2013), American Psychoanalytic Association (2012), and the National Association of School Psychologists (Just the Facts Coalition, 2008). Additionally, in the United States (U.S.) conversion therapy has been banned for minors in twenty states (Conversion "Therapy Laws, 2020). Despite widespread denouncement of the practice and a firm oppositional stance by major psychological organizations, SOCE continue to have proponents.

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Amy Przeworski https://orcid.org/0000-0002-0149-7077
Emily Peterson https://orcid.org/0000-0002-6414-3110
Alexandra Piedra https://orcid.org/0000-0003-4831-6824
Correspondence concerning this article should be addressed to Emily Peterson, Psychology Department, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106, USA. Email: ekp28@case.edu

Various theoretical approaches to SOCE have been practiced, including psychoanalytic (e.g., MacIntosh, 1994; Socarides, 1997), psychodynamic (e.g., Nicolosi, 1991), cognitive-behavioral (Morrow & Beckstead, 2004), Christian or pastoral (e.g., Consiglio, 1991), and integrationist approaches (Byrd, 1993). Regardless of the theoretical orientation, SOCE are based on the inaccurate belief that sexual attraction and homosexuality are not inborn, but rather that they develop in response to pathological, relational, or environmental experiences, and therefore can, or should be, altered (Drescher, 1998, 2002, 2003, 2015). Even the moniker "reparative therapy" suggests that its practitioners believe that same-sex attraction is something that ought to be repaired (Morrow & Beckstead, 2004).

Psychoanalytic or psychodynamic approaches to SOCE are often based on the idea that poor parental relationships can prevent a person from progressing through typical psychosexual development (Rado, 1940), resulting in same-sex attraction. The goal of such approaches is often to uncover unconscious conflict and aid in progressing through this development. Therapy often consists of hypnosis and psychoanalytic techniques (Morgan & Nerison, 1993; Morrow & Beckstead, 2004). However, the idea that same-sex attraction results from familial dysfunction or childhood trauma has been discredited, as there is a lack of evidence supporting this theory (APA, 2009; Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; Green, 1987; Peters & Cantrell, 1991).

Cognitive-behavioral SOCE, meanwhile, are based on the perspective that sexual orientation may be altered by overcoming cognitive barriers to heterosexuality (Morrow & Beckstead, 2004). Behavioral methods include masturbatory reconditioning and aversion therapy, in which a negative response to same-sex attraction is conditioned by pairing an electric shock with pictures of same-sex individuals (Bancroft, 1969; Birk, Huddleston, Miller, & Cohler, 1971; Callahan & Leitenberg, 1973; Fookes, 1960; Freeman & Meyer, 1975; Hallam & Rachman, 1972; MacCulloch & Feldman, 1967; MacCulloch, Feldman, & Pinshoff, 1965; McConaghy, 1969; Solyom & Miller, 1965; Tanner, 1974, 1975). However, these practices have since been deemed unethical and inhumane (Bancroft, 2003; Davison, 1976, 1978). Social skills training and cognitive restructuring have also been used to address anxiety about heterosexual relationships (Haldeman, 2002; James, 1978).

Other forms of SOCE include abstinence training and teaching traditional gender roles (Morgan & Nerison, 1993; Morrow & Beckstead, 2004). Biological methods, including electroconvulsive therapy, surgery (lobotomy, castration, removal of ovaries; Cramer, Golom, LoPresto, & Kirkley, 2008), or hormone therapy, have historically been used, although such practices are considered highly unethical and are currently seldom used (Morrow & Beckstead, 2004; Silverstein, 1991). Finally, religious methods of SOCE are among the most prevalent methods conducted today (Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015). Such methods involve prayer, scripture study, relying on God to change one's sexual orientation, and threats of damnation for homosexuality (Morrow & Beckstead, 2004).

SOCE have been hotly debated, with proponents suggesting that therapy is effective and that it is important to provide therapeutic options for "dissatisfied" LGBQ individuals (e.g., Byrd, 1993; Consiglio, 1991; Nicolosi, 1991). Critics, such as Haldeman (1999), cited that the large majority (70%) of participants in studies asserting the efficacy of SOCE do not report changes in their sexual orientation or behaviors (Shidlo & Schroeder, 1999). Further, these studies are often fraught with methodological limitations, including biased recruitment, retrospective study designs, lack of generalizability, reliance on samples of bisexual individuals rather than those who are predominantly homosexual, and the use of sexual or social behavior (e.g., engaging in sex with or marrying an individual of a different gender) as the outcome instead of sexual orientation (Haldeman, 1991).

Support for SOCE would require such efforts to be considered "well-established" or "probably efficacious" using the APA Division 12 Task Force criteria for evaluating empirically supported treatments (Chambless & Hollon, 1998; Chambless & Ollendick, 2001). In addition to examining whether SOCE are efficacious at changing one's sexual orientation, it is also important to examine whether participation in SOCE is associated with harm. The mere existence of SOCE reinforces existing societal prejudices with the implication that sexual orientation ought to be altered (Davison, 1976). Further, SOCE are associated with harm to participants, including, but not limited to, depression, suicidality, and self-hatred (Beckstead & Morrow, 2004; Dehlin et al., 2015; Flentje, Heck, & Cochran, 2014; Jacobsen & Wright, 2014; Shidlo & Schroeder, 2002), as well as internalized homonegativity and sexual dysfunction (Shidlo & Schroeder, 2002). As such, even if one were to claim the efficacy of SOCE, the ethical costs and potential for harm outweigh any perceived benefits (Davison, 1976, 1978).

The purpose of the present systematic review is to examine (a) whether SOCE meet criteria for well-established or probably efficacious treatments and (b) whether data suggest that there are negative outcomes associated with SOCE. The ethical implications of the practice of SOCE will also be examined.

Methods

The present systematic review examined whether evidence indicates that SOCE are efficacious in changing clients' sexual orientation, as well as the reported positive and negative outcomes associated with the practices. This was achieved by investigating the results of empirical articles studying the efficacy of SOCE and exploring the methodological limitations in SOCE research. Following the review, the harms associated with SOCE and the ways in which such efforts violate APA's (2012) ethical guidelines for working with LGBQ individuals were examined. It is important to note that the present paper focuses on LGBQ populations, as there are currently no data examining the impact of therapies seeking to alter the gender identity of transgender and gender-nonconforming individuals.

The following search terms were entered into PsycINFO: "conversion therapy" or "reparative therapy" or "reorientation therapy" or "sexual orientation change efforts," as these are the most common phrases associated with SOCE. This search identified 239 results. However, this search did not yield articles published prior to 1981, as the key terms utilized were not prevalent during that period. Therefore, additional articles (n = 55) were identified through the examination of a thorough review of the early literature on SOCE (APA, 2009). As this 2009 review was comprehensive, the present review will only briefly examine these studies.

Once duplicate articles ($n = 4$) were removed, this yielded a total of 290.

These records were screened to exclude results under the following parameters: dissertations, nonempirical studies, and results that were not published in peer-reviewed journals. Additional filters were applied to ensure that articles were written in English and conducted with human subjects. This led to the exclusion of 202 articles. The resultant 88 articles were then advanced to full-text review and assessed for eligibility. Case studies and studies with fewer than 10 participants were excluded, as were articles that were determined to lack relevance to SOCE. One study (Feldman & MacCulloch, 1965) was excluded because it presented preliminary analyses on a subset of data that were later published in full in a separate article (MacCulloch & Feldman, 1967). Five additional results were excluded from the review of efficacy, as they detailed therapists' beliefs about SOCE rather than subjects' experiences, and they will be discussed in the ethics section of the paper (Bartlett, Smith, & King, 2009; McGeorge, Carlson, & Toomey, 2015; McGeorge, Carlson, & Maier, 2017; McGeorge, Carlson, & Toomey, 2014; Nicolosi, Byrd, & Potts, 2000a). See Figure 1 for a flow diagram utilizing the Preferred Reporting Items for Systematic Reviews and Meta-Analyses method (PRISMA; Moher, Liberati, Tetzlaff, & Altman, 2009) to illustrate the process used for article identification and the number of articles excluded at each step. The final number of articles included in the present review is 35. Table 1 includes abbreviated details of the demographics, sample size, results, and limitations of each study.

Outcome Research on the Efficacy of SOCE

Various forms of SOCE have been evaluated in research. Numerous early studies employed aversion therapy techniques, such as the administration of electric shocks or nausea-inducing drugs, paired with images of men, to create a conditioned aversive response to arousal. For several of these (McConaghy, 1969; McConaghy, Proctor, & Barr, 1972; Tanner, 1975), same-sex attraction was measured primarily through physiological response when presented with stimulating images. For example, through the use of penile plethysmography, McConaghy (1969) and McConaghy et al. (1972) and Tanner (1975) found that a majority of participants experienced a decrease in arousal in a laboratory setting; however, it is likely that this decrease was related to a general reduction in sexual arousal to any stimulus (McConaghy, 1999), as penile response to images of women also declined for some participants (McConaghy, 1969; McConaghy et al., 1972). Only one study examining aversion therapy compared a treatment group to a nontreatment control group (Tanner, 1974). In this study, Tanner (1974) found a decline in laboratory-measured arousal response to male stimuli at 8 weeks following an electric shock treatment. However, this decline did not occur for all participants, and no significant difference in the postintervention frequency of same-sex sexual activity was found between the experimental and control groups.

In their review of the literature published prior to 1976, Adams and Sturgis (1977) reported that 34% of participants in controlled treatment studies experienced a decrease in same-sex arousal and

Figure 1

Coding Diagram Illustrating the Process of Determining Article Inclusion

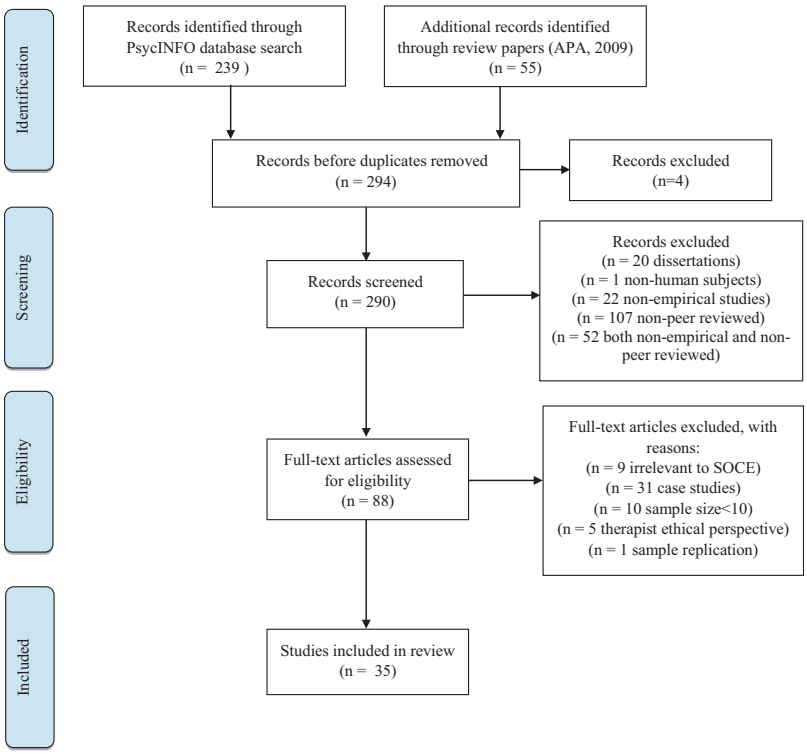

Table 1
Efficacy and Outcomes of Sexual Orientation Change Efforts (N = *35*)

Author(s), Year	*N*	Demographics	Methods/conditions	Results	Limitations
Beckstead and Morrow (2004)	50	5 women, 45 men. 100% White	Interviews (does not specify whether or not structured, most likely unstructured) about participants' motives for seeking SOCE	4 environments tended to lead respondents to want to be heterosexual rather than LGBQ: religious, family, peer, and "straight" societies	All LDS church members, White, and overwhelmingly male. Qualitative study design. All participants underwent SOCE
Birk (1974)	66	100% male, ethnic demographics not reported	Testing treatment of homosexuality in therapy lead by a male–female therapist team	85% "partial heterosexual shifts," 52% "complete heterosexual shifts" (defined by change in Kinsey number)	Defines "homosexuality" as a behavior, not an identity. 100% male sample. No control group. Does not describe treatment in detail
Birk et al. (1971)	18	100% male, ethnic demographics not reported	Tested an "avoidance conditioning" SOCE technique, compared against a placebo control group	"homosexual response" (measured by frequency of sexual behavior and rating scales) eliminated in 5/8 of experimental group participants and none of control group participants	Small sample, all male, "strong desire for treatment" was included as an eligibility criterion
Bradshaw et al. (2015)	898	197 women, 700 men; ethnic makeup not reported	Surveyed members of LDS church about their same-sex attraction	42% reported SOCE not effective, 37% reported was harmful, affirming therapy reported to have positive results	Few bisexual individuals, men overrepresented, large variation in experiences with therapy.
Byrd et al. (2008)	882	86% Caucasian, 2% Black individuals, 3.6% Asian, 3.5% Hispanic, 1.8% Native American. 78% men, 22% women	Open-ended, unstructured survey regarding experience with and perception of SOCE	82.31% had undergone SOCE. Pre-SOCE: 89.7% saw selves as homosexual; post-SOCE: 35.1% saw selves this way. Majority thought SOCE beneficial	Nongeneralizable: very religious, recruited through pro-SOCE means. No standardized measures. Retrospective. Did not ask about harm/negative outcomes
Dehlin et al. (2015)	1,612	76% male, 24% female; 100% White, 100% members of LDS church at some point	Surveyed members of LDS church about their same-sex attraction	High religious orthodoxy and low familial support associated with SOCE; those with goal to change orientation reported least success; participants rated therapist-run SOCE as most effective and least damaging SOCE method	Convenience sample, not generalizable: participants, all members of LDS church, and White. Self-report and retrospective reports limit validity
Fjelstrom (2013)	15	Not reported	Structured interviews asking about experience of self-identified gay men and lesbians who went through SOCE and later saw self as gay or lesbian	Participants' sexual orientations never changed; SOCE resulted in suppression and inauthenticity	PI had undergone SOCE and divulged to participants—may have biased their responses, retrospective accounts, small sample
Flentje et al. (2014)	38	31 male, 7 female; 86.8% Caucasian, 2.6% Black individuals, 2.6% Latino/a, 2.6% Asian/Pacific Islander, 5.3% multiracial	Survey (unstandardized) of individuals who identify as gay/lesbian who had undergone SOCE	Most frequent short-term benefits of SOCE included sense of support/connectedness (18.6%), feeling of acceptance/not alone (13.3%). 12.4% said it did not help, 31% said did not help in long term, 11.5% said it solidified gay identity	Only included individuals who went through SOCE and currently identify as LGB. Nonrandom sampling: Recruitment occurred through an "ex-ex-gay" web site. Correlational design. Based on retrospective and self-reports

(*table continues*)

Table 1 (*continued*)

Author(s), Year	*N*	Demographics	Methods/conditions	Results	Limitations
Flentje et al. (2013)	38	86.8% Caucasian	Survey (not standardized) of individuals who had undergone SOCE and identified as LGBQ afterward	Responses indicate that SOCE are often religion-based and often include homonegative messaging	All participants claimed LGBQ identity post-SOCE. Based on retrospective and self-reports
Fookes (1960)	27	100% male, ethnic demographics not described	Testing shock therapy on homosexuals, "exhibitionists," and "fetishist-transvestites"	60% of cases were deemed "successful"	No control group, small sample, did not describe outcome measures and did not describe statistical analyses
Jacobsen and Wright (2014)	23	100% LDS church members at some point, 100% women, 1 participant "identified as an ethnic minority"	Semistructured interviews about same-sex attraction and LDS church; interviews were coded and reviewed for themes	A few participants (total number not disclosed) attempted reparative therapy. Reported SOCE ineffective, depression and weight gain as a result	Based on retrospective accounts, small sample, not ethnically diverse sample, did not describe statistical analysis related to SOCE, just qualitative interview exerpts
James (1978)	40	100% male, ethnic not described	A desensitization therapy group versus aversion therapy group	Desensitization more effective than aversion therapy	No true control group, small sample
Johnston and Jenkins (2006)	14	13 Caucasian, 1 Hispanic; 10 men, 4 women	Analysis of 14 narratives included in the document Finally Free: How Love and Self-Acceptance Saved Us from "Ex-Gay" Ministries (Besen, 2000)	7 common themes: turn to SOCE out of desperation, vulnerability, self-loathing, conflict between religion and orientation, inability to change orientation, SOCE involves gender conformity, and able to gain self-accept	Based on secondary data and nonrandom sampling
Jones et al. (2003)	600	66% women, 90% White	Surveys (not standardized)	In LGBQ people who accepted their sexual orientation, conversion therapy practices found to be the least predictive of positive results in therapy, as compared to other forms of psychotherapy	Self-report, retrospective data, nonrandom sampling, largely White sample
Karten and Wade (2010)	117	100% men; 101 White/Caucasian, 5 Latino, 3 Middle-Eastern, 1 Black individuals, 1 Asian, 1 Native American, 6 not reported	Self-report surveys on sexual orientation change in participants of SOCE	Respondents reported most helpful therapy: retreats, seeing psychologists, mentorship, exploring causes of homosexuality, and deviant relationships	Self-report. Majority highly religious and White sample, all men, all respondents dissatisfied with same-sex attraction and participated in SOCE, lack of control group; correlational
Maccio (2010)	263	52.9% female; 85.9% White	Surveys (nonstandardized) compared how different correlates with participation in SOCE	Negative reactions from family members (actual or expected) and high relig. associated with high religious orthodoxy increases likelihood of participation in SOCE	Nonstandardized surveys, mostly White, nonrandom sample, did not record how respondents recruited, self-report and retrospective
Maccio (2011)	37	75% White, 62.2% male	Survey of sexual orientation and sexual identity before and after participating in SOCE	No statistically significant difference was found in sexual orientation and sexual identity before and after participating in SOCE	Nonrandom sampling: self-selection in study. Retrospective and self-reports. No objective measure of sexual orientation
MacCulloch and Feldman (1967)	43	Not reported		25 "improved to a sufficient degree for	No control group, small sample, participants

(*table continues*)

Table 1 (*continued*)

Author(s), Year	*N*	Demographics	Methods/conditions	Results	Limitations
			Testing aversion therapy using a shock stimulus on homosexuals	treatment to be described as successful," 11 "were unimproved," 7 did not complete treatment	self-selected treatment, specific measures of success were not outlined
McConaghy and Barr (1973)	46	100% men, ethnic demographics not reported	Classical conditioning, avoidance conditioning, or backward conditioning (22 sessions + 6 booster sessions)	Difference in arousal to images of men and women when groups collapsed	Small sample, no discuss of negative outcomes, no subjective, or self-reported sexual orientation
McConaghy (1969)	40	100% male, ethnic demographics not reported	Two aversion therapy groups (immediate or delayed aversion-relief therapy) versus 2 control groups (immediate or delayed apomorphine therapy)	Experimental group showed a significant difference in the direction of heterosexuality measured by arousal	All actively sought SOCE. Small sample. No discussion of negative outcomes. No measure of subjective or self-reported sexual orientation
McConaghy (1976)	Study 1: 40, Study 2: 40, Study 3: 46, Study 4: 31	100% male, ethnic demographics not reported	Study 1: apomorphine or aversion relief. Study 2: apomorphine or avoidance conditioning. Study 3: classical, avoidance, or backward conditioning. Study 4: classical aversive or positive conditioning	Aversive treatments caused decrease in arousal. In one of four studies, aversive treatments caused significant larger difference than positive conditioning treatments	Republishes findings from McConaghy, 1969 paper. Small samples. No discussion of negative outcomes of therapy. No measure of subjective or self-reported sexual orientation
McConaghy et al. (1981)	20	100% male, ethnic demographics not reported	Participants received either aversive shock therapy or covert sensitization therapy	Neither condition resulted in changes in "homosexual urges"	Small sample. All actively sought SOCE. No discussion of negative outcomes of therapy
McConaghy et al. (1972)	40	100% male, ethnic demographics not reported	Participants received either apomorphine aversion or avoidance conditioning	Participants showed decreased arousal in response to men and women after treatment	Small sample. All sought SOCE. No measure of negative outcomes, subjective or self-reported sexual orientation
Nicolosi et al. (2000a)	882	78% male, 22% female; 86% Caucasian, 14% other	Survey (not standardized) about beliefs regarding SOCE and beliefs about possibility of orientation change	726 have participated in SOCE. 35.1% identified as homosexual after SOCE. Significant portion of respondents reported reductions in "homosexual thoughts & fantasies" post-SOCE	Based on self-report and retrospective accounts. Nonrandom sampling: Participants were recruited from ex-gay ministries and NARTH. Largely White and male sample
Pattison and Pattison (1980)	11	100% male, 100% White	Retrospective study of individuals who had undergone "folk therapy" and reported having been able to successfully change their orientation	8 no longer identified as homosexual or engaged in homosexual acts, 3 were "functionally heterosexual" but still experienced homosexual urges. All had change in Kinsey score	Only recruited participants who claimed to have changed orientation through SOCE, 100% White, male sample. Small sample. Retrospective. Therapy and study methods were not described
Ponticelli (1999)	15	100% women, ethnic demographics not reported	Observation of individuals undergoing SOCE, interviews, participant testimonies, and material reviewed for themes. Analyzed conditions deemed necessary for sexual identity reconstruction	Concluded that homosexuality results from deviant issues (e.g., a poor parent/child relationship);to alter sexual identity, must foster religious identity, "confess" "sins as lesbian", use full self-disclosure in sessions, follow a religious mentors	Correlational, qualitative, not generalizable. Individuals were already participating in SOCE and all women, small sample. No outcome measure.

(*table continues*)

Table 1 (*continued*)

Author(s), Year	*N*	Demographics	Methods/conditions	Results	Limitations
Schaeffer et al. (2000)	248	184 males, 64 females; 228 Caucasian, 6 Asian, 5 Black individuals, 3 Hispanic, 4 other, 2 not reported	Survey (not standardized) of individuals who underwent SOCE to determine its efficacy	Reported being more heterosexual currently than at age 18. Heterosexual association with greater mental health. Did not find support for efficacy of SOCE. Religious association with sexual orientation	Self-report based and retrospective. Nonrandom sampling: participants recruited from a religious ex-gay conference. Did not use standardized surveys
Schaeffer et al. (1999)	140	102 males, 38 females; 94.2% Caucasian, 1.4% Black individuals, 2.9% Asian American, 1.4% Hispanics	Follow-up study of individuals who had participated in a previous study testing SOCE methods using an original survey	Males: 60.8% success rate (success: 1-yr abstinence from homosexual contact). Females: 71.1% success rate. Positive mental health and strong religious association. with success. 88.2% of those not "successful" reported still wanting to change	Overwhelmingly White and majority male sample, all participants had been actively seeking SOCE. Survey not standardized. Survey asked about homosexual behaviors but did not measure personal sexual orientation as an identity
Schroeder and Shidlo (2001)	150	9% female; 85% Caucasian, 5% Latino/a, 2% Asian American, <1% Black individuals	A series of qualitative accounts of individuals who participated in conversion therapy	Current practices may be inconsistent with APA Ethics, including lack of inadequate informed consent, confidentiality, and coercion	Self- report and retrospective accounts. All participants elected to participate in SOCE. Does not report on prevention of ethics violations
Shidlo and Schroeder (2002)	202	86% Caucasian, 5% Hispanic/Latino, 2% Asian American, 2% Jewish, <1% Black individuals; 10% female, 90% male; 66% considered selves religious, 24% nonreligious	Semistructured interviews about motivation, perceptions of harmfulness/helpfulness, treatment goals, information provided by clinician on mental health issues in LGBQ individuals and planned intervention, informed consent, intervention type, perceived help and harm, and assessment of sexual orientation	87% reported feeling as though they had "failed" SOCE. 4% reported change in orientation. 9% reported being content with celibacy. Many respondents reported negative effects of SOCE, including depression, suicidality, harm to self-esteem, impairments in relationship, and spiritual harm	Qualitative. All participants had SOCE. Quantities of respondents who endorsed different themes not reported. Exclusive of bisexuals and transgender individuals. Do not include objective data of "successes" and "failures" of SOCE. Retrospective and self-reports
Spitzer (2003)	200	143 male, 57 female. 95% Caucasian	Structured interviews	79% conflict between religious beliefs and orientation as reason for wanting change. 37% of males, 35% of females reported thoughts of suicide related to sexual orientation. 87% reported SOCE helped to feel more masculine (males)/more feminine (females)	Included those who reported change in orientation. Majority White sample. No control group. Self-report of sexual orientation change and retrospective. Does not examine risks besides and depression. Interviewers not blind to study's purpose
Tanner (1974)	16	100% men, ethnic demographics not reported	One group received aversive shock therapy, the comparison group was placed on a wait list	Shock therapy group decreases arousal to men and increases frequency of sex with women, socialization with women, and sexual thoughts about females	Ethnic demographics not reported, no true control group, small sample
Tanner (1975)	10	100% men, ethnicity not reported			

(*table continues*)

Table 1 (*continued*)

Author(s), Year	*N*	Demographics	Methods/conditions	Results	Limitations
			2 aversive shock groups, 1 group booster session, control: no therapy	Booster sessions did not increase effectiveness of SOCE	Ethnicity not reported, no true control group, small sample
Throckmorton and Welton (2005)	28	96% Caucasian	Survey (standardized) of individuals who had undergone SOCE on their therapists' methods	Respondents preferred clinicians who were familiar with LGBQ issues, affirmed ex-gay identities, did not fixate on orientation, and explored sources of same-sex attraction	Not generalizable: All participants sought SOCE, overwhelmingly White, highly religious sample. Nonrandom sampling: Participants were recruited through online "ex-gay" groups
Tozer and Hayes (2004)	206	76 women, 130 men; 192 European American, 3 Latino/a, 1 Black individuals, 1 Asian, 1 Native American, 3 "other"	Surveys (standardized) of the influence of religiosity, identity development, and internalized homophobia on likelihood to seek out SOCE.	Religious "quest" and "intrinsic" religious orientation association with seeking out SOCE. Internalized homophobia-mediated relationship	All participants had internet access, largely White, well-educated, Judeo-Christian sample

18% reported a decrease in same-sex sexual behavior at follow-up, as drawn from the studies that reported these metrics (APA, 2009). Meanwhile, only 26% and 8% reported increases in heterosexual arousal and sexual behavior, respectively.

Several studies of aversion therapy (Fookes, 1960; MacCulloch & Feldman, 1967) used a single group and drew conclusions based on comparisons of pre- and postintervention measures. Fookes (1960) combined electric shocks with restricted caloric intake in order to create a more aversive environment during the experimental phase. He then utilized aversion relief to pair images of women with a sense of reduced anxiety. Fookes reported that 60% of participants were able to change their orientation, but he did not define this change.

In another study of aversion therapy, MacCulloch and Feldman (1967) utilized an anticipatory avoidance learning technique, in which participants were instructed to view images of men and press a button when they were no longer attracted to the image. If participants took longer than eight seconds, they received an electric shock. In one-third of cases, participants received a shock regardless of whether they pressed the button within eight seconds. This technique was interspersed with images of women, during which the participant would not receive a shock. The authors reported that 58% of participants experienced a shift in Kinsey score (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) in the heterosexual direction.

In contrast, James (1978) examined the efficacy of systematic desensitization in reducing social anxiety related to heterosexual experiences. Participants were asked to visualize scenarios that depicted such experiences through the use of hypnosis. Each vignette was paired with relaxing imagery in order to reduce participants' anxiety and increase arousal before progressing to increasingly anxiety-evoking scenarios. The author compared this technique to anticipatory avoidance, similar to that utilized by MacCulloch and Feldman (1967), as described above. James (1978) found that systematic desensitization was more effective than avoidance learning at reducing homosexual fantasies, interest, and behavior, while increasing heterosexual fantasies, attraction, and behaviors in men who had anxiety about heterosexual experiences.

Several studies of aversion therapy used nonequivalent groups to compare methods of eliminating same-sex attraction (Birk, 1974; Birk et al., 1971; McConaghy, Armstrong, & Blaszczynski, 1981). McConaghy et al. (1981) assigned 20 individuals to aversive shock treatments or covert sensitization (Cautela, 1967) and found no difference in same-sex attraction between treatments. Overall, 50% of participants reported decreased sexual feeling one year after treatment; however, the authors conceded that this decrease in arousal did not indicate a change in sexual orientation. Birk et al. (1971) reported that, while aversive conditioning led to decreased homosexual behavior as compared to associative conditioning, only one-eighth of aversion therapy participants had decreased long-term same-sex arousal after 1 year. Overall, the results of these three studies do not indicate that these interventions lead to change in sexual orientation in most participants.

One study examined the efficacy of group psychotherapy designed to encourage behavior consistent with traditionally masculine norms in homosexual male clients. The goals of this procedure included increasing assertiveness and identification with the male therapist, as well as producing "heterosexual shifts" (Birk, 1974). "Shifts" were defined as a change in position on the Kinsey scale in the heterosexual direction (Kinsey et al., 1948, 1953). Of the 40% of participants who did not drop out of the study within 18 months, the majority experienced some purported shift toward heterosexuality. However, Birk did not define what constitutes a "partial" or "complete" heterosexual shift.

Many later studies used retrospective designs while asking participants to describe their experiences with any form of SOCE (Beckstead & Morrow, 2004; Byrd, Nicolosi, & Potts, 2008; Nicolosi, Byrd, & Potts, 2000b; Pattison & Pattison, 1980; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005). Of these, many have drawn the conclusion that SOCE may be perceived as successful to those who wish to alter their sexual orientation (Beckstead & Morrow, 2004; Byrd et al., 2008; Nicolosi et al., 2000b; Schaeffer et al., 2000; Spitzer,

2003). Prior reviews have determined that studies in support of SOCE had a 30% "success" rate as the highest rate of change after SOCE (Haldeman, 1999).

In a study of individuals who sought any form of SOCE, 60.8% of male and 71.1% of female respondents reported that their efforts were "successful" (Schaeffer, Nottebaum, Smith, Dech, & Krawczyk, 1999). Success in this case was defined behaviorally as abstinence from homosexual contact for 1 year. However, it is important to note that abstinence does not capture the nuance of same-sex attraction or LGBQ identity, and it does not equate to a change in sexual orientation. Similarly, while Schaeffer et al. (2000)'s survey of participants from the same subject pool indicated that participants reported experiencing "significantly more heterosexuality" than they retrospectively recall experiencing when they were 18, the authors determined that there was insufficient evidence to conclude that therapeutic SOCE are effective in altering sexual orientation.

Pattison and Pattison (1980) used a retrospective convenience sample of individuals who participated in a Pentecostal Church Fellowship, described as "religious folk therapy." Of the 30 participants who took part in the fellowship, 11 reported some degree of change, 8 of whom reported that they no longer self-identified as homosexual and no longer engaged in "homosexual acts." Three men were described as "functionally heterosexual" but still experienced homosexual urges.

Nicolosi et al. (2000b) surveyed 882 participants who were "dissatisfied" with their same-sex attraction and sought various forms of SOCE in the past, including self-guided, online, and in-person conversion therapy with licensed therapists or pastoral counselors. Prior to SOCE, 2.2% of these participants described themselves as exclusively or almost entirely heterosexual, and 34.3% saw themselves this way at the time of this study. Of the 313 individuals who initially described themselves as exclusively homosexual, 17.1% reported a shift to exclusively heterosexual after SOCE and another 28.3% reported changes in their sexual orientation to more heterosexual than homosexual, or almost entirely heterosexual.

In a similar study, Spitzer (2003) recruited 200 participants who reported a change in their sexual orientation that had lasted at least 5 years following SOCE. These methods included ex-gay ministries, therapy, and religious support groups. Many participants reported healthy heterosexual relationships, with little or no thoughts of same-sex attraction. The majority of participants reported some change in their sexual orientation, although Spitzer acknowledged that reports of complete change were uncommon. In a 2012 reassessment of his study, Spitzer conceded that the study's methodology was not sufficient to conclude that SOCE resulted in sexual orientation change and offered an apology to the LGBQ community (Spitzer, 2012). He noted that, based on his methods, there was no way to conclude that sexual orientation change had, in fact, occurred, as his self-report measure of change was subjective and open to biases. Additionally, the sample was inherently biased, as Spitzer (2003) only recruited those who reported a change.

In Shidlo and Schroeder's (2002) research, 87% of the 202 former SOCE participants saw themselves as conversion therapy failures, across a wide variety of reported types of SOCE, including individual therapy, cognitive-behavioral or behavioral therapy, psychoanalysis, aversive conditioning, religious therapy, group therapy, hypnosis, couples therapy, and inpatient therapy. Meanwhile, 13% viewed the therapy as successful, with 4% reporting some level of change, and the remaining 9% using cognitive techniques to simply manage their same-sex attraction or accept celibacy. The average number of therapy sessions per participant was 118. In another study, of the 37 participants who had previously participated in any form of SOCE, none reported a significant difference in their sexual orientation or identity from the time prior to the SOCE intervention to present (Maccio, 2011).

In a 2015 survey of 1612 same-sex-attracted current and former members of the Church of Jesus Christ of Latter-day Saints (LDS), 73% of male and 43% of female participants reported that they attempted some form of SOCE (Dehlin et al., 2015). Of these individuals, only 3.1% of participants indicated some change in same-sex attraction. Of this 3.1%, approximately half described a decrease in frequency of attraction rather than complete elimination, while many reported only a decrease in sexual behavior. No participant reported a complete erasure of same-sex attraction. The most commonly sought change methods were private and religious, facilitated by clergy members as opposed to trained therapists (Dehlin et al., 2015). These methods, including practices such as prayer, temple attendance, and improving one's relationship with the church, were reported to be the least effective and the most damaging, in that many participants associated them with decreased self-esteem and increased shame, depression, and anxiety.

For individuals who ultimately came to embrace their LGBQ identity, SOCE were found to have the lowest ratings of benefit, as compared to other methods of psychotherapy (Jones, Botsko, & Gorman, 2003). In Dehlin et al. (2015), participants rated therapist-run SOCE as more effective and less psychologically damaging than other forms, including clergy-run SOCE. However, it was noted that "effective" did not necessarily indicate that sexual orientation change occurred, but instead often referred to other positive outcomes, such as acceptance of LGBQ orientation and improvements in mental health or family relationships. In fact, fewer than 4% of the sample reported any change in same-sex attraction, while 42% reported that their therapy was not at all effective in its intended goal to reduce attraction (Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015). Further, 37% found change-oriented therapies to be moderately to severely harmful. Meanwhile, therapies that affirmed an individual's LGBQ identity were often described as helpful in decreasing depression, increasing self-esteem, and improving relationships.

Methodological Limitations in SOCE Research

The majority of SOCE research contains methodological limitations that prevent causal attribution of perceived sexual orientation change. For instance, almost all of the aforementioned studies seeking to establish a relationship between SOCE and a change in sexual orientation lack a nonexperimental control group, instead comparing within subjects (McConaghy, 1969, 1976; McConaghy & Barr, 1973; McConaghy et al., 1972; Tanner, 1975). While the exception, Tanner (1974), found a decrease in arousal response to male images and an increase in frequency of sexual relations with women in experimental group subjects, there was no significant difference between the control and experimental groups in terms of frequency of same-sex sexual behavior. Thus, the only

conclusion that could be drawn from the early experimental research is that some men were able to decrease their sexual arousal through aversive conditioning.

The majority of studies on SOCE have specifically sought participants whose views were consistent with those of the authors, exclusively recruiting those who believed that their SOCE experiences were successes or failures. Few studies recruited both (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Further, the majority of research relied on a retrospective design in which individuals who have undergone SOCE were asked to recall their prior experiences (Byrd et al., 2008; Dehlin et al., 2015; Fjelstrom, 2013; Flentje, Heck, & Cochran, 2013; Flentje et al., 2014; Jacobsen & Wright, 2014; Jones et al., 2003; Maccio, 2010, 2011; Nicolosi et al., 2000b; Pattison & Pattison, 1980; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003). As time elapses, people have a tendency to incorrectly recall the frequency or intensity of past experiences and beliefs, due to response–shift biases (Schwartz & Rapkin, 2004). It is difficult to determine whether participants' recalled reports of their previous attraction or sexual behaviors were accurate; therefore, it is difficult to know whether a significant change occurred. This limits the conclusions that can be drawn from studies such as Spitzer (2003), in which participants were recruited 5 years after participating in SOCE, or Nicolosi et al. (2000b), in which participants indicated a mean of 6.7 years since their reported sexual orientation change, with 23% indicating that it had been 10 or more years.

An additional flaw in the retrospective design comes from the tendency of individuals to want to present themselves favorably when researchers expect change in sexual orientation after undergoing SOCE (APA, 2009; Fisher & Katz, 2000; Hill & Betz, 2005; Paulhus, 2002; Ross, 1989; Sprangers, 1989). This flaw would be especially prevalent in studies that recruit highly religious or "dissatisfied homosexual" individuals referred through conversion therapists, "ex-gay ministries," and pro-SOCE organizations, such as Exodus International or the National Association for Research and Therapy of Homosexuality (NARTH; Byrd et al., 2008; Nicolosi et al., 2000b; Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003).

Schaeffer et al. (2000) found that participants whose desire to alter their sexual orientation were highly motivated by religious beliefs were more likely to perceive that SOCE were successful. Similarly, those who were less religious were more likely to identify as LGBQ post-SOCE. For this reason, many studies that tout the efficacy of SOCE are not entirely generalizable, in that they exclusively recruit highly religious samples. For instance, in Spitzer (2003), 93% of participants described themselves as "extremely religious" and 79% reported that their motivation to change their sexual orientation stemmed from a conflict between their sexual orientation and religious beliefs. In Nicolosi et al. (2000b), this number was 96%. Additionally, participants who have been recruited from religious organizations may have an incentive to report, or at least convince themselves to believe, that their sexual orientation has changed. If individuals are coerced to participate in SOCE by their family or religious organization (Shidlo & Schroeder, 2002), this incentive is stronger.

An additional flaw in much of the research on SOCE is the lack of ethnic and gender diversity and therefore lack of generalizability to populations outside of the study samples. While Nicolosi et al. (2000b) claim that conversion therapy is efficacious, they acknowledge that the results are not generalizable past the present sample. Throughout the history of SOCE research, the participants in the majority of studies were either exclusively or predominantly White men. While more recent studies, particularly those reporting on negative outcomes, have included more female and racially and ethnically diverse participants (Dehlin et al., 2015; Flentje et al., 2013, 2014; Jacobsen & Wright, 2014; Nicolosi et al., 2000b; Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003), the existing research is still overwhelmingly oriented toward White men.

Negative Outcomes and Harms

Participation in SOCE is associated with numerous negative effects, including depression, suicidality, decreased self-esteem, and self-hatred (Beckstead & Morrow, 2004; Dehlin et al., 2015; Flentje et al., 2014; Jacobsen & Wright, 2014; Shidlo & Schroeder, 2002), as well as negative views of homosexuality, internalized homonegativity, sexual dysfunction, impaired familial and romantic relationships (Shidlo & Schroeder, 2002), and decreased overall sexual attraction (Jacobsen & Wright, 2014). In other studies, SOCE participants reported being encouraged to enter heterosexual relationships, marry, and have children, and many felt that they had failed if they were unable to follow through with these expectations (Drescher et al., 2016). This has also led to family dysfunction and increased stress for spouses, partners, and children (Beckstead & Morrow, 2004; Drescher et al., 2016). Some religiously motivated participants have reported a loss of faith, a distrust in God, or a feeling that God wanted them to suffer (Dehlin et al., 2015; Shidlo & Schroeder, 2002). Participants have also reported decreased capacity for intimacy and increased internalized homonegativity (Beckstead & Morrow, 2004). Finally, participants in aversion therapies, including those subjected to electric shock or nausea-inducing drugs, have reported decreased sexual attraction regardless of their partner's gender (McConaghy, 1969, 1999; McConaghy et al., 1972). This indicates that some participants experienced a level of conditioning such that they associated sexual arousal of all types with aversive stimuli.

Other reported negative and harmful aspects of SOCE include misinformation regarding the likelihood of sexual orientation change, treatments based on unsupported methods, discouragement of pursuing alternative treatments, and criticism for lack of progress (Schroeder & Shidlo, 2001). Others reported receiving false and stigmatizing information regarding LGBQ individuals (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). In some cases, harmful stereotypes were perpetuated. For instance, some SOCE methods included the ideas that homosexuality is a mental illness, that LGBQ people are inherently promiscuous and will contract HIV, or that gay men cannot be masculine (Flentje et al., 2013). Others grouped LGBQ individuals alongside child molesters, people with paraphilias, or other groups deemed sexually deviant (Flentje et al., 2013; Fookes, 1960). Further, many therapies used a misinformed psychoanalytic approach to attempt to identify the cause of a client's homosexuality, such as poor father–son relationships or childhood trauma (Byrd et al., 2008; Karten & Wade, 2010), despite the lack of evidence supporting these theories (APA, 2009; Bell et al., 1981; Freund & Blanchard, 1983; Green, 1987; Peters & Cantrell, 1991).

Studies have found that many individuals who turn to SOCE to change their sexual orientation experience high levels of internalized homonegativity (Tozer & Hayes, 2004), fear of negative familial reaction to their same-sex attraction (Maccio, 2010), a feeling of desperation, and a sense of vulnerability due to conflicts between religious identity and sexual orientation (Johnston & Jenkins, 2006). It was also found that these therapies often increased clients' sense of self-loathing, level of perceived pressure to conform to gender norms, and conflict between religious and sexual identities (Johnston & Jenkins, 2006). Similarly, participants have reported suppression of same-sex attraction, disconnection from their LGBQ identity, and a sense of inauthenticity, rather than a true orientation shift to heterosexuality (Fjelstrom, 2013). Some SOCE participants cite self-acceptance and the realization that sexual orientation change is not possible as reasons for ultimately embracing their LGBQ identity (Flentje et al., 2014). For many, it was only once they were able to accept themselves and their identities that they were able to heal from their negative SOCE experiences (Johnston & Jenkins, 2006).

Alternative Therapeutic Methods

Some participants did report positive outcomes associated with SOCE. For instance, some who reported that conversion therapy had been successful described development of coping strategies, a sense of belonging within an "ex-gay" community, spiritual connection, and a sense of hope in the idea that their LGBQ identity can be changed (Beckstead & Morrow, 2004; Byrd et al., 2008; Nicolosi et al., 2000b; Shidlo & Schroeder, 2002). Methods reported as most helpful included cognitive and behavioral techniques, such as reframing same-sex attraction as a psychological symptom resulting from emotional distress, and imagining aversive thoughts during arousal, such as contracting HIV (Shidlo & Schroeder, 2002). Other techniques that some reported as helpful included psychotherapy and self-guided methods, such as reading relevant literature and attending lectures (Nicolosi et al., 2000b; Ponticelli, 1999), and interventions including men's weekend retreats, mentoring relationships, and developing nonsexual same-sex relationships (Karten & Wade, 2010).

Despite these findings, it is likely that many of the above-mentioned positive outcomes may be achieved through other methods, such as affirming therapies, that are not associated with the negative outcomes of SOCE. For example, some SOCE participants reported an increase in hopefulness (Shidlo & Schroeder, 2002). However, Skerven, Whicker, and LeMaire (2019) outline the ways in which dialectical behavior therapy (DBT) can be used with LGBQ clients and note that increasing hopefulness is a primary target of DBT. Shidlo and Schroeder (2002) also reported that some participants were able to find effective coping strategies through SOCE. However, DBT's core tenant of radical acceptance teaches clients to balance accepting difficulties that cannot be easily changed, such as societal and structural homophobia, while working toward changing things within their power, such as how they interact with and react to homophobic individuals in their daily life.

Respondents in the study by Shidlo and Schroeder (2002) also reported feeling relief due to the self-disclosure aspect of some SOCE interventions. Some reported that this was the first time that they had a forum to discuss their conflicted feelings about their sexual orientation. Similarly, "dissatisfied homosexual" respondents who had pursued SOCE reported improved self-acceptance and self-understanding as a result of SOCE (Nicolosi et al., 2000b). However, as these participants were recruited through conversion therapists and ex-gay ministry groups, it is likely that sampling bias may have led to recruitment of those who were more likely to report benefits of SOCE.

Benefits such as self-disclosure, self-acceptance, and self-understanding may also be gained through other forms of therapy that are not associated with negative outcomes, such as LGBQ-affirming therapies (Milton, Coyle, & Legg, 2002). In affirming therapy, the client is given the space to talk about their difficulties with a nonbiased therapist. Additionally, the therapist emphasizes a discriminatory culture, rather than homosexuality itself, as problematic, which creates a more open space for self-disclosure. While many respondents felt that they gained a sense of community connectedness through SOCE-oriented support groups (Byrd et al., 2008; Flentje et al., 2014; Ponticelli, 1999), the benefit derived from connection with those who have had similar experiences can also be attained in an affirming environment.

Many individuals who seek to alter their sexual orientation do so because they feel that it does not align with their religious doctrines. Respondents in both the Nicolosi et al.'s (2000b) and Shidlo and Schroeder's (2002) studies emphasized an increased closeness with God and improved spirituality as a result of SOCE. However, there are other means of increasing one's sense of spirituality, if desired, without the risk of SOCE-related harms and without denying or attempting to change one's sexual orientation. Such means may include forming a relationship with a congregation that is LGBTQ-affirming or by integrating religion into therapeutic practices (Beckstead, 2001; Haldeman, 2004; McGeorge et al., 2014; Throckmorton, 2007).

Ethical Guidelines

Distinctions have been made regarding whether SOCE should be administered on both empirical and ethical grounds (Davison, 1976, 1978). Empirically, it can be argued that SOCE are ineffective in altering sexual orientation for the majority of participants, and the studies that have reported successes are hindered by methodological limitations. Ethically, it has been argued that therapists should work according to general ethical values rather than personal morals and that such an approach would better serve clients' interpersonal and psychological struggles. As such, arguments regarding whether it is empirically possible to alter sexual orientation are secondary to whether a therapist ethically should (Davison, 1976, 1978).

Several studies have reported that SOCE consumers experience treatment that violates therapists' ethical values (Flentje et al., 2013; Schroeder & Shidlo, 2001), including inadequate informed consent, breaches of confidentiality, and coercion (Schroeder & Shidlo, 2001). Flentje et al. (2013) found that 26.3% of participants reported experiencing interventions, such as aversive therapies or covert sensitization, in which they were to associate pain or unpleasant images with homosexual fantasies. These techniques were considered to be ethically questionable as they not only cause pain, but also have been associated with decreased sexual arousal to any stimulus (McConaghy, 1969, 1999; McConaghy et al., 1972).

The issue of voluntary participation has been present throughout SOCE practice and research. In several early studies on the efficacy of SOCE, some or all subjects were court-ordered to participate in conversion therapy treatments, due to either the criminalization of homosexual conduct or a paraphilia conviction unrelated to same-sex attraction (Callahan & Leitenberg, 1973; James, 1978; MacCulloch & Feldman, 1967; McConaghy, 1969, 1976; McConaghy et al., 1972). In addition, some participants report being forced into SOCE. For instance, in Shidlo and Schroeder's (2002) study of the experiences of former recipients of conversion therapy, approximately 25% of participants felt that they were coerced into pursuing SOCE by their families or religious organizations. Other participants reported that they were mandated to participate in SOCE by religious universities under threat of losing financial aid (Shidlo & Schroeder, 2002). Further, it may be argued that societal prejudice and familial isolation, paired with the resultant feelings of shame and guilt that many LGBQ individuals experience, detract from the voluntariness of their decision to participate in SOCE (Davison, 1976).

Studies of therapists have found that only a small percentage report that they would conduct SOCE-oriented therapies (Bartlett et al., 2009) and that a majority believe that conversion therapy is unethical (McGeorge et al., 2015, 2017). A belief that conversion therapy is not unethical was associated with decreased clinical competence when working with LGBQ clients and increased negative beliefs about LGBQ individuals (McGeorge et al., 2015). Similarly, a 2000 pro-SOCE survey of therapists who practice reorientation therapy found that 90% of the 206 individuals surveyed maintain the belief that homosexuality is a developmental disorder (Nicolosi et al., 2000a), despite the significant scientific evidence to the contrary (American Psychiatric Association, 1973; American Psychological Association, 2000; Gonsiorek, 1991).

The APA's "Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients" (2012) presents a series of considerations that are important in working with LGBQ clients. In addition to a lack of empirical evidence supporting the efficacy of SOCE and data suggesting that SOCE are associated with negative outcomes, SOCE also violate the APA's ethical standards for psychologists, counselors, and other service providers, as described below.

The Importance of Recognizing the Impact of Stigma on LGBQ Individuals

LGBQ individuals experience high rates of stigma, heterosexism, violence, and discrimination (Herek, 1991, 2009; Mays & Cochran, 2001; Meyer, 2003). One-eighth of lesbian and bisexual individuals and four-tenths of gay men in the United States report that they have been victimized due to their sexual orientation (Herek, 2009). Discrimination may contribute to difficulties in accepting one's sexual orientation and a struggle to develop a positive identity.

Discrimination can also contribute to the development of psychological symptoms. The minority stress model (Meyer, 1995, 2007; Meyer & Dean, 1998) suggests that individuals who are minorities experience discrimination, victimization, and microaggressions. These experiences create chronic levels of stress that lead to internalization of negative societal views, expectations for future discrimination, and vigilance about when discrimination will occur, which in turn contribute to higher rates of psychological symptoms in LGBQ individuals.

The time during which LGBQ young people begin to identify their own same-gender attraction is often associated with confusion, anger, and guilt (McCarn & Fassinger, 1996), likely due to the recognition and internalization of negative societal views. Participation in SOCE also perpetuates these views, as it implies that LGBQ orientations should be changed. Participation in SOCE may be driven by experiences of discrimination, which often lead LGBQ individuals to experience greater difficulty embracing their sexual orientation. Thus, it is not surprising that the propensity to seek SOCE is associated with lack of LGBQ identity development (Tozer & Hayes, 2004) and that individuals who seek SOCE may be highly vulnerable and distressed.

LGBQ Sexual Orientation is not a Form of Psychopathology

SOCE are built on the premise that same-sex attraction is pathological and distressing and that if an individual experiences conflict regarding their sexual orientation, it should be changed. Value is placed on heterosexual relationships, even if the individual continues to have same-sex attraction (Nicolosi et al., 2000b). Consistent with this, one study found that two-thirds of participants in SOCE reported that their therapists claimed that they could not lead positive or fulfilling lives as gay individuals (Shidlo & Schroeder, 2002). This pathologization of same-sex attraction and behaviors is in violation of the APA's ethical guidelines.

Although homosexuality was considered a diagnosis in the Diagnostic and Statistical Manual (DSM) until 1973 (American Psychiatric Association, 1952; APA, 1968, 1973; Bayer, 1981; Drescher & Merlino, 2007), this view is antiquated and has been refuted in recent literature. As early as 1957, Hooker conducted assessments on heterosexual and homosexual men and did not find differences in their psychological functioning. Empirical research has since amassed demonstrating that same-sex attraction is not associated with poorer psychological functioning (Gonsiorek, 1991; Pillard, 1988; Rothblum, 1994), including a lack of difference between heterosexual and gay/lesbian individuals in psychological symptoms and self-esteem (Coyle, 1993; Herek, 1990; Savin-Williams, 1990). While differences in various aspects of psychological functioning have been found between gay and straight individuals, including increased rates of anxiety and mood disorders (Gilman et al., 2001; Mays, Cochran, & Roeder, 2003), substance use (DiPlacido, 1998; Gilman et al., 2001), and suicidality (DiPlacido, 1998; Gilman et al., 2001; Rotheram-Borus, Hunter, & Rosario, 1994), these differences are thought to be related to experiences of discrimination and minority stress (Kessler, Michelson, & Williams, 1999; Markowitz, 1998).

Therapists Should Identify Their Own Biases and Attitudes and Refer if Necessary

Therapists who see same-sex attraction as a form of psychopathology are likely to communicate this bias to their client, unintentionally or otherwise, even if the client does not identify their LGBQ identity as an issue (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Liddle, 1996; Nystrom, 1997). In fact, Shidlo and Schroeder (1999) reported that a large number of

clients lied to their therapist regarding their same-sex attraction or sexual behaviors in order to appease their therapist. This is clear evidence of the influence that therapists' actual or perceived beliefs can have on clients. In addition, heteronormativity pervades psychological therapy and theories (Anderson, 1996; Brown, 1989; Gingold, Hancock, & Cerbone, 2006) as well as standardized questionnaires, interviews, and medical forms. An inability to acknowledge bias against LGBQ individuals can lead therapists to ignore discrimination related to sexual orientation and deny this source of stress (Garnets et al., 1991; Winegarten, Cassie, Markowski, Kozlowski, & Yoder, 1994).

Recognize Bisexual Individuals' Unique Experiences

Some bisexual individuals have reported that they do not feel that they are visible or legitimate members of the LGBTQ community, as they may be assumed to be heterosexual if they are in mixed-gender relationships (Ochs, 1996). Bisexual individuals also may experience discrimination and identity erasure from within the LGBTQ community (Herek, 1999; Herek, 2002; Mohr & Rochlen, 1999). Conversely, bisexual individuals may be assumed to be gay if they are dating a same-gender partner and may face homophobic discrimination from heterosexual individuals (Bradford, 2004; Keppel & Firestein, 2007; Rust, 2007). As such, some bisexual individuals report that they feel uncomfortable being open about their sexual orientation due to discrimination from multiple groups (Balsam & Mohr, 2007). A lack of self-disclosure may reduce discrimination (Mays & Cochran, 2001), but it also may lead to greater internalized negativity about one's bisexual identity (Brewster, Moradi, DeBlaere, & Velez, 2013).

SOCE do not distinguish between bisexual and lesbian/gay individuals, nor do they recognize bisexual individuals' unique experiences. In fact, many pro-SOCE empirical studies rely on mixed samples of lesbian, gay, and bisexual clients (Byrd et al., 2008; Nicolosi et al., 2000b). Proponents report that the fact that clients are engaging in mixed-gender relationships indicates that clients' sexual orientations were changed; when in fact, many clients reported either that they were bisexual or that they already had a level of mixed-gender attraction. This indicates that it was likely not the clients' sexual orientation that changed, but rather the proportion of clients who were engaging in mixed-gender relationships.

Recognize that Some Families do not Embrace LGBQ Individuals

Social support from family and friends is associated with higher self-esteem, better psychological adjustment, and reduced psychological symptoms in LGBQ individuals (Grossman, D'Augelli, & Hershberger, 2000; Hershberger & D'Augelli, 1995; Munoz-Plaza, Quinn, & Rounds, 2002; Waller, 2001; Williams, Connolly, Pepler, & Craig, 2005; Zea, Reisen, & Poppen, 1999). Despite the important role that familial support can serve for LGBQ individuals, many families are not supportive (Doty, Willoughby, Lindahl, & Malik, 2010; Higa et al., 2014; Pearson & Wilkinson, 2013). Familial rejection is associated with psychological symptoms (Bouris et al., 2010; Haas et al., 2010; Higa et al., 2014), including dramatically increased rates of suicide attempts, depression, and substance use (Ryan, Huebner, Diaz, & Sanchez, 2009).

SOCE reinforce the rejection that LGBQ individuals experience from family and community members and promote internalization of negative attitudes. In some SOCE practices, individuals are removed from group therapy if they engage in same-sex sexual behaviors, therein reducing sources of social support and contributing to isolation.

Note Whether LGBQ Identity is Consistent With Other Identities Including Ethnic/Racial and Religion/Spirituality

Forty percent of LGBTQ adults are racial or ethnic minorities (Gates, 2017), and this percentage has steadily been increasing since 2012 (Newport, 2018). Individuals of intersecting minority identities may experience conflict between various aspects of their identity (Cochran & Mays, 1994; Díaz, Ayala, Bein, Henne, & Marin, 2001; Wilson & Yoshikawa, 2004). Having multiple minority identities may reduce opportunities for support, as some individuals have reported feeling isolated from the LGBTQ community due to their racial, ethnic, or religious identity (Greene, 2007; Ward, 2008). Further, some individuals experience isolation from their racial, ethnic, or religious community due to their LGBTQ identity (Ward, 2008). These experiences of discrimination and community exclusion can lead to identity confusion and internalization of homonegativity (Martinez & Sullivan, 1998).

Inconsistencies between identities may also cause internal conflict and distress, which can lead an individual to seek SOCE. However, as we describe below in the section on affirming therapy, it is quite possible to integrate religion into affirming therapy and to provide a supportive environment in which to discuss conflict between a client's racial, ethnic, or religious identity, and their sexual orientation.

Psychologists Should be Accurate in Disseminating Research on Sexual Orientation

As always, one of the most important ethical guidelines for therapists is to be honest and accurate regarding what they know about sexual orientation. Due to limited training on working with LGBQ clients, many therapists or student therapists are unaware of the efficacy of affirming therapy for LGBQ individuals or the dearth of methodologically sound studies supporting SOCE. Future training should focus on increasing therapists' knowledge about the research literature and specialty training should be implemented in training programs.

Affirming Therapy

Affirming therapy is an alternative option that is consistent with APA guidelines for working with LGBQ individuals (Cramer et al., 2008). Affirming therapists use a supportive approach to convey acceptance and to view the client as a valuable individual (Milton et al., 2002). When conducting affirming therapy, the client's sexuality is not identified as problematic. In contrast, affirming therapies recognize that sexual attraction and behaviors fall along a continuum.

When clients seek therapeutic services related to distress about their sexual orientation or conflict between intersecting identities, such as religious, ethnic, or racial identities and sexual orientation,

therapists should provide a safe space to examine whether this distress may be related to internalized homonegativity (Przeworski & Piedra, 2020; Tozer & Hayes, 2004). Affirming therapy recognizes the impact that discrimination and internalized homonegativity may have on the mental health of LGBQ individuals (Chernin & Johnson, 2003; Milton et al., 2002). As such, affirming therapy teaches methods of coping with discrimination or isolation, including becoming engaged with and seeking support from the LGBTQ community and allies. In doing so, LGBQ individuals who experience identity conflicts may find new sources of support and connect with others who share their intersecting identities. In order for therapists to be able to increase a client's community engagement, therapists need to be aware of the available resources, community connections, and LGBTQ culture (APA, 2012; Przeworski & Piedra, 2020).

Affirming therapists can also work to help religious LGBQ clients to identify ways in which their religious beliefs and sexual orientation are consistent. In a survey of 341 family therapy students, McGeorge et al. (2014) found that students were more likely to perceive affirming therapy as more congruous with religious beliefs than SOCE. Further, training in integration of religion and spirituality into therapeutic practice was positively associated with support of affirming therapies and a positive view of LGBQ individuals. When individuals experience conflicts between their sexual orientation and religious identity, affirming therapists can help clients to find ways to integrate both identities, such as finding a congregation that is welcoming to LGBTQ individuals (Beckstead, 2001; Haldeman, 2004; Throckmorton, 2007).

Affirming therapists recognize all sources of social support, including family, chosen family, friends, community members, and service providers, and strive to increase connection with community resources. They also recognize that family members may lack understanding or acceptance of LGBQ orientations and the impact that this may have on a client's self-acceptance. In some situations, family members may be motivated to learn more about the LGBTQ community or to become more accepting. However, Miville and Ferguson (2004) emphasize that affirming therapists should not always encourage clients to come out or assume that coming out is always adaptive. Instead, affirming therapists should examine the potential consequences of coming out to help the client to make an educated decision regarding whether to do so. This may include coming out to some family members but not others or coming out to friends and community members but not to family. If a client would like to come out to family members who may not be affirming, therapists should work with the client to prepare for the potential emotional and relational issues that may follow. When appropriate, affirming therapy also aims to teach family members and friends to be supportive and aids LGBQ individuals in communicating their needs to loved ones.

Haldeman (1999) suggested that affirming therapists should tell clients who have attempted SOCE in the past that they do not need to lie or pretend to have beliefs that they do not have in order to please the therapist. If they are experiencing ambivalence or conflict regarding their sexual orientation, therapy is a safe place to examine these feelings, and the therapist should accept this uncertainty or conflict as part of forming one's sexual identity.

Additionally, affirming therapists should ensure that therapy goals are created collaboratively (Beckstead & Israel, 2007). The affirming therapist should validate the client's experience and provide a safe and accepting environment for clients to explore their identity and combat maladaptive cognitions (APA, 2012; Haldeman, 1991). As Davison (1976) and Halleck (1971) argued, a therapist should not strive to achieve ethical neutrality in acquiescing to a client's perceived desire to alter their sexual orientation. Rather, therapists should affirm the client's LGBQ identity in order to help the client to reconceptualize their internalized negative self-views.

Discussion

Based on the aforementioned standards, as set forth by the APA Division 12 Task Force (Chambless & Hollon, 1998; Chambless & Ollendick, 2001), SOCE do not meet the criteria to be deemed efficacious or well-established. The few studies that assert the efficacy of SOCE demonstrate limited success. Further, they are fraught with methodological flaws that call their validity into question and prevent the generalizability of the results. Meanwhile, there are many contrasting studies that detail the numerous harms and negative outcomes associated with SOCE. SOCE therapies, inclusive of conversion, reparative, and reorientation therapies, have been deemed both ineffective and harmful by the APA (APA, 2009; Haldeman, 2002; Serovich et al., 2008; Shidlo, & Schroeder, 2002). Despite this, they continue to be implemented (Mallory, Brown, & Conron, 2018). These therapies tend to function under the flawed notion that sexual orientation is a learned behavior that can be changed, rather than an innate trait (Drescher, 1998, 2002, 2003, 2015).

Papers citing research on SOCE were published as early as 1948 (Kinsey et al., 1948). From this point through the 1980s, researchers had a tendency to focus on methods through which to alter sexual orientation, with several studies reporting some form of support for the practice. Coinciding with the de-pathologization of homosexuality in the DSM (American Psychiatric Association, 1973) and the push by major psychological organizations to destigmatize LGBQ identities and denounce SOCE, perceptual tides have begun to shift. A more common theme in recent literature has been the inefficacy of SOCE and the harmful effects and unethical practices associated with these efforts.

It is likely that results interpreted by proponents of SOCE as indicative of the efficacy of SOCE research are due to methodological flaws of the studies as well as invalid interpretations of findings. Many studies relied on retrospective reports, which can be biased and may not be reliable (Beckstead & Morrow, 2004; Byrd et al., 2008; Nicolosi et al., 2000b; Pattison & Pattison, 1980; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005). Numerous studies used problematic methods of measuring change in sexual orientation as their outcome measures, such as involvement in a heterosexual relationship, sexual arousal in response to same-sex pictures, and reports of sexual behaviors (Birk, 1974; Birk et al., 1971; Callahan & Leitenberg, 1973; McConaghy, 1969, 1976; McConaghy & Barr, 1973; McConaghy et al., 1972; Pattison & Pattison, 1980; Schaeffer et al., 1999; Tanner, 1974). Many studies' designs did not include a comparison group, and because of this, any results found cannot be attributed to the therapy implemented (McConaghy, 1969, 1976; McConaghy & Barr, 1973; McConaghy et al., 1972; Tanner, 1975). Studies also used nonrandom samples of individuals, such as those from highly

religious populations, who are more likely to perceive and report orientation change post-therapy (Nicolosi et al., 2000b; Shidlo & Schroeder, 2002; Spitzer, 2003). Additionally, studies were conducted in primarily Caucasian samples, limiting the generalizability (Nicolosi et al., 2000b).

In some studies, participants reported positive experiences. These positive experiences included hopefulness, improved coping strategies, relief due to self-disclosure, improved self-acceptance, and improved self-understanding (Beckstead & Morrow, 2004; Nicolosi et al., 2000b; Shidlo & Schroeder, 2002). DBT- and LGBQ-affirming therapies are alternatives which also address these areas but do so in a way that is less likely to cause negative effects when compared to SOCE (Milton et al., 2002; Skerven et al., 2019).

Not only is there insufficient evidence to deem SOCE effective, but it has also been associated with negative outcomes (Schroeder & Shidlo, 2001), including depression, suicidality, self-harm, internalized homonegativity, sexual dysfunction, and impaired relationships (Beckstead & Morrow, 2004; Dehlin et al., 2015; Flentje et al., 2014; Shidlo & Schroeder, 2002). SOCE target those who are already at risk to experience stigma, heterosexism, violence, and discrimination (Herek, 1991, 2009; Mays & Cochran, 2001; Meyer, 2003) and may compound these experiences, lead to greater identity difficulties, and perpetuate broader societal notions of homonegativity.

Future research exploring the harms and negative outcomes associated with SOCE should address the lack of racial, ethnic, and gender diversity in the samples. The majority of studies were conducted in predominantly or exclusively Caucasian and cisgender male samples. Additionally, many studies were conducted in highly religious samples, limiting the generalizability of findings. It is important to understand the ways in which intersecting racial, religious, and gender identities may interact with the negative effects of SOCE. While a significant body of research identifies the negative outcomes of SOCE, there is virtually no research regarding potential harmful effects of attempts to alter gender identity. Finally, further research should be conducted on affirming therapies in order to determine how to best integrate identities and tailor treatments to the unique needs of LGBTQ individuals.

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