UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY, Plaintiff, v. **NICHOLAS W. BROWN**, in his official capacity as Attorney General for the State of Washington; **DENNIS WORSHAM**, in his official capacity as Secretary of Health for the State of Washington; and **SHAWNA FOX**, in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health, Defendants.	Case No. 3:21-cv-05359-RJB **DECLARATION OF D. PAUL SULLINS, PH.D.**

I, D. Paul Sullins, Ph.D., hereby declare under penalty of perjury of the laws of the United States that the statements in my expert report attached hereto are true and accurate to the best of my knowledge and represent my professional opinions.

DATED this 17th day of June, 2026, at Hyattsville, Maryland.

D. Paul Sullins, Ph.D.

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Expert Report of

D. Paul Sullins, Ph.D.

Tingley v. Ferguson

United States District Court
Western District of Washington

Table of Contents

I. Credentials and Qualifications 1

II. Compelling scientific evidence refutes the assertions that same-sex sexual orientation is biologically determined and is immutable. 3

A. "Sexual orientation" is not clearly defined. 3

B. Same-sex orientation is not genetically determined. 5

C. Same-sex orientation often changes in a heterosexual direction over the life course 7

D. Most nonheterosexual persons report both same-sex and other-sex attractions, leaving room for agency and choice in sexual behavior. 9

III. Current scientific evidence does not support the conclusion that the primary cause of the psychological difficulties of sexual minority persons is so-called "minority stress" 11

A. The problem of poor mental health in the LGB population. 11

B. The Minority Stress Theory. 13

C. Methodological defects and data limitations 15

1. Studies done using non-representative "convenience samples" do not permit conclusions about the general population. 15

2. Self-reports relating to mental health are known to be unreliable and subject to bias. 20

3. "Success exclusion" renders many studies of change-allowing sexual orientation therapy statistically meaningless. 23

D. Explanations for a correlation between LGB identity and poor mental health other than the Minority Stress Theory exist, and have not been excluded. 25

1. Reverse Causation 25

2. Common Causation 27

3. Confounding Variables 28

E. Important evidence inconsistent with the MST exists. 31

1. The mental health of LGB populations is not better in countries that are widely recognized to be more accepting of LGB identities. 31

2. The mental health of LGB individuals has not improved across time as society has become vastly more accepting of sexual minorities and alternative sexual lifestyles. 33

3. Some studies have failed to find other correlations predicted by the Minority Stress Theory. 34

IV. Current scientific evidence does not support the conclusion that voluntary therapeutic conversations which may lead to change in sexual attraction, behavior, or orientation are harmful to most persons. 37

A. Therapeutic approaches to unwanted same-sex attractions or behaviors have changed radically over time. 37

B. Advocates of censoring counseling and therapeutic speech conflate unrelated therapies, misdescribe actual clinical practices, and misleadingly invoke obsolete practices. 39

1. The claim that current change-allowing sexual orientation therapy assumes that homosexual orientation is a mental disorder is false. 40

2. Criticism of trauma intervention by change-allowing therapists is unfounded. 41

3. Misleading suggestions that current change-allowing sexual orientation therapy employs coercive or aversive techniques are false. 43

C. SOCE-critical research has substantial methodological limitations. .. 45

1. Some SOCE-critical reviewers acknowledge these limitations. 45

2. Cross-sectional studies cannot definitively predict the risk of harm. 46

3. Multiple studies of current talk therapy that have not excluded non-LGB respondents have reported substantial psychological benefit and/or lack of harm from change-allowing sexual orientation therapy. 49

D. Studies claiming harm from change-allowing sexual orientation or gender identity therapy have been subject to disabling biases that render their findings invalid. 57

1. First, SOCE-critical studies have improperly excluded participants who do not self-identify as LGB. 57

2. Second, studies claiming harm from change-allowing sexual orientation or gender identity therapy have improperly attributed pre-existing harm to the therapy. 61

E. SOCE research has understated the possibility of sexual orientation change and overstated harm by focusing on male experience to the detriment of women. 70

F. Advocates of censoring counseling and psychotherapeutic speech risk harm to patients by ignoring patients' religious convictions and identities. 72

1. SOCE-critical research has minimized the importance of deeply held religious convictions that conflict with same-sex orientation to the persons who experience them. 72

2. Dr. Yarhouse's method of therapy for highly religious persons with same-sex attraction does not render SOCE unnecessary.. 75

V. Research and publication on SOCE has been corrupted by pervasive and explicit ideological bias. 76

A. The social science academy has become a self-policing "tribal moral community" that "distorts and undermines" objective science. 77

B. The published scientific record is further skewed by censorship at multiple levels. 78

C. Pronouncements of professional associations, and particularly the APA, represent ideology rather than science. 82

References 87

I. Credentials and Qualifications

1) I am an Associate Professor of Sociology (retired), with a current appointment as Research Professor, at the Catholic University of America, with particular expertise in inferential statistics, the sociology of religion, and issues in human sexuality. During my teaching career, I taught both basic and advanced statistical research methods at both the graduate and undergraduate levels. I have authored or co-authored over 150 peer-reviewed journal articles, book chapters, and applied survey research reports on these and other topics. At Catholic University, I am a Distinguished Senior Fellow of the Institute for Human Ecology and Director of the Leo Initiative for Social Research. I am a Member of the Board, Society of Catholic Social Scientists, and either past or current member of the American Sociological Association, American Psychological Association, Association for the Sociology of Religion, Mensa, and the Society for the Scientific Study of Religion. I obtained my B.A. in Philosophy and Religious Studies in 1973, a Master's of Divinity in 1981, an M.A. in Sociology in 1995, and a Ph.D. in Sociology in 1998. My full *curriculum vitae* is appended.

2) Within the last four years, I have provided expert testimony by written documents, deposition, or trial in one case in the United States (*Wyatt Bury, LLC v. City of Kansas City*, No. 4:25-cv-00084-RK (W.D. Mo. Apr.14, 2025)) and two cases in the United Kingdom (*Ngole v. Touchstone Leeds Limited* and *Leger v. Teaching Regulation Agency*).

3) I have recently authored or co-authored five peer-reviewed scientific research studies on the topic of sexual orientation change:

- "Sex Differences in Reported Effectiveness and Psychosocial Effects of Therapy-Assisted Sexual Orientation Change. Cureus. 18(3): e104735 (March 5, 2026).

- "What sexual orientation change efforts change: evidence from a United States sample of 72 exposed men" Cureus 16(9): e68854 (September 07, 2024).
- "Sexual identity-behavior discordant heterosexuals in Britain: findings from the National Survey of Sexual Attitudes and Lifestyles 2010-12 (NATSAL-3)." With Maria Calatrava (lead author) and Steph James. Sexes 2023, 4 (December): 601-621.
- "Critiques strengthen and improve the original findings: A rejoinder to comments on Sullins (2022)." Archives of Sexual Behavior (March 2023): 889-899.
- "Sexual orientation change efforts do not increase suicide: Correcting a false research narrative." Archives of Sexual Behavior 51, no. 7 (October 2022): 3377-93.
- "Absence of behavioral harm following non-efficacious sexual orientation change efforts: A retrospective study of United States sexual minority adults 2016-2018" Frontiers in Psychology 13:823647 (2022): 1-12.

4) I have been asked to offer opinions on the strength of the scientific evidence regarding the following three propositions: 1) that sexual orientation is always inherent and immutable; 2) that the psychological difficulties of sexual minority persons are attributable wholly or mainly to social stress and discrimination due to their sexual minority status (the Minority Stress Theory); and 3) that voluntary counseling which may support a change in sexual orientation is necessarily harmful. In brief, my opinions on these questions are that strong, compelling scientific evidence refutes the first proposition (that sexual orientation is always inherent and immutable), and that current scientific evidence does not permit a positive conclusion regarding the remaining two propositions. I have also been asked to offer an opinion on the general state of credibility, objectivity, ideological bias and censorship in the academic literature on these and related questions. My opinion is that the pertinent academic psychological literature has been corrupted by pervasive, extreme and explicit ideological bias. The evidence

supporting each of these four opinions is presented in the major sections of the following report.

5) For purposes of preparing this report, I have reviewed the books and the many peer-reviewed articles listed in the attached bibliography.

II. Compelling scientific evidence refutes the assertions that same-sex sexual orientation is biologically determined and is immutable.

6) It is often asserted that same-sex sexual orientation is inherent and immutable in each person. But such assertions appear to be driven by ideology and advocacy, rather than science. Empirical research contradicts rather than confirms such claims.

A. "Sexual orientation" is not clearly defined.

7) At the threshold, it is important to understand that—contrary to the lay understanding—the concept of sexual orientation is neither simple nor clearly defined. There is wide disagreement among researchers regarding what comprises the dimensions, patterns, behaviors, identities, and experiences that define a particular sexual orientation. Persons of the same sexual orientation may have different dimensions, patterns, identities, behaviors, and experiences, and these categories can overlap between persons of different sexual orientations. This is especially the case when considering non-heterosexual orientations, and particularly problematic when considering changes in orientation.

8) In a prominent review of the state of measurement in this field, Wolff et al. conclude: "The lack of consistent methods for defining and assessing sexual orientation and sexual minority status obstructs an accurate understanding of the populations who experience sexual orientation–related health disparities" (Wolff et al., 2017, p. 508). A review panel of prominent sexuality researchers at the National Academy of Sciences agrees: "Sexual orientation and gender nonconformity are multifaceted concepts, and defining them operationally can be challenging"

(Institute of Medicine et al., 2011, p. 3). Dr. Lisa Diamond, co-editor of the American Psychological Association (APA) Handbook of Sexuality and Psychology, confirms that "sexual orientation is not easy to define or measure.... Different researchers have emphasized different facets, and the facets themselves do not always coincide," and she emphasizes that "none of the studies reviewed here can claim to have assessed the core construct of sexual orientation, given its inherently multidimensional nature" (Diamond & Rosky, 2016, p. 365). Wolff et al. identify three main dimensions by which sexual minorities are typically defined: "sexual identity labels such as 'lesbian,' 'gay,' or 'bisexual' (LGB), those who express attraction to individuals of the same sex or gender, or those who have had any sexual experiences with same-sex partners regardless of their sexual identity label" (Wolff et al., 2017, p. 508).

9) Complicating matters further, unlike the heterosexual majority, for most sexual minority persons, these three main dimensions of sexual orientation are often not congruent or integrated in population measures. Most persons identifying with a same-sex orientation experience only one or two of the three dimensions of that orientation at any given time. In their survey of a representative sample of the American population, Laumann et al. (1994) found that, of persons who experienced same-sex orientation on any one of the three dimensions, only 24% of males and 15% of females experienced it on all three dimensions (p. 299). Likewise, the 2010 British survey of National Sexual Attitudes and Lifestyles (NATSAL) revealed that only 26% of non-heterosexual men and 14% of non-heterosexual women reported same-sex orientation on all three dimensions. (Geary et al., 2018, p. 9). In sum, about three-fourths of same-sex oriented men and over five-sixths of same-sex oriented women do not experience same-sex orientation on all three dimensions.

10) Same-sex orientation, therefore, is not a discrete, coherent condition so much as it is a set of loosely affiliated inclinations and behaviors which operate largely independently of each other. This makes it difficult to conceptualize what constitutes change. For example, if a man is sexually attracted to other men but identifies as heterosexual (as some do), and has sex with other men (as some do) (Geary et al., 2018, p. 9), but seeks counsel to stop doing so for health reasons, perhaps because he is among the approximately 30% of such men who are in an opposite-sex marriage (Calatrava et al., 2023, p. 408, Table 3), is his counselor trying to help him change sexual orientation? What if an LGB-identified man, who is among the 8% of such men who neither experience same-sex attraction nor have sex with men (Geary et al., 2018, p. 9), wishes to discuss calling himself heterosexual?

11) The vagueness and variety of definitions of sexual orientation in the research literature greatly complicate any attempt to discuss the evidence and science concerning change in sexual orientation. The failure of many researchers and advocates to state what definition of sexual orientation they themselves are using exacerbates the problem.

B. Same-sex orientation is not genetically determined.

12) The search for a specific genetic basis for sexual orientation (a "gay gene") went on for years, and the existence of such a gene has often been asserted with great certainty, almost as a matter of faith. However, despite extensive effort, no one has discovered a reliable genetic or hormonal marker for sexual orientation. The American Psychological Association (APA) (2008) states: "Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit

scientists to conclude that sexual orientation is determined by any particular factor or factors" (2008).

13) Now, newly available tools of genomic analysis have recently led to a strong and well-accepted conclusion that no such gene exists. In 2019, a team of geneticists at the Massachusetts Institute of Technology (MIT) led by Andrea Ganna examined the genomes of over 475,000 individuals to determine, by direct observation, whether there was any association between particular genes or combinations of genes with self-report of any prior homosexual sexual activity. Rebutting widespread belief, the study concluded that: "there is certainly no single genetic determinant (sometimes referred to as the "gay gene" in the media)" that causes same-sex sexual behavior. (Ganna et al., 2019, p. 6). On the contrary, "the variants involved are numerous and spread across the genome," each increasing a person's *propensity* for same-sex behavior by an extremely small amount. (Sullins, 2019). All of a person's variants "together explain only part [32%, they found (p. 2)] of the genetic heritability at the population level and do not allow meaningful prediction of an individual's sexual preference" (p. 6). The point is that genetic factors may marginally increase an individual's propensity to engage in same-sex behaviors, but no gene or combination of genes dictates or foreordains that an individual will engage in same-sex behavior. The same is also true, they concluded, of same-sex attraction and identity. (Ganna et al., 2021, p. 1). By contrast, Ganna et al. "found several personality traits (loneliness and openness to experience), risky behaviors (smoking and cannabis use) and mental health disorders, but not physical [i.e. genetic] traits, to be significantly correlated with same-sex sexual behavior" (Ganna et al., 2019, pp. 4–5).

C. Same-sex orientation often changes in a heterosexual direction over the life course.

14) Empirically, it is false that same-sex orientation (whether in terms of attraction, behavior, or identification) is universally static and immutable.

15) From a review of the evidence on this question, Professor Lisa Diamond, a widely published researcher in the area of sexual orientation and expression, with co-author Clifford Rosky concludes that studies "unequivocally demonstrate that same-sex and other-sex attractions *do* change over time in some individuals. The degree of change is difficult to reliably estimate, given differences in study measures, but the occurrence of change is indisputable" (Diamond & Rosky, 2016, pp. 368–69 (emphasis in original)). They state further that "arguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attraction remain fixed over the life course" (p. 364).

16) Self-identification as non-heterosexual is strikingly impermanent in the case of teens and young adults, with a large proportion of those who initially self-identify as other than exclusively heterosexual coming to identify as "completely" or "100%" heterosexual within a few years.

17) Diamond and Rosky (2016) summarized the results of the Ott et al. (2011) analysis of over 13,000 young adults in the Growing Up Today Study (GUTS) as follows: "Of the 7.5% of men and 8.7% of women who chose a nonheterosexual descriptor at ages 18 to 21, 43% of the men and 46% of the women chose a different category by age 23. Among the same-sex-attracted youth who changed, 57% of the men's changes and 62% of the women's changes involved switching to completely heterosexual" (pp. 369–70).

18) These authors also summarized results reported by Savin-Williams et al. (2012) from the National Longitudinal Survey of Adolescent to Adult Health (Add Health) (available at https://addhealth.cpc.unc.edu/) with over 20,000 cases this way: "[R]espondents were asked to describe themselves as 100% heterosexual, Mostly heterosexual, Bisexual, Mostly homosexual, or 100% homosexual. Of the 5.7% of men and 13.7% of women who chose one of the nonheterosexual descriptors at [age 22 on average], 43% of the men and 50% of the women chose a different sexual orientation category six years later. Of those who changed, two-thirds changed to the category 100% heterosexual" (p. 369).

19) The reviewed studies just noted are not based on retrospective recall of earlier states but employed true longitudinal time series measures of the same individuals at different ages. They thus present the best available objective scientific evidence for observing valid change in individuals over time. This strong evidence is what justifies the definitive, strongly-worded conclusions from prominent researcher Diamond, quoted above, that sexual orientation change is "indisputable" and the claim that sexual orientation is immutable is "unscientific"

20) In addition to the high rate of incongruity already noted, the British National Survey of Sexual Attitudes and Lifestyles (NATSAL) survey included retrospective measures of sexual behavior which indicate high rates of probable desistance from non-heterosexual orientation or identification. Silva and Fetner et al. (2022) observed from the NATSAL dataset that "a majority of people in the UK who have ever had same-sex experiences identify as heterosexual" (p. 159). Calatrava et al. (2023) found that the proportion of heterosexual-identified persons who reported substantial past same-sex behavior but none currently—a population group they termed "Desisters"—was, in raw numbers, 43% as large as currently-identified homosexual women and 34% as large as currently identified homosexual men. (p. 609, Table 2). Thus, the number of persons who have changed from at least

some homosexual behavior to solely heterosexual sex behavior, with or without the support of counseling, is substantial.

D. Most nonheterosexual persons report both same-sex and other-sex attractions, leaving room for agency and choice in sexual behavior.

21) Arguments concerning counseling and the possibility of "change" in gender identity are often framed as though sexual orientation were a binary and a fixed-sum construct within which "change" would necessarily require turning off desires that the individual experiences and turning on desires that the individual does not experience. Empirically, this is very far from the truth. Instead, among those classed as nonheterosexual—that is, all those who are not *exclusively* heterosexual—a sizeable majority of men and almost all women report experiencing some heterosexual attractions.

22) For example, one finding of the survey conducted as part of Ganna et al.'s (2019) genome study is that "[i]ndividuals can be high on both same-sex and opposite-sex behavior or attraction (some bisexual individuals), and individuals can be low on both (asexual)" (Ganna et al., 2021, p. 2). Even using the Kinsey scale, which ranges from exclusively heterosexual to exclusively homosexual and thus enforces the fixed-sum concept that more homosexual attraction must mean less heterosexual attraction, the large majority of nonheterosexual persons report something less than exclusive homosexual attraction or behavior. The Kinsey scale places persons into one of seven categories of sexual orientation: (1) exclusively heterosexual, (2) almost exclusively heterosexual, (3) more heterosexual than homosexual, (4) equally heterosexual and homosexual, (5) more homosexual than heterosexual, (6) almost exclusively homosexual, or (7) exclusively homosexual. (Kinsey, Pomeroy, & Martin, 1948, pp. 638–655). Developed from Alfred Kinsey's influential 1948 study of male sexuality, it is the most widely used metric in research on sexual orientation. In assigning overall orientation, persons categorized

5-7 are generally classified as "homosexual," 1-3 as "heterosexual" In a study on a related topic, Savin-Williams (2013) reports the Kinsey scale results for a large number of population surveys. (pp. 62–66, Table 1). From these reports, it can be computed that the percentage of respondents not identified as heterosexual who nevertheless reported mixed sexual attractions in these surveys was, by sex:

- National Health and Social Life Survey (USA age 18–59): men 61%, women 93%;
- National Survey of Sexual Attitudes and Lifestyles (UK age 16–44): men 88%, women 98%;
- Add Health Wave 4 (USA ages 24–33): men 72%, women 95%;
- National Survey of Family Growth 2006-2008 (USA ages 18–44): men 80%, women 95%;
- Dunedin Multidisciplinary Health and Development Study (DMHDS: current sexual attraction) (New Zealand age 26): men 77%, women 95%.

23) This fact has implications for understanding sexual orientation change, again keeping in mind the widely accepted three-axis nature of sexual orientation. The point is that some individuals may "change" their lived sexual orientation not by working a change in their sexual attractions, but rather by choosing to act on and build their relationships around one among their mixed sexual attractions (whether heterosexual or same-sex), and/or by choosing to identify socially and to themselves based on one among their mixed sexual attractions. And, even as to attractions, "change" for many individuals need not imply a complete reversal, but rather change from one mix or intensity of attractions to both sexes to a different balance or mix of attractions to both sexes. Thus, "sexual orientation change" may not consist in a radical re-orientation but in more measured, incremental change.

24) Some SOCE-critical reviews ignore or downplay this evidence. For example, the Przeworski et al. (2021) review of the SOCE research begins with the unsupported declaration that SOCE are based on: "the inaccurate belief that sexual attraction and homosexuality are not inborn" (Przeworski et al., 2021, p. 82). Przeworski et al. later add that SOCE "therapies tend to function under the flawed notion that sexual orientation is a learned behavior that can be changed, rather than an innate trait" (Przeworski et al., 2021, p. 94). These statements are definitively contradicted by the research discussed above, which finds that genetic influences explain only about a third of the variation in homosexuality and that minority sexual orientation is highly mutable over the life course. None of this research, which strongly supports views they simply pronounce to be "inaccurate" or "flawed," is even acknowledged, much less discussed or rebutted, by Przeworski et al.

III. Current scientific evidence does not support the conclusion that the primary cause of the psychological difficulties of sexual minority persons is so-called "minority stress".

A. The problem of poor mental health in the LGB population.

25) From 1973, when homosexuality was declassified as a pathology, through the 1990s, the consensus among psychological scholars was that "research evidence has conclusively shown that homosexuals did not have abnormally elevated psychiatric symptomatology compared with heterosexuals" (Meyer, 2003, p. 683).

26) However, this "conclusive" finding was heavily discredited beginning in 1999 by two methodologically strong studies—a long-term longitudinal study and a twin study—published in the journal *Archives of General Psychiatry* which presented evidence that LGB persons were "at a substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder" (Bailey, 1999, p. 883, cited by Meyer, 2003; see also Fergusson et al., 1999;

Herrell et al., 1999). The existence of broadly worse mental health among the LGB population continues to be generally accepted to the present: "Research has repeatedly found mental health disparities between lesbian, gay, and bisexual (LGB) and heterosexual people, with LGB people showing higher rates of mood and anxiety disorders and more substance use and suicide attempts than heterosexual people"(Kiekens et al., 2021, p. 407).

27) Suicidality and suicide attempts are rightly of particular concern and have been the subject of several major studies. A panel of twenty-six prominent suicidality research scientists led by Ann Haas reviewed multiple studies of suicide and suicide risk in LGBT populations. They found "strong indications of elevated risk of suicidal behavior in lesbian, gay, bisexual, and transgender people" (Haas et al., 2011, p. 12). The panel summarized the findings of selected component studies as follows:

a) Fergusson et al. (1999). This high-quality longitudinal study "found that elevated rates of reported suicide attempts in youth who identified as LGB were associated with significantly higher rates of depression, generalized anxiety disorder and conduct disorder than were observed among heterosexual youth. LGB youth were also six times more likely to have multiple disorders" (Haas, 2011, p. 20).

b) Summarizing the results of six large population studies: "Since the early 1990s, population-based surveys of U.S. adolescents that have included questions about sexual orientation have consistently found rates of reported suicide attempts to be two to seven times higher in high school students who identify as LGB, compared to those who describe themselves as heterosexual" (Haas, 2011, p.17).

c) "A similar finding emerged from the population-based Vietnam Era Twin Registry, consisting of 4,774 male-male identical or fraternal twin

> pairs born between 1939 and 1957 (citing Herrell et al., 1999). This study found that middle-aged men who reported any male sex partners after age 18 were six times more likely to have made a lifetime suicide attempt than were their male twins who reported only opposite-sex sexual behavior. Among U.S. urban gay and bisexual men, about 12% reported making a lifetime suicide attempt, about three times the rate among American adult males overall (citing Paul et al., 2002)" (Haas, 2011, p. 18).

28) Haas et al. (2011) also summarized findings that "in the [sexual minority] population as a whole, mental disorders constitute the single largest risk factor for suicidal behavior," (p. 20), and that "[e]levated rates of mental disorders, including substance use disorders, have also been reported in one-quarter to one-third of LGB adult respondents in large-scale health surveys that have defined sexual orientation based on self-identity [citing 7 studies] or gender of sexual partners [citing 2 studies]" (p. 20).

29) Confronted with evidence of a higher incidence of mental health disorders among the LGB population, the obvious and important question is "Why?"

B. <u>The Minority Stress Theory.</u>

30) One possible answer is given by the Minority Stress Theory or Hypothesis ("MST"). That theory, set forth most influentially by psychologist Dr. Ilan Meyer (Meyer 1995; Meyer 2003), has recently been summarized as follows: "The foundation of minority stress theory lies in the hypothesis that sexual minority health disparities are produced by excess exposure to social stress faced by sexual minority populations due to their stigmatized social status (relative to heterosexual populations)" (Frost & Meyer, 2023, p. 1). In his influential 2003 article, Meyer proposed that excess "stigma, prejudice and discrimination create a hostile and stressful social environment" that puts "LGB people … at risk for excess mental

distress and disorders" (Meyer, 2003, p. 674). On this theory, disapproval of sexual minority status through discrimination and stigma are not merely unpleasant experiences that may cause temporary upset, anger or resentment and/or result in social or economic disparities, but are also the primary objective causes of long-term psychological disorders in the LGB population that are not evident to a similar extent in the heterosexual population which is not subject to comparable stressors. The theory hypothesizes that although LGB persons can enhance or diminish the effect by internalizing or resisting the stigma, the producers of the social environment are primarily responsible for any relative deficiencies in LGB mental health. In this way "[t]he minority stress perspective, which views social conditions as the source of morbidity and distress for minority persons, advances an ideological agenda that promotes social change toward a more egalitarian society" (Meyer, 1995, p. 52). Perhaps for those ideological reasons, the MST was rapidly accepted as a working hypothesis—or even assumed to be true—by psychologists and social scientists.

31) The MST framework is the foundation of much of the research literature critical of therapies open to change in sexual orientation (which refers to them as "SOCE," for "sexual orientation change efforts") which sees "minority stress theory [as] a useful framework when explaining the harmful impact of SOCE on mental health among LGB individuals" (Lee et al., 2021, p. 429). For example, Hendricks (2022) argues: "SOCE and GICE [referring to gender identity change efforts], because they aim to change the individual's sexual orientation or gender identity—essential aspects of identity—are inherently disaffirming of the individual's identity and, thereby, the individual" SOCE and GICE also "deprive those who undergo [them] of affirmation of the self and support of a community that potentially enhances their resilience and sense of well-being" (pp. 72–73).

32) However, as I detail below, the Minority Stress Theory remains what its name implies—an unproven theory. Indeed, few empirical efforts have been made to test whether MST can explain real-world population data, and some of the few studies that have attempted to test the validity of MST have found that it does *not* fit the data. Meanwhile, alternative explanations for the relatively poor mental health of the LGB population do exist, have not been disproven, and indeed remain largely untested and unexplored.

C. Methodological defects and data limitations.

33) I note at the outset that any attempt to draw firm conclusions in this area is undermined, and perhaps rendered impossible, by widespread and serious methodological weaknesses in many of the leading studies. Before commenting on specific literature, I explain these limitations.

1. Studies done using non-representative "convenience samples" do not permit conclusions about the general population.

34) A population representative sample, in which each person in the population has an equal chance of being in the sample, is a statistical necessity for drawing valid conclusions about any population. This is usually accomplished by some form of rigorous random selection, for example randomly selecting, from the complete database of U.S. phone numbers, ten thousand numbers to call for interviews.

35) However, recruiting a representative sample is time-consuming and expensive. Accordingly, many preliminary studies in the social sciences use "convenience samples" A convenience sample is any sample recruited in a manner that does not ensure that the sample is statistically representative of the larger population of interest. Consequently, it is well recognized that a study done using a convenience sample can only tell us something about the persons in the sample, but

not about any larger population. A convenience sample study can raise questions and possibilities; it cannot give valid answers.

36) Unfortunately, the overwhelming majority of studies in the SOCE literature are based on nonrepresentative convenience samples recruited from gay-themed publications, websites or gatherings, or from opt-in online surveys publicized through such channels. Samples recruited in this way cannot be representative of the general population. More, they are necessarily weighted towards those individuals who not only actively identify themselves as LGB at the time of the survey, but have a personality and priorities such that they choose to spend time reading such websites or attending such gatherings. The prominent sexuality scholar Ritch Savin-Williams of Cornell University criticizes this problem in research on sexual minorities: "The importance of recruiting a representative sample of nonheterosexuals, as well as the costs (i.e., skewed findings and lack of generalizability) of failing to do so, is usually conceded in individual studies. Thereafter, however, these limitations are minimized or summarily dismissed. Yet it greatly matters how sexual orientation is defined and where participants are obtained. For example, a common strategy for recruiting nonheterosexuals is to mine gay organizations, websites, conferences, resource centers, and pride marches, *venues most sexual minorities do not frequent*" (Savin-Williams, 2016, p. 38 (emphasis added)).

37) Dr. Savin-Williams' concern is not overstated. With one notable exception (Blosnich et al., 2020), which suffers from different debilitating problems as discussed later, none of the SOCE-critical studies discussed in this report employed a representative sample, whose results could be meaningfully extrapolated to the general population of sexual minority persons. For example, Green et al. (2020) surveyed LGBTQ-identified social media participants aged 13–24 recruited through advertisements on Instagram and Facebook. Higbee et al.

(2022) reported results from 475 respondents to a survey of persons recruited by advertisements in social media from organizations willing to receive public "recognition as a partnering organization" with the Southern LGBTQ Institute, an organization that was established to "create a public imperative for LGBTQ equality" (Wright et al., 2018, p. 4). The authors conceded that the resulting data were "a convenience sample … [which] may not be truly representative of all LGBTQ people in the South," and "particularly underrepresents the experiences of nonwhite respondents" (Higbee et al., 2022, p. 626). Salway et al. (2020) consulted a convenience sample (n = 8,388) of respondents to the *Sex Now* survey, which originated at Canadian gay pride festivals. (www.cbrc.net/sex_now) and concededly cannot "precisely determine how representative" the sampling "is of the total population of sexual minority men in Canada" Ryan et al. (2020) reported on a convenience sample of 245 sexual minority young adults whose parents had initiated their SOCE participation. By contrast, the fifth study, by Blosnich et al. (2020), did collect a careful representative sample, but the sample members did not report higher suicidality after SOCE (D. P. Sullins, 2022a), as I discuss later in this report. To round things out, another study by Goodyear et al. (2022) stated: "[O]ur recruitment strategies and study advertisements reflected our research team's stance that SOGIECE are harmful; for example, our advertisements indicated our desire to hear from 'survivors' of SOGIECE" (Goodyear et al., 2022, p. 601). Put differently, interviewees were purposely sought to exemplify the authors' preexisting belief of harm.

38) Further highlighting the fact that a study sample recruited through gay-themed publications, websites or gatherings will be radically non-representative of the population that chooses to engage in voluntary change-oriented therapy, Karten & Wade (2010) found that among a sample of 117 men who had participated in sexual change efforts, 42% were heterosexually married,

and 43% had children (p. 87), and these men experienced significantly more change in sexual feelings and behavior than did unmarried men in the sample (pp. 93–94), even though members of both these subsets were on average "highly intrinsically religious" (p. 92). Karten & Wade noted that the married subset likely experienced differing motivations and support than did unmarried men: "in contrast to single men, [married men] may be more invested in making changes in their sexual behavior because they stand to risk a life-mate, and even family, if they fail at SOCE. They may also benefit from the support of a loving marital relationship" (p. 86). *A fortiori*, it is not possible to extrapolate from a sample recruited through LGB-activist organizations or websites the motivations and experiences of married, religiously motivated men who choose to pursue sexual change efforts.

39) Karten & Wade (2010) flag another stark and almost certainly important difference between the population that chooses to participate in change-oriented therapy and convenience samples recruited through LGB channels, or even the broader sexual minority population—that is, a radical difference in religious identification and motivation. Empirically, the vast majority of patients seeking SOCE therapy do so in the context of strong religious practice and convictions. Spitzer's classic study of 200 SOCE clients reporting homosexual to heterosexual orientation change found that 93% rated religion as very important or extremely important in their lives. (Spitzer, 2003a, p. 406). In my recent study of 72 SOCE participants, 83% reported attending religious services weekly or more often (25% reported attending several times a week) and only 3% reported attending rarely or never. (Sullins, 2024, p. 5). By contrast, in the Generations Study's population samples, only 25% of transgender persons said that religion was important in their lives (Meyer, 2021, p. 41), and among LGB-identified sexual minorities, only 9% reported at least weekly religious service attendance and 69% reported attending seldom or never. (Meyer, 2020, p. 324). By these measures, SOCE participants are

far more religious, but the general sexual minority population is far less religious, than the general American population, of whom 31% reported attending religious services at least weekly and 34% seldom or never in 2018/2019. (Pew Research Center, 2019, p. 12).

40) A sample limited to those who identify as LGBT is thus highly prone to bias, and will almost certainly misrepresent the true characteristics of sexual minority persons in general. (Andrade, 2021) A sample drawn only from activist and trans- or gay-affirmative sources cannot give us an accurate picture of the mental health of sexual minority persons more generally, any more than a sample drawn from Bible study participants could give us an accurate picture of how religious most Americans are.

41) The fact that convenience samples give biased and inaccurate results is not a merely theoretical criticism. Instead, it has been concretely observed in studies relating to sexual orientation, where evidence from convenience samples of self-identified and self-selected gay populations has often differed substantially from that derived from population-representative data that include sexual minority persons. The latter has tended to find higher psychopathology but less unique stigma or discrimination among sexual minorities, thus providing less support for MST. Kuyper et al. (2016), for example, comparing "a convenience sample recruited at LGB venues" with a general population sample of LGB persons in the Netherlands, reported that the convenience sample "had lower levels of internalized homonegativity," but "encountered more negative social reactions on their LGB status" (p. 683). Cochran and Mays (2006) argued that the use of "national health data sets to study issues related to psychiatric morbidity among lesbians and gay men" "avoids common sources of sampling bias that plague volunteer-based surveys … dependent on participation in the visible gay and lesbian community" (p. 147). Using national data, they and others have consistently found higher

psychopathology in the U.S. sexual minority population than reported from convenience samples. For example, using the National Household Survey of Drug Abuse, a large population-representative dataset, they reported a higher risk of major depression among homosexual men and alcohol abuse among homosexual women, after noting that earlier studies which "relied on convenience samples drawn from the visible lesbian and gay community" had found "no increased risk [of psychopathology] in comparison with heterosexuals" (Cochran & Mays, 2000b, p. 516).

2. Self-reports relating to mental health are known to be unreliable and subject to bias.

42) Studies of minority stress rely on individual self-reports, a method which is well known to be subject to several kinds of bias that may render the findings unreliable. (Stone et al., 1999) Perhaps the best-known source of bias is social desirability bias, in which "research participants respond in a way that makes them look as good as possible. Thus, they tend to underreport behaviors deemed undesirable by researchers … and they tend to overreport behavior viewed as desirable" (Donaldson et al., 2000, p. 587). There is reason to be concerned that among the community that actively frequents LGB websites, a narrative that emphasizes both societal discrimination and LGB mental health suffering is favored, and that such a narrative may bias self-reports. However, to my knowledge, no study has attempted to detect the effects of such bias, if any.

43) The most common source of bias, however, is long-term forgetting, which is the tendency for reports of past experiences to be less accurately reported the longer they are distant in time. (Bradburn et al., 1987) This pervasive cognitive bias most strongly affects reports of long-ago or time-unspecified experiences, such as reports of childhood abuse or "lifetime" discrimination that are common in MST research. Sensitive issues such as those relating to sexuality, sexual attraction, and

sexual experiences, or to reports of mental health, are also subject to desires for concealment or, sometimes, exaggeration.

44) By contrast to studies rife with these errors, I discuss later in this report two prospective, longitudinal studies of participants in change-allowing therapy which relied on well-recognized metrics of psychological well-being rather than vague self-report, and found benefit rather than harm. (Jones & Yarhouse 2011; Pela & Sutton 2021).

45) Self-report bias compounds when the correlation between self-reported measures are computed, such as when recalled discrimination and reported mental health problems are observed in MST research. As a widely cited study of the psychological literature explains, "if the measures of Construct A [for example, discrimination or stigma] and the measures of Construct B [for example, mental health problems] also share common methods [for example, they are both self-reported], those methods may exert a systematic effect on the observed correlation between the measures" (Podsakoff et al., 2003, p. 879). This common method variance "pose[s] a rival explanation for the correlation observed between the measures" and thus "can have a serious confounding influence on empirical results, yielding potentially misleading conclusions" (p. 879). Podsakoff et al. demonstrated that combined systematic error bias can make two entirely uncorrelated self-report measures appear to be significantly correlated. What the correlation actually reflects, in other words, is not the real-world realities the measures attempt to reflect, but the common error in the two measures. Five systematic reviews of the social science literature "found that, on average, the amount of variance accounted for when common method variance was present was approximately 35%" (p. 880). On this estimate, about a third of the correlations reported in MST research using only self-reports could be a phantom due to common method error. Well-known methods to correct for self-report response bias and common method bias exist

(Campbell & Fiske, 1959; Donaldson et al., 2000), but MST research has not yet applied such corrective measures.

46) Relevant to MST, there has been a specific and recurrent concern that some sexual minority populations, particularly homosexual men, may overstate some indicators of psychological distress, particularly suicidal behavior. Herek, a strong MST proponent, suggested (Herek, 2009) that "persons with high levels of felt stigma may have a heightened sensitivity to the occurrence of stigma enactments and consequently may be more likely than others to attribute ambiguous incidents to stigma" (p. 70). For example, a study finding elevated suicide risk among homosexual men on the National Health and Nutrition Examination Survey (NHANES), a large population representative survey administered by the Centers for Disease Control (CDC), concluded by suggesting that "the differences observed may result from widely disparate factors" which may include stigma or discrimination but also may be due to "differences in response bias in which there is possibly a lower threshold among homosexual men for reporting negative psychological symptoms" (Cochran & Mays, 2000a, p. 577). Balsam et al. (2005), reporting the counter-intuitive finding that "[s]exual orientation was unrelated to current psychological distress, psychiatric hospitalizations, and self-esteem," but did predict higher self-reported suicidality (p. 471), likewise suggested that "the possibility that cultural factors might impact self-reports of mental health problems should be explored" (p. 474). To test the accuracy of self-reports of depression by LGBT youth, one study compared the results of a widely used screening instrument, the Brief Symptom Inventory 18, with professional clinical diagnoses derived from the DSM-IV's structured Diagnostic Interview Schedule of the American Psychiatric Association's fourth Diagnostic and Statistical Manual (DSM-IV). (Mustanski et al., 2010). These authors found that the self-reports overstated true depression by 400%: "When

using DSM-IV diagnosis of major depression in the prior year as the criterion … only one fourth of the positive cases [from the BSI 18] met major depression criteria" They cautioned that "the use of such established case norms [i.e., self-report screening instruments] will likely overestimate depression among LGBT youths" (p. 2430). Another well-crafted methodological study which followed up reports of attempted suicide with detailed questions about methods and timing (Savin-Williams, 2001) found that sexual minority youth over-reported suicide attempts by over 100%, suggesting that "some [sexual minority] youths may come to subscribe to a 'suffering suicidal' script, a myth stating that suicide is a rite of passage for being young and gay" (p. 989). Whatever the reason, findings such as these suggest that, particularly with regard to suicidality, the differential distress reported by sexual-minority persons may be a phantom of differential reporting, not real-world facts.

3. "Success exclusion" renders many studies of change-allowing sexual orientation therapy statistically meaningless.

47) Where the question to be answered concerns the efficacy, benefits, and/or harms of change-allowing sexual orientation therapy, convenience samples recruited through LGB community communications channels are particularly ill-suited to the question. First, those whose beliefs or preferences might lead them to voluntarily seek professional assistance to achieve desired change in sexual behaviors, relationships, or attractions—that is, precisely the population relevant to understanding the impact of voluntary change-allowing sexual orientation therapy—are particularly *unlikely* to frequent such communications channels. For example, a recent review combining the results of 73 studies (Lefevor et al., 2021) concluded: "Our results suggest that sexual minorities who access [community centers, LGBTQ bars/clubs, and Pride events]—or at least those who are surveyed from these venues—are much less likely to report a positive relationship between

[religion/spirituality] and health" (p. 658). Second, even if they frequented such channels in the past, those who engaged in a change of sexual orientation in the past and for whom it was a positive experience, and who feel that therapy that was open to change in minority sexual orientation provided some help towards their personal goals for their behavior and self-identity, are particularly unlikely to *currently* be frequenting LGB community communications channels. (T. Campbell & Rodgers, 2023; Phelan et al., 2022; Rosik et al., 2023) As a result, surveying only current participants in LGB communications channels to measure the efficacy, benefits, and harms of change-allowing gender identity or sexual orientation therapy is like bar-hopping to recruit participants in a survey to evaluate the efficacy, benefits and harms of a sobriety program. And, at least one study intentionally excluded a participant because the participant "described their experience with SOGIECE favourably" (Goodyear et al., 2022, pp. 602–603). The authors wrote this participant described himself as a "conversion therapy thriver," due to the perceived support and religious affirmation he received during SOGIECE. [He] also indicated that his experience with SOGIECE had not been 'effective,' as he still experiences 'same-sex attraction' but fills this desire with his religious faith. This participant nonetheless described being staunchly supportive of SOGIECE, particularly with regard to an individual's right to choose whether or not to attend SOGIECE. "Given the unique disposition of this participant, … we have excluded this data from the present analysis" (Goodyear et al., 2022, pp. 602–603). A study that parses pertinent cases from the sample that do not support a pre-existing ideological narrative cannot be legitimately described as attempting to discover or convey scientifically validated facts.

48) Other studies discount potential benefits by imposing unrealistic criteria for success. Przeworski et al. rejected the findings of three studies that found change rates of 40% to 50% because "the results of these three studies do not

indicate that these interventions lead to change in sexual orientation in most participants" (Przeworski et al., 2021, p. 88). But to require that all or even most participants reflect a treatment effect imposes an unscientific standard on treatment efficacy. To show that treatment is effective, an experiment need not demonstrate that every person in the treatment group experiences an effect or the same effect, but only that the average outcome in the treatment group is different than the average outcome in the control group. For example, if only a third fewer persons receiving a vaccine benefit from the vaccine compared to those not receiving the vaccine, we conclude that the vaccine is efficacious, and should be recommended. We do not require the vaccine to be effective in every case, or even most cases. This standard recognizes that very few medical treatments have the same effect on every individual; rather, almost all have a range of effects that vary according to individual characteristics.

D. Explanations for a correlation between LGB identity and poor mental health other than the Minority Stress Theory exist, and have not been excluded.

49) After showing that a hypothesized cause is correlated with an outcome, to prove its case, a social science theory must then empirically exclude other possible causes, or else the hypothesized cause remains an unproven theory. Even if an unbiased correlation between LGB identity and poor mental health were established by statistically valid methods, there exist multiple potential explanations for such a correlation.

1. Reverse Causation

50) Hypothetically, aspects of personal relationships and lifestyle associated on average with LGB identity might be less conducive to mental health. To illustrate the point with a less politically charged example, it is well documented that, other things equal, unmarried heterosexual adults have significantly worse

mental health on average than heterosexual adults in stable first marriages. (Waite & Gallagher, 2002; Thomeer et al., 2013). Possibly, less mentally healthy individuals are less likely to get married and stay married. Possibly, living in a stable marriage relationship on average results in better mental health. We could not decide between those two hypotheses without more complex and careful studies. In either case, to note the possible causal relationship is not to make any moral statement about marriage or singleness at all.

51) Scholars in the field have flagged the problem that such "reverse causation" could be the true explanation for reported poor mental health that MST advocates unjustifiably assert is caused by sexual orientation discrimination. In one of the first assessments of the LGB population in regards to the proposal that stress may cause mental health problems, Mays and Cochran (2001) cautioned that "Psychiatric morbidity may, in fact, generate a tendency to perceive higher levels of discrimination or may disrupt social functioning, resulting in more negative experiences" (p. 1874). Frisell et al. (2010) similarly noted: "However, the causal direction of this [MST] association is not clear" because "mental disorder may increase the actual risk of suffering discrimination and victimization but also the likelihood of recalling and reporting of such" (p. 320). By 2016 Kenneth Zucker, editor of the eminent journal *Archives of Sexual Behavior*, observed that MST had still not resolved the theory's central theoretical problem: that "direction of effect cannot be conclusively determined (i.e., whether prejudice and discrimination lead to a greater likelihood of developing mental health problems, or whether mental health problems lead to a greater likelihood of experiencing—or perceiving—prejudice and discrimination)" (Zucker et al., 2016, p. 230).

52) Similarly in another area of research, Liu and Alloy (2010) explain with regard to depression, "depression-prone individuals are not simply passive

respondents to stressful events in their lives, but active agents in the creation of depressogenic life stressors" (p. 583).

53) In plain English, what these researchers are saying is that individuals who suffer from poor mental health may have a higher tendency to *cause* negative social interactions or—even where no such negative interaction actually occurred—to review social interactions looking for, and to obsess over, perceived slights and criticisms in interactions in which healthy individuals would perceive no slight or stigma at all. Thus, poor mental health causes the reality or perception of discriminatory or hostile experiences, rather than the reverse.

54) In light of these continuing and unanswered uncertainties, in 2020 the prominent sexuality researcher Michael Bailey published an editorial calling for reconsideration of MST on the grounds that research studies thus far had not been able to eliminate the possibility that "the increased prevalence of mental health problems in nonheterosexual persons is, at least in part, the cause, rather than the effect, of increased self-reported experiences of stigmatization, prejudice, and discrimination" (Bailey, 2020, p. 2265).

2. Common Causation

55) Possibly, non-heterosexual orientation and poor mental health do not have a causal relationship with each other in *either* direction, but both are correlated to some third causal factor. In the abstract, such a factor could, for example, be social, familial, or personality traits. To illustrate, Ganna et al. (2019) found "loneliness [and] risky behaviors … to be significantly correlated to same-sex sexual behavior," while "family-based heritability" of same-sex sexual behavior was larger than accounted for by all genetic contributors combined. (pp. 4–5). Thus, Ganna's data leave open the possibility that family dynamic factors and/or loneliness contribute to both non-heterosexual orientation (on one or more axes) and

poor mental health, resulting in *correlation* between those outcomes without *causation* between them in either direction.

3. Confounding Variables

56) Where studies are not carefully designed, it is possible that a reported correlation between reported sexual orientation discrimination and poor mental health is spurious, being in fact the result of some other variable not controlled for. This problem of confounding variables and spurious observations of correlation has in fact been discovered repeatedly with respect to studies attempting to measure the impact of sexual orientation discrimination. Of course, if there is no correlation between sexual orientation discrimination and poor mental health, then there is not even any question of causality to be answered.

57) McCabe et al. (2010) "examined the associations between 3 types of discrimination (sexual orientation, race, and gender) and substance use disorders" (p. 1946), using the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a large population-representative dataset which included "the largest US national probability sample of LGB-identified adults" to that date (p. 1950). The authors found that while race discrimination and a combination of race and sexual orientation discrimination were associated with substance use disorders, their analysis yielded the "unexpected result … that there was no statistically significant relationship between substance use disorders and sexual orientation discrimination alone" (p. 1950). In this strong representative data, which was sensitive to the effect of other kinds of discrimination, there was no evidence of the negative effect of sexual orientation stress on mental health that is predicted by MST. The authors commented: "Given the putative relationships among discrimination, stress, substance use, and mental health disorders posited in the minority stress model, this finding was surprising" (p. 1950).

58) A later study (Bostwick et al., 2014) also used NESARC's large sexual minority sample to examine the association of discrimination by race, gender, and sexual orientation on past-year mental health disorders. Like McCabe et al. (2010), they found that sexual minority persons who had experienced both racial and sexual orientation discrimination were prone to higher mental health disorders, but that, contrary to MST predictions, "sexual orientation discrimination alone was not associated with higher odds of a mental health disorder" (p. 8). The authors also reported: "Within the context of the minority stress model, one might expect those with the worst mental health outcomes—i.e., bisexual groups—to correspondingly report the highest prevalence of discrimination. However, in the current study, the bisexual group was significantly *less* likely than lesbian and gay counterparts to report any discriminatory experiences" (p. 9).

59) Frisell et al. (2010), examining depression and ADHD in over 17,000 adult twins in Sweden, found that there was a correlation of these disorders with discrimination and victimization when those variables were considered alone. But when they also included genetic and early family influences in the prediction model, the effect of discrimination or victimization vanished: "genetic and/or environmental familial factors explained most or all of the increased current depression and ADHD symptoms among individuals with any same-sex sexual partner, independent of the adjustment for perceived discrimination or hate crime victimization" (pp. 320–321). In other words, despite the correlation, careful analysis that took into account other potential causes found that the elevated levels of depression and ADHD could not be attributed to discrimination or victimization at all.

60) I discuss above that while genes do not determine same-sex sexual orientation, they do correlate to about a third of the variation in same-sex sexual behavior. What if these same genetic components also correlate with a greater affinity for some psychological disorders? This would introduce a confounding

variable that presents a special challenge to MST, since an individual's genetic structure, formed before birth, cannot possibly be the result of later social stress. The same is true, to a slightly lesser extent, of early childhood experiences such as sexual abuse or family instability. Zietsch et al. (2012) explored the possible influence of genes and early family environment on an observed correlation between LGB identification and depression using a methodologically strong classic twin study in a population-representative sample (that is, not a convenience sample) of LGB persons. The authors found that "genetic factors accounted for a majority (60%) of the correlation between sexual orientation and depression. In addition, childhood sexual abuse and risky family environment were also separately significant predictors" (p. 521). Altogether, these three factors—each of which entirely or largely preceded any "minority stress" associated with sexual orientation or gender identity—accounted for over three-fourths of the association between minority sexual orientation and higher rates of depression. (p. 528). Ganna at al.'s subsequent genome-wide association study confirmed, by direct observation of the participants' genomes, the presence of a substantial genetic correlation (.33 for males and .44 for females) of non-heterosexual sexual orientation with depression. (Ganna, 2019, p. 5).

61) These results leave no room to blame discrimination and resulting "minority stress" as anything more than minor factors affecting LGB depression and related problems such as suicidality. While being presented with a non-affirming assessment of one's LGB orientation may be a negative experience, these findings suggest that it can have, at best, only a relatively small effect on depression and suicidality. Notably, despite these findings, no study of MST has yet (to my knowledge) adjusted its models for genetic influence, to examine how much influence of stress and discrimination on mental health problems, if any, may remain after doing so.

62) Conversely, if minority stress were the sole or dominant force in the production of LGB mental health problems as MST claims, prediction models that included minority stress along with other possible causes of psychopathology in the LGB population would show a strong effect of minority stress and no effect or only weak effects of the other possible causes. As the studies reviewed above show, careful studies find the opposite.

63) In sum, while scientific journals continue to publish articles that purport to document a correlation between LGB identity and poor mental health—and which often simply *assume* the causal relationship that is hypothesized by MST—I am not aware of any methodologically sound study that has succeeded in rejecting alternative explanations of this correlation, including reverse causation, common causation, and confounding variables.

64) I will note that, because humans and society are complex, and accuracy in sociological studies is difficult to achieve, it is possible that some or all of these alternative hypotheses are true to some extent.

E. Important evidence *inconsistent* with the MST exists.

65) By contrast, important evidence exists which appears to be *inconsistent* with the Minority Stress Theory.

1. The mental health of LGB populations is not better in countries that are widely recognized to be more accepting of LGB identities.

66) If minority stress were the primary cause of LGB mental health, we would expect non-heterosexual persons in societies with lower LGB intolerance and discrimination to have lower rates of mental health problems than those in more intolerant social settings. Yet this is not found to be the case.

67) Surveys in the Netherlands, a highly LGB-affirming culture, have found high rates of affective distress among LGB persons that are not significantly

different from those found in the less tolerant United States. One such study stated: "By many social, legal and economic measures, gay men in the Netherlands might not be seen as a disadvantaged minority. Despite this apparent equity, population surveys in the Netherlands find that mental health disparities between gay and heterosexual men are as large as those found in countries with less legal and social support for gay equality" (Aggarwal & Gerrets, 2014, p. 106); compare Cochran et al., 2003, reporting U.S. prevalence). A recent population-based study also found significantly higher mental health problems among gender-variant youth than among non-gender-variant youth in the Netherlands. (Ghassabian et al., 2022).

68) A meta-analysis of 28 international studies of LGB mental health by Lewis (2009) noted that the similarity of results for U.S. and European countries "does not support the expected finding that gay respondents from the United Kingdom and Netherlands—because of less stigma and institutional prejudice (e.g., legalized gay marriage in the Netherlands)—would have a lower prevalence of poor mental health outcomes [than the United States]" (p. 1033).

69) Sandfort et al. (2001) examined sexual orientation and mental health using a large representative dataset of the Dutch population in 1996 (over 7,000 cases), with well-validated measures of psychological disorders. They found large differences in mental health by sexual orientation. Lifetime and 12-month prevalence of anxiety and mood disorders were about three times greater among homosexual Dutch men than heterosexual ones. (p. 85). In a later study, Sandfort and other scholars found that 14.6% of gay men in the Netherlands had engaged in suicidal self-harm, a rate 9 times higher than among heterosexual men. (de Graaf, Sandfort, and ten Have, 2006, p. 257, Table I). According to MST, these large differences should not exist in the Netherlands, perhaps the most gay-tolerant society on Earth. Sandfort et al. (2001) noted that MST predicted the differences should at least be larger in other countries: "To the extent that the level of social

acceptance of homosexuality induces differences in mental health status in relation to homosexuality, the observed differences might be greater in other Western countries than in the Netherlands" (p. 89). In fact, differences in other Western countries were very similar to those in the Netherlands. The authors proposed several other possible causal influences, including behavioral ("Reverse Causation") and hormonal factors ("Common Causation"), that may explain the differences in mental health by sexual orientation.

70) Frisell et al. (2010) studied over 17,000 adults in highly gay-tolerant Sweden and reported that women and men who had ever had same-sex partners were respectively 1.7 and 1.8 times more likely to suffer depression and 1.9 and 3.2 times more likely to experience anxiety disorder than those who had never had same-sex partners, rates that are very similar to those in less gay-tolerant social settings such as the United States. (Table 2).

2. <u>The mental health of LGB individuals has not improved across time as society has become vastly more accepting of sexual minorities and alternative sexual lifestyles.</u>

71) MST equally predicts that the mental health of LGB individuals will have improved across the last half century in the U.S., as societal acceptance has radically increased. Evidence has found the opposite is true.

72) In 2021, Meyer (the originator of MST) and his co-authors (Meyer et al., 2021) examined the relation of minority stress to suicide in three cohorts of LGB persons who came of age in the 1960s, 1980s, and 2000s, using representative data with extensive measures of minority stress and psychological distress. While LGB discrimination and stigma broadly declined over this period, Meyer et al. (2021) found that LGB suicidality rose significantly over the period. (p. 13). The difference was dramatic and strong: every measure of stress and discrimination in the data declined over the period, but suicidality and psychological distress rose sharply. For

example, having property vandalized or stolen due to one's sexual orientation was reported by 65% of the 1960s cohort but only 29% of the 2000s cohort. Over the same period, lifetime self-reported suicide attempts by LGB persons rose by almost half (45%), from 21% of the 1960s cohort to 30.5% of the 2000s cohort—even though the oldest cohort had lived more than 30 years longer than the youngest. (p. 10, Table 3). Meyer et al. (2021) conceded: "Our findings are clearly inconsistent with the [minority stress] hypothesis" (p. 13). This result is all the more significant as it resulted from the Generations Survey data, which is the largest population-representative sample of LGB persons yet collected, with extensive measures of minority stress.

73) Likewise in the Netherlands, when Sandfort et al. (2014) examined a replication of their 2001 large representative survey a decade later, they reported: "Although we expected that disparities in rates of psychiatric disorders between homosexual and heterosexual persons would have decreased, as acceptance of homosexuality in Dutch society had increased, this was not supported" The authors suggested that "other mechanisms than prejudice and discrimination also affect the observed disparities" (pp. 7–8), including genetic and environmental factors such as sexual abuse.

3. Some studies have failed to find other correlations predicted by the Minority Stress Theory.

74) In the general population, poor mental health is strongly correlated with a wide range of self-rated physical health co-morbidities. As a result, MST predicts that self-rated physical health would be generally lower among sexual minorities. However, multiple research studies using national data have failed to find this to be the case. Gorman et al. (2015), analyzing data from the CDC's Behavioral Risk Factors Surveillance System (BRFSS), unexpectedly found not only an absence of lower self-rated health but "a self-reported health advantage among

lesbians and gay men" (p. 1377) compared to their heterosexual counterparts, contrary to their initial predictions. Strutz et al. (2015) found no difference in the self-rated health of sexual minority men compared to heterosexual men, and "[i]n some cases, [non-heterosexual] men experienced better health than their majority counterparts" (p. 81), based on data from the National Longitudinal Survey of Adolescent to Adult Health (Add Health). Likewise, Wolf (2021) found a "lack of significant difference in self-rated health between gay and lesbian respondents and their heterosexual counterparts" in nationally representative data from the National Survey of Family Growth, a finding the author noted "appears counterintuitive" from the standpoint of MST. (p. 55).

75) Other studies have found poorer mental or physical health among sexual minority persons even where minority stress was not likely to be a strong factor. Vrangalova and Savin-Williams (2014) found, in a review of 60 papers, that persons reporting a small amount of same-sex sexuality but identifying as "mostly heterosexual" experienced, like gays and lesbians, higher distress on a large variety of physical and mental health outcomes, yet were not clearly susceptible to minority stress. The authors noted that minority stress processes "require a nonheterosexual person to possess a salient sexual-minority identity, have same-sex partners, belong to a sexual-minority community, or be perceived by others as being a sexual minority in order to experience minority or lifestyle stressors. Yet these conditions seldom characterize [mostly heterosexuals]" (p. 412).

76) It is commonly hypothesized that, on average, religious individuals who experience same-sex attractions will experience greater internal identity conflict than non-religious individuals who experience those attractions. Thus, MST predicts that non-heterosexual members of religious groups would suffer greater proximal stress, and thus worse mental health, than their non-religious LGB peers. Rosik et al. (2021) compared a sample of LGB-identified persons with a sample of

religious persons who experienced same-sex attraction but refused to identify as LGB. They found: "Contrary to expectations, these differences were not associated with health differences in depression, anxiety, and social flourishing" (p. 27). This was true even though the group that chose not to identify as LGB (a largely religiously motivated group) *did* report significantly higher levels of internalized homonegativity (p. 38)—commonly assumed to be an important stressor in MST. The authors commented that this finding "seems at odds with minority stress and sexual identity theories that assume adoption of an LGB identity is the healthiest pathway of sexual minority identity development" (p. 39).

77) "Religious" is of course a very broad and diverse category. Focusing more precisely, exposure to *non-affirming* religion replicates the alleged pathway of harm MST proponents attribute to change-allowing sexual orientation therapy by disaffirming LGB identity. The relation between exposure to non-affirming religion and LGB mental health is therefore of particular interest. Barnes and Meyer (2012) explicitly examined the hypothesis that LGB persons exposed to non-affirming religion would thereby experience lower mental health. However, their study produced the "unexpected finding" that "there was no main effect of non-affirming religion on mental health" (p. 505).

78) Thus, on the specific question implicated by change-allowing sexual orientation therapy, *i.e.*, whether exposure to non-affirming views or beliefs contributes to lower LGB mental health, the evidence from MST research is in the negative.

IV. Current scientific evidence does not support the conclusion that voluntary therapeutic conversations which may lead to change in sexual attraction, behavior, or orientation are harmful to most persons.

A. Therapeutic approaches to unwanted same-sex attractions or behaviors have changed radically over time.

79) As with "sexual orientation," the term "conversion therapy" is used loosely and has no consistent definition, while the nature of therapeutic interventions at issue in particular studies is often not made clear. Too often, the term "conversion therapy" is stretched to include radically dissimilar therapeutic theories and clinical approaches.

80) From the 1940s through the 1970s a dominant theory in psychology was behaviorism, which advocated psychological conditioning and behavior modification through avoidance of negative stimuli, resulting in various "aversive therapies" to treat a number of compulsive or addictive behaviors such as alcoholism, drug abuse, and compulsive gambling. Aversive therapy is "a form of behavior therapy in which the client is conditioned to change or eliminate undesirable behavior or symptoms by associating them with noxious or unpleasant experiences, such as a bitter taste (for nail biting) or nausea (for alcoholism)" (APA Dictionary of Psychology, available at https://dictionary.apa.org/aversion-therapy)

81) In this period, during which homosexuality was designated a mental health disorder by leading authorities, aversive therapy was also tried as a means to change same-sex attractions. The most common technique for homosexuality was to pair exposure to sexually attractive same-sex images with mild electric shocks or vomit-inducing drugs.

82) With the declining assessment of homosexuality as a disorder, spurred by the APA's 1974 removal of homosexuality from the DSM classification of disorders, combined with a wider generational decline in adherence to behaviorist

psychology, aversive treatments related to sexual orientation disappeared completely from therapy settings by the early 1980s. In 2009, a committee formed by the APA published a Report on Appropriate Therapeutic Responses to Sexual Orientation (APA Task Force Report). (Glassgold et al., 2009). That committee found no studies after 1981 involving behavioral interventions to change same-sex attractions or behaviors. (p. 27). One should be aware, however, that aversive conditioning has never been categorically rejected by mental health professionals, and it continues to be used as a therapeutic tool for certain other purposes.[1]

83) Although homosexuality was no longer considered intrinsically pathological, the 1973 DSM retained a diagnostic criterion for "ego-dystonic" homosexuality, in which "[t]here is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress" (American Psychiatric Association, 1980) According to the American Psychiatric Association, persons with unwanted homosexual attractions remained legitimate patients in need of treatment. For the last 40 or more years, therapists and counselors willing to help patients who desired to reduce either same-sex attractions or behaviors have instead looked to non-coercive, non-aversive techniques. As the APA Task Force Report recognized, these have included psychotherapy, but also a range of interventions such as weekend retreats, self-help groups, and religious exercises. (p. 27). As I detail below, studies of such techniques have found that many participants report that they experienced benefits from these non-coercive, non-aversive techniques.

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[1] For example, in 2017, researchers at the University of Washington published a study of "Chemical Aversion (Emetic) Therapy for Alcohol Use Disorder," and concluded that "After treatment ... patients reported avoidance/aversion to alcohol" R. Elkins et al. (2017), *The Neurobiological Mechanism of Chemical Aversion (Emetic) Therapy for Alcohol Use Disorder: An fMRI Study*, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC5625029/.

B. Advocates of censoring counseling and therapeutic speech conflate unrelated therapies, misdescribe actual clinical practices, and misleadingly invoke obsolete practices.

84) Despite recognizing the dramatic differences between aversive conditioning and such modern interventions or support, the 2009 APA Task Force Report authors lumped together all "behavioral techniques, psychoanalytic techniques, medical approaches, [and] religious and spiritual approaches … that aim to change a person's same-sex sexual orientation" under the label of "sexual orientation change efforts," or SOCE. (p. 2). The authors also combined methods by "mental health professionals" and "lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups)" (p. 2). But I am not aware of empirical evidence supporting assimilating these two forms of counseling. Many recent studies have extended this confusion by the introduction of the acronym "SOGICE," which further conflates counseling for sexual orientation (SOCE) with counseling for gender identity (GICE, for "gender identity change efforts"). Some studies have gone even further to speak of "SOGIECE" (which stands for "sexual orientation and gender identity and experience change efforts") by which time what the inflated term comprises "are not a circumscribed set of practices … [but include] heterosexual- and cisgender-dominant social norms expressed and enforced across a wide range of settings and circumstances" (Kinitz et al., 2022, p. 442).

85) As in many areas of science, the scientific literature on the controversial topic of SOCE is sharply divided between studies that hypothesize or report ineffectiveness or harm from SOCE, many of which openly support restricting this form of therapy, and studies that hypothesize or report effectiveness and benefits from SOCE, many of which openly oppose restrictions. In this report, I will refer to the first category as "SOCE-critical studies" and the second category as "pro-SOCE studies" These are not intended to be strict classifications, merely labels

for convenience. A few studies also have mixed or neutral findings, which do not clearly fit into either category.

1. The claim that current change-allowing sexual orientation therapy assumes that homosexual orientation is a mental disorder is false.

86) It is simply false that contemporary therapists who support clients who desire change in sexual orientation describe or approach same-sex orientation as "disorders" This may have been true of some undefined number of practitioners fifty years ago, and for a short time after that, but it is decidedly not true today. But just because same-sex orientation is not considered a mental disorder, that does not mean a person lacks any legitimate reason for trying to change it. Such a view ignores the fact that many people seek counseling for many personal struggles that are not mental disorders. In its guidance for therapists on evidence-based practice, the APA recognizes this fact: "We use the term *patient* … to refer to the … population receiving psychological services. However, we recognize that in many situations there are important and valid reasons for using such terms as *client*, *consumer*, or *person* in place of *patient* to describe the recipient of services.… [P]sychologists target a variety of problems, including but not restricted to mental health, academic, vocational, relational, health, community, and other problems in their professional practices" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273).

87) The falsehood of the claim that change-allowing therapists today perceive same-sex orientation as a mental disorder is also evident from the fact that, unlike fifty years ago, there is today no attempt to urge such therapy on the general population of LGB persons. Those who participate in change-allowing therapy today are notably distinct from the large majority of LGB persons. Multiple studies (Karten & Wade 2010; Sullins 2024; Grincola & Smith 2011) have found

that most or indeed almost all participants who seek therapy with a goal of change in some aspect of sexual orientation are highly religious persons who seek counseling to help manage difficult personal conflicts between their same-sex attractions and religious convictions incompatible with same-sex sexual activity or desires. Such persons are motivated by a particular ideal of sexual morality that is not widely held among LGB persons. Consequently, change-allowing therapy is as a practical matter, practiced primarily among the subset of all persons with same-sex attractions who are motivated by deeply held religious convictions.

2. Criticism of trauma intervention by change-allowing therapists is unfounded.

88) Change-allowing therapists may address early life trauma or sexual abuse. There are good reasons for this. The APA's Handbook of Sexuality and Psychology itself acknowledged that there are "associative and potentially causal links" between childhood sexual abuse and homosexuality. (Mustanski et al., 2014, pp. 609–610). This handbook, citing several reviews, reports that "studies using varying methodologies have reported a correlation between different types of child abuse and varying components of a homosexual sexual orientation, including data from clinical samples and case studies, surveys of MSM [men who have sex with men], and cross-sectional surveys.… One of the most methodologically rigorous studies in this area used a prospective longitudinal case-control design that involved following abused and matched nonabused children into adulthood 30 years later. It found that men with documented histories of childhood sexual abuse had 6.75 times greater odds than controls of reporting ever having same-sex sexual partners" (Mustanski et al., 2014, p. 609). Another methodologically strong 2013 study by faculty of the Harvard School of Public Health concluded that "sexual abuse may increase the likelihood of the three dimensions of same-sex sexuality for both sexes" (Roberts et al., 2013, p. 170). Subsequent studies have debated the

question and presented contrasting findings, with some confirming the suggestion that early life trauma may influence the development of homosexual orientation, usually in conjunction with other factors. Qin et al. (2018), for example, studying 1,120 Chinese men, reported: "More frequent occurrence of physical ... emotional ... and sexual ... abuse during childhood was significantly associated with the development of male homosexuality" in connection with two genetic variants. (p. 36).

89) The APA Handbook of Sexuality and Psychology reviewed theories to explain the association between childhood sexual abuse and adult homosexuality including the view that childhood sexual abuse has a causal effect on homosexuality. The handbook observes that "this case often is made in the context of proposing that psychological treatment for abuse can 'reorient' an LGB individual's sexual orientation toward heterosexuality" (Mustanski et al., 2014, p. 609). The handbook discusses mechanisms that may bring about such an effect, and reviews competing theories as well.

90) While the presence, nature, and degree of causality between early life trauma and sexual orientation is a matter of continued scientific debate and exploration, today it is unexceptional to observe, as does a 2025 review article that "[t]he development of homosexuality can be influenced by early exposure to traumatic events. These include neglect, sexual, emotional, or physical abuse" (Alagha et al., 2025, pp. 11–13). Studies in this area have called for greater attention to trauma intervention for sexual minority persons struggling with mental health. In sum, therapists who incorporate and consider the possibility of trauma resolution in assisting persons struggling with same-sex sexual orientation are practicing in accord with evidence on a possible etiology of sexual orientation, in contrast to therapists who ignore or dismiss the evidence of a possible link between sexual abuse and sexual orientation.

3. Misleading suggestions that current change-allowing sexual orientation therapy employs coercive or aversive techniques are false.

91) Despite the APA's acknowledgement of their discontinuation decades ago, the APA itself, along with its widespread scientific and popular advocacy of "conversion therapy bans," consistently invokes the specter of long-obsolete painful aversive practices as justification for restrictions on the current forms of benign voluntary therapy. For example, the APA's 2022 book opposing conversion therapy contains the following present tense language: "When SOCE/GICE are practiced by mental health professionals, these efforts typically take one of the following forms: psychotherapy; behavioral conditioning; electroconvulsive therapies and aversive therapy treatments (e.g., electric shock to the hands or genitals and nausea-inducing drugs paired with homoerotic stimuli" (Haldeman, 2022, p. 221).

92) The following are representative samples of similarly misleading misrepresentations as repeatedly expressed in the academic literature, reviews, and public talking points:

- Salway et al. (2020), publishing in the *Canadian Journal of Psychiatry*, falsely states that "SOCE" "draw on a range of discredited methods including **aversion therapy (e.g., electric shock)**, [and] attempted desensitization to same-gender/sex erotic materials…" (p. 503, emphasis added).

- The Blosnich et al. (2020) study of SOCE and suicide, published in the *American Journal of Public Health*, characterizes SOCE this way: "SOCE include a variety of approaches such as immersion in heterosexual-focused cognitive exercises, amplification of shame for same-gender attraction, and **physical punishment (e.g., electric shock) intended to condition** against mental or physical attraction to the same gender" (p. 7, emphasis added).

- Meanley et al. (2020), published in the journal *Sexuality Research and Social Policy*, states: "Conversion therapies manifest in a variety of methods ranging in severity (e.g., psychotherapy, religious/prayer-based conversion, **aversion/shock therapy**, and gender norm reinforcement/policing)" (p. 335, emphasis added).

- Green et al. (2020): "SOGICE (sexual orientation or gender identity change efforts) can include the use of **aversive stimuli**[.]" (p. 1221, emphasis added).

- Przeworski et al. (2021): "Biological methods [of SOCE], including electroconvulsive therapy, surgery (lobotomy, castration, removal of ovaries; or hormone therapy) [citation in original], have historically been used" (p. 82).

- Goodyear et al. (2022): "SOGIECE [sexual orientation or gender identity or expression change efforts] draw on a number of ineffective and discredited techniques, including aversion therapies (e.g., electric shock)." (p. 602). SOGIECE includes a wide range of "non-affirming contexts" faced by LGBT persons, including "messages that equated 2SLGBTQ+ identities with undesirable lifestyles;" (Goodyear et al., 2022, p. 604) "denial of access to gender-affirming care (hormone-replacement therapy [or puberty blockers]), and surgeries specifically" for transgender youth. (Goodyear et al., 2022, p. 604).

- Kinitz et al. (2022): "These practices have ranged from physically invasive procedures, such as lobotomies and electroshock therapy, to psychological interventions, such as talk 'therapies.'" (p. 443). These practices include "even … conversation with a persistent aim of persuading 2SLGBTQ+ people to deny or suppress their "same-sex attraction," gender identity, and/or gender expression" (Kinitz et al., 2022, p. 450).

- Higbee et al (2022): "Conversion therapy efforts can include various painful forms of aversion therapy ranging from hypnosis to inducing vomiting or paralysis or administering electric shocks while showing the individual homoerotic images. 'In extreme cases, they may also include surgical and hormonal interventions, or so-called 'corrective' rape' [citation in original]" (p. 613).

- Veale et al. (2022): "Change efforts include castration, hormone intake, electroshock and chemical aversion therapy.… For TNB [transgender or nonbinary] people, these include preventing people from taking social or medical steps to affirm their gender, often enforced through physical, psychological, or sexual violence" (p. 479).

- Haldeman (2024): "In [conversion "therapy"], mental health workers and related paraprofessionals employ a loosely defined repertoire of cognitive, **behavioral,** and classic talk therapy strategies," recounting 1972 opposition to "using **electric-shock aversion techniques** to extinguish same-sex desire" as the first "challenge [to] the conversion therapy paradigm" (p. 11, emphasis added).

- American Medical Association (AMA), "Talking Points on LGBTQ change efforts ("conversion therapy")" (at www.ama-assn.org/system/files/2019-12/conversion-therapy-talking-points.pdf): "These interventions often include unethical techniques including **electric shock, deprivation of food and liquids, chemically induced nausea and masturbation reconditioning**" (emphasis added).

93) All this leads to prejudicial confusion, not relevant to the actual options and choices facing patients, practitioners, and legislators today.

C. SOCE-critical research has substantial methodological limitations.

1. Some SOCE-critical reviewers acknowledge these limitations.

94) As already noted, the APA's Task Force Report (Glassgold, 2009) concluded: "There are no scientifically rigorous studies of recent SOCE [since 1981] that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (p. 83). Two of the main reasons for this conclusion were (1) the absence of population representative samples, whose findings would reflect the true characteristics of the population of persons potentially undergoing SOCE (p. 33); and (2) the absence of experimental studies, which would measure variables of interest before and after SOCE using multiple surveys or interviews years apart, instead of cross-sectional retrospective surveys, which asked persons, in a single survey or interview, to report from memory about their past experiences and conditions. (pp. 28–29). Six years later Dehlin et al. (2015a) correctly observed: "No known study to date has drawn from a representative sample of sufficient size to draw conclusions about the experience of those who have attempted SOCE. Furthermore, no known study to date has provided a comprehensive assessment of basic demographic information, psychosocial well-being, and religiosity, which would be required to understand the effectiveness, benefits, and/or harm caused by SOCE" (p. 96).

95) A 2022 review of SOCE research for the APA presented a two-fold classification of recent studies: "most SOCE research from 2008 to 2020 falls into two broad categories that use retrospective reports: (a) studies of individuals who have undergone SOCE to explore their experiences (Bradshaw et al., 2015; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015a; Fjelstrom, 2013; Flentje et al., 2014; Maccio, 2011; Weiss et al., 2010), and (b) studies that compare sexual minority individuals who have undergone SOCE with those who did not (Blosnich et al., 2020; Green et al., 2020; Higbee et al., 2020; Ryan et al., 2018; Salway et al., 2020)" (Haldeman, 2022, p. 29).

96) The 2022 APA review states: "The literature review did not find any … studies … which could assess a clear causal impact of SOCE on outcomes" (Haldeman, 2022, p. 29). This repeatedly stated conclusion, that the research is at present unable to support scientific inference that SOCE causes certain outcomes, accurately describe the state of the research.

97) The APA review made clear that neither group of studies from categories (a) and (b) from 2008 to 2020 included any experimental evidence and so those studies could not determine causation.

98) The APA review (Haldeman, 2022), states that both groups of studies rely on "retrospective recall," a feature that weakens the methodological quality of their evidence because it "increase[s] subjective judgments in the reporting of results that are vulnerable to reappraisal, omission, social desirability, and distortion" (p. 27). And all the studies cited in (a) and (b) used cross-sectional samples.

2. Cross-sectional studies cannot definitively predict the risk of harm.

99) Given the ubiquity of cross-sectional studies in the literature, it is important to understand their limitations. Only some types of observational

research can establish correlations and associations that suggest risk factors or harms, but none of the current literature, including the group (a) and (b) studies, consists of these types of studies (to my knowledge). Evidence-based medical research recognizes three types of observational or non-experimental studies: cohort studies, case-control studies, and cross-sectional studies. The studies in group (a) and (b) are cross-sectional surveys. Cross-sectional surveys collect a "snapshot" of information on a sample at only one point in time. A commonly held standard of evidence in psychology holds that "[c]ross-sectional studies … are a good starting point to establish any associations between variables, while longitudinal [cohort or case-control] studies … are necessary for studying cause and effect" (Simkus, 2023). The view that cohort or case-control studies can establish causation, however, is contested, due to studies which have found a low rate of replication of observational study claims by randomized clinical trials of the same hypothesis. (Ejima et al., 2016). For that reason, a popular textbook on psychology research methods reaffirms that "the experimental method is the only method that allows us to determine causal relationships" (Jhangiani et al., 2019, p. 47).

100) While some methodologists argue that cohort and case-control studies can support causal inference, virtually all agree that "[b]ecause the temporal relationship between disease occurrence and exposure cannot be established, cross-sectional studies cannot assess the cause and effect relationship. (Song & Chung, 2010, p. 2234). Cross-sectional studies only collect data at one point in time, when two variables in such data are associated, and it is difficult to tell whether the variable the researcher conceives as "exposure" caused the variable the researcher conceives as "outcome" or the other way around. This is a possibility called "reverse causality" (Rothman & Greenland, 1998).

101) "Most [comprehensive effectiveness reviews] will include data on harms from different types of studies. Statistical combination of data from

observational studies is often inappropriate and should be avoided unless there is clear rationale to do so" (Chou et al., 2010, p. 510). Regarding cross-sectional studies the AHRQ report only states: "Although cross-sectional studies have features in common with cohort studies, it is difficult to establish causality because exposures, and outcomes are evaluated simultaneously. Indeed, associations in cross-sectional studies may sometimes be due to from reverse causality" (Chou et al., 2010, p. 505). In SOCE-critical research, reverse causality would mean that mental health problems may have been a reason for engaging in SOCE rather than a result of doing so. This is a disabling problem for SOCE-critical studies that I discuss elsewhere in this report.

102) The field of evidence-based medicine has raised additional questions and cautions about the use of observational studies, including cohort, case-control and cross-sectional studies, in medical reviews due to the discovery of two problems: first, for technical reasons related to the computation of standard errors, combining the results of multiple observational studies makes their findings appear more certain than is warranted, a statistical phenomenon dubbed "spurious precision," (Egger et al., 1998; Irsova et al., 2025); second, observational studies are especially susceptible to publication bias, which is the tendency for empirical results "that are statistically significant, that confirm some prior belief or, conversely, that are surprising" to be more likely to be published than others. (Andrews & Kasy, 2017; Ioannidis, 2008).

103) That's why the general recommendation is to use cross-sectional studies only in addition to other stronger research, either to develop hypotheses for further study (Frieden, 2017) or to develop practical treatment guidelines that help apply the results of random clinical trials to differing clinical populations. (Mulder et al., 2018). But causal harm cannot be definitively established by cross-sectional

studies. No source in the literature on this topic, to my knowledge, recommends the use of cross-sectional studies *by themselves* to predict causal outcomes.

104) The prevailing minimal scientific standard for medical research is that cross-sectional studies, either alone or in combination with another cross-sectional study, cannot be relied on to predict the risk of harm from medical or psychological interventions. The conclusion in the 2022 APA review, that none of these studies "could assess a clear causal impact of SOCE on outcomes," (Haldeman, 2022, p. 29), correctly reflected the scientific standard of medical evidence on such questions.

3. Multiple studies of current talk therapy that have *not* excluded non-LGB respondents have reported substantial psychological benefit and/or lack of harm from change-allowing sexual orientation therapy.

105) Participants in multiple clinical studies of change-allowing therapy or support that were not limited to LGB respondents with unsuccessful experiences have reported successful change along the homosexual-to-heterosexual continuum and strong net psychological benefit.

106) Nicolosi et al. (2000) examined self-reported benefit and harm from 882 "dissatisfied homosexual people" who had attempted to change sexual orientation, 726 of them with the help of conversion therapy. Before attempting to change, 90% met the Kinsey scale criteria for homosexual orientation, reporting themselves to have been "more homosexual than heterosexual," "almost exclusively homosexual," or "exclusively homosexual" in orientation (p. 1071). The authors reported: "After receiving therapy or engaging in self-help, 305 (35.1%) of the participants continued to view their orientation in this manner.… They also reported large improvements in their psychological, interpersonal, and spiritual well-being" (p. 1071). On average, participants reported statistically significant increases in self-acceptance, self-understanding, self-esteem, emotional stability, and positive personal relationships, and a statistically significant decrease in

depression. In unprompted open-ended comments, respondents reported that: "(1) therapy helped them grow in self-esteem, self-understanding, and self-acceptance; (2) therapy helped free them from feelings of shame, guilt, self-condemnation, and unworthiness; (3) therapy helped them feel more accepted and loved; (4) therapy helped them feel more intimate-physically and emotionally-with their spouse; (5) therapy helped them decrease their homosexual thoughts and behaviors to varying extents (from "some reduction" in homosexual thoughts and behavior to "completely free" from such thoughts and behaviors); (6) therapy helped men feel more masculine and women more feminine; and (7) therapy helped them enjoy healthier relationships with others" (p. 1081). Nicolosi et al. did not claim that these results were likely for most sexual minority persons, or that persons who were satisfied with a homosexual identity should seek to change. Rather, the authors asserted that their study was "important because it documents the existence of a group of dissatisfied homosexually oriented people who experienced conversion therapy from professional therapists and pastoral counselors and perceived that they benefited. It provides clear *prima facie* evidence that conversion therapies and pastoral counseling do help at least *some* dissatisfied homosexually oriented people" (p. 1083). The 2009 APA Task Force Report dismissed the findings of this study in a footnote, claiming that it used the wrong statistic in its analyses (chi-square). (p. 32, note 34). But this is true for only one analysis in the study. Importantly here, the study employed the correct statistic (paired t-test) to assess psychological benefit. The 2009 APA Task Force Report itself said that the paired t-test was appropriate. (p. 32, note 32). Because the 2009 APA Task Force Report agreed that the paired t-test was an appropriate test, and Nicolosi et al. used the paired t-test to assess psychological benefit, the 2009 APA Task Force Report should have more fully acknowledged the findings regarding the psychological benefits of conversion therapy for at least some persons.

107) Shidlo & Schroeder's (2002) early study is often cited as evidence of harm from change-allowing sexual orientation therapy. The APA's (2021) Resolution supporting SOCE bans cites it three times; a review in *The Case Against Conversion "Therapy"* falsely asserts that the study "found little evidence of change and documented harm" (Haldeman, pp. 21–22). In fact, Shidlo & Schroeder recount that they began their study with a goal of documenting harm, but "[a]fter the first 20 interviews, we discovered that some participants reported having been helped as well as harmed" To the authors' credit, they revised their inquiry to capture recollections of both benefit and harm. (p. 251). And indeed, many of the 202 participants they interviewed reported both benefits and harm, in very different amounts depending on whether they considered their experience to have been a success or failure (13% of the sample reported successful change or management of unwanted homosexuality) (p. 253). From the respondents' reports, each clinical intervention they received was rated as having been "helpful only," "both helpful and harmful," "harmful only," or "neither helpful nor harmful" (p. 257).

108) Not surprisingly, the "failure" respondents rated 51% of their clinical courses as harmful only, but they considered 43% of those clinical interventions both helpful and harmful, and 5% helpful only. Further, they rated 64% of their non-clinical interventions (e.g., peer support groups or peer individual or peer couple counseling) as only or partly helpful. In sum, even those subjects who considered that they had "failed conversion therapy" (p. 253) rated 54%—more than half—of the interventions they underwent to be at least helpful in part (p. 257).

109) By contrast, the "success" respondents felt that 71% of their clinical treatment courses were helpful only, and that 29% of those courses were both helpful and harmful. Likewise, they rated 67% of their non-clinical courses as helpful and 33% to have been both harmful and helpful. None recalled any of the

clinical or non-clinical interventions they underwent to have been only harmful. (p. 257).

110) Overall, the participants in this study reported that 61% of the interventions they received had been at least partially helpful. Almost a quarter (24%) were rated as being only helpful, without any harm. This is not evidence of pervasive harm from this therapy. No SOCE-critical study has ever (to my knowledge) acknowledged, discussed, or weighed the positive results reported by Shidlo & Schroeder (2002). The strikingly different results for the success and failure groups also illustrate the highly biased and unrepresentative assessment of harm from change-allowing sexual orientation therapy that results when samples are drawn so as to exclude any successful participants in therapy or support oriented towards change of sexual attractions or behaviors.

111) A team of researchers (Bradshaw et al., 2015) examined an online survey of 1,612 formerly or currently same-sex-attracted Mormons who had undergone sexual orientation therapy. The sample did not formally exclude respondents who identified as heterosexual, although the survey recruitment process—primarily through gay-affirmative organizations and "snowball sampling" (Bradshaw, Dehlin et al., 2015, p. 396; Dehlin, Bradshaw et al., 2015a, p. 98; Dehlin et al., 2015b, p. 8)—may have suppressed their proportional participation. As with Shidlo & Schroeder's (2002) study, the 2021 APA review cited these studies as evidence that SOCE is intrinsically harmful, when in fact they showed the opposite, reporting both harm and benefit from SOCE. Bradshaw and collaborators concluded, in fact, that harms were "much less frequent" than benefits: "Many found therapy to be a helpful, even life-saving experience.… Of particular interest was the large number of individuals who reported decreased levels of depression and anxiety and improved feelings of self-worth.… As a general rule, … experiences

of harm or iatrogenic distress were much less frequent than reports of benefit" (Bradshaw et al., 2015, p. 406).

112) Spitzer (2003) conducted extensive structured evaluations of 200 "individuals who report that their sexual orientation had been predominantly homosexual, but who now report that because of some kind of therapy they have sustained for at least 5 years some change to a heterosexual orientation," with the 143 males of this sample collectively reporting a mean homosexual-to-heterosexual change in sexual attraction of 68 points on a 100-point scale following therapy. (pp. 405, 408). Spitzer reported: "Even participants who only made a limited change nevertheless regarded the therapy as extremely beneficial" (p. 413). "For the participants in our study, there was no evidence of harm. To the contrary, they reported that it was helpful in a variety of ways beyond changing sexual orientation itself" (p. 414). Since virtually all these men identified as heterosexual following therapy, none of them would be included in recent studies that draw only LGB samples. This well-known study's evidence was ignored without citation in the APA's (2021) Resolution supporting SOCE bans.

113) Karten & Wade (2010) asked the 117 male participants in change-allowing sexual orientation therapy in their sample, which was not screened for current sexual identity, to assess their positive psychological change from change-allowing sexual orientation therapy as being either not at all (1), slightly (2), moderately (3), markedly (4), extremely so (5), or not applicable (0) on six areas of psychosocial function identified by Shidlo & Schroeder's (2002) study, i.e. depression, suicidality, self-harmful behavior, self-esteem, social functioning, and alcohol or substance abuse. The average degree of positive change self-reported for each area of psychosocial function was:

- depression, 3.9 (at the high end of the "moderately" range);
- suicidality, 3.9 (high moderately);

- self-harm, 3.9 (high moderately);
- self-esteem, 4.2 (low extremely):
- social functioning, 4.0 (low extremely); and
- alcohol/substance abuse, 3.3 (low moderately).

The authors reported: "With respect to psychological well-being, on average men reported there was a positive change in their psychological functioning" (p. 93). This study's evidence was not cited in the APA's (2021) Resolution supporting SOCE bans.

114) Jones and Yarhouse (2009) explicitly tested the hypothesis that "the attempt to change sexual orientation is intrinsically harmful," finding "no evidence that the attempt to change sexual orientation was harmful on average for these individuals" (p. 9) Indeed, persons who most strongly pursued change "showed modest gains in the diminishing of psychological distress" (p. 9).

115) Jones and Yarhouse (2011) further presented strong, measured evidence that change-allowing sexual orientation therapy did not induce psychological harm, in a 6-year longitudinal study that followed 58 change-allowing sexual orientation therapy participants for six years of annual assessment. At Time 6, 53% of participants reported success in changing sexual orientation at least partially; 25% reported failure, most of these reverting to a gay identity; and 23% were continuing in change-allowing sexual orientation therapy or did not respond to the question. Jones and Yarhouse measured psychological distress using the Symptom Checklist-90, a well-validated instrument for assessing psychological distress with a general index of distress and a measure of the intensity of distress. The authors reported modest average improvements in each of three measures of distress for each of the two cohorts, regardless of outcome, from Time 1 to Time 6.

(p. 418). The authors concluded that their findings "contradict the commonly expressed view that sexual orientation is not changeable and that the attempt to change is highly likely to result in harm for those who make such an attempt" (Jones & Yarhouse, 2011, p. 425). This study's methodologically strong evidence regarding lack of harm from change-allowing sexual orientation therapy was not cited in the APA's (2021) Resolution supporting SOCE bans.

116) Pela & Sutton (2021) reported on a 24-month longitudinal clinical outcome study of 75 clients treated by certified reintegrative therapists, finding small average changes in sexual attraction but a large increase in well-being. Reintegrative therapy is a form of therapy that does not attempt to change sexual attractions but treats early life trauma. However, because changes in sexual attractions are a common by-product of such therapy it is sometimes included in condemnations of conversion therapy. Over the course of the treatment, participants "experienced significant improvement in their well-being" (p. 76) as indicated by an average before/after improvement in symptom distress, interpersonal functioning and social role functioning of 23% (effect size of .80) on the Outcome Questionnaire 45.2, a widely used instrument for measuring psychiatric treatment outcomes.

117) Sullins & Rosik (2025) examined a sample of 125 male former and current SOCE participants not screened for current sexual orientation. Though 4% reported increased same-sex attraction after SOCE, 69% reported reducing same-sex attraction, 19% to full heterosexual attraction. (pp. 7–8). We used a slightly modified version of Karten & Wade's questions discussed above, rating psychological improvement as "not applicable" (0), "not at all" (1), "slightly" (2), "moderately" (3), "markedly" (4), or "extremely" (5) in the same six problem domains, i.e. depression, suicidality, self-harmful behavior, self-esteem, social functioning, and alcohol or substance abuse. (p. 29). To encourage reports of any

psychological harm, they also added questions about possible negative psychological changes as well as improvement. More than two-thirds of respondents reported no negative psychological change for each of the six problem domains. (p. 28, Table 9). Comparing reported negative and positive psychological change, we found that ranged across the six problem domains: "From 0.8% to 4.8% of participants reported marked or severe negative psychosocial change following SOCE, but 12.1% to 61.3% reported marked or severe positive psychosocial change. Net change [positive change minus negative change] was significantly positive for all problem domains" (p. 1).

118) Sullins (2026) reported on a sample of 129 men and 54 women who reported changing from homosexual to heterosexual orientation, 98 of whom had done so with the assistance of change-allowing sexual orientation therapy. Repeating the same measures of psychosocial change used by Sullins & Rosik (2025), I likewise found overall net psychological change (positive change minus negative change) of 2.50 on the ten-point scale of combined positive and negative change, consistent with "moderately" positive psychological improvement. Over each of the six problem domains, on average, men reported positive psychological change from 2.6 to 3.1 and negative change from 0.13 to 0.30; women reported positive change from 2.8 to 3.3 and negative change from 0.15 to 0.30. (p. 16, Table 7). Both changing sexual orientation and undergoing change-allowing sexual orientation therapy were independently associated with net increases in positive psychological change. For both men and women, the largest ratings for positive change were more than ten times larger than the largest ratings for negative change. I concluded: "For all domains, both individually and combined, for both men and women, net change was invariably positive and of relatively large magnitude. Clearly, in the minds of these participants, leaving pride behind was far more psychologically beneficial than harmful" (p. 17).

119) Separate and apart from the question of "success" as defined by possible change in sexual orientation, multiple studies presented in this section—including studies from authors who by no means favor change-allowing therapy—have reported that high percentages of participants in change-allowing therapy found at least some aspects of that therapy helpful or showed improvements in psychological well-being. The prevalence of such benefits, even among those for whom sexual orientation did not change, was recognized by the 2009 APA Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation (Glassgold, 2009). "[A] key finding from our review," stated the Report, "is that those who participate in SOCE, regardless of the intentions of these treatments, … may evolve during the course of their treatment in such areas as self-awareness, self-concept, and identity. These changes may include (a) sexual orientation identity, including changes in private and public identification, behavior, group membership, and affiliation; (b) emotional adjustment, including reducing self-stigma and shame; and (c) personal beliefs, values, and norms, including changes in religious and moral beliefs and behaviors and motivations" (p. 66).

D. Studies claiming harm from change-allowing sexual orientation or gender identity therapy have been subject to disabling biases that render their findings invalid.

120) A larger problem than the methodological weakness of SOCE-critical research, however, has been the presence of persistent and often unacknowledged bias. This is a larger problem because, while methodological weaknesses reduce confidence in making assertions from the evidence, bias increases confidence in making assertions that are not true.

1. First, SOCE-critical studies have improperly excluded participants who do not self-identify as LGB.

121) SOCE-critical research in the past 15 years has not merely been methodologically unsound but also persistently biased. Since the 2009 APA Report,

all SOCE-critical and GICE-critical studies of which I am aware that have reported net psychological harm from change-allowing sexual orientation or gender identity therapy have drawn samples entirely or predominantly restricted to self-identified sexual minority persons, expressly or structurally screening out any potential participants who do not currently identify as LGBT. (Goodyear et al., 2022; James et al., 2016; Phelan et al., 2022; Rosik, 2022, pp. 870, Table 1; D. P. Sullins, 2024, p. 16). The samples used in these studies have typically been selected or identified exclusively by referrals from LGB advocacy organizations, or self-selection in community settings such as LGB-focused bars, bookstores, social media sites, communities, and forums, which are openly opposed to change-allowing sexual orientation therapy. Such samples contain, inevitably, few persons for whom change-allowing therapy has been a positive experience. This methodological choice gravely biases the sample of these studies, almost guaranteeing a finding of harm.

122) To accurately evaluate the effectiveness and benefit of any therapeutic treatment requires that the study includes cases for which the treatment has been successful, where such exist. As I recount in detail below, those who experience success in changing sexual orientation (on any axis) in the course of therapy, compared to those not successful, report much greater satisfaction, substantial psychological benefit, and little or no harm. (Jones & Yarhouse, 2011, pp. 422–24; Shidlo & Schroeder, 2002, p. 257; Spitzer, 2003, pp. 413–14). Thus, excluding them improperly distorts the assessment of the balance of benefit and harm for persons who have undergone change-allowing sexual orientation therapy.

123) Further, if the question to be answered is "Is change-allowing therapy beneficial and/or harmless to religiously (or otherwise) motivated individuals who affirmatively seek such therapy?", then it is precisely a population of such individuals that one must study. For purposes of this question, it is studies whose

sampling methods directly or indirectly *exclude* individuals who may have benefited from such therapy that are distorted by sampling bias.

124) Excluding possible successes when evaluating the efficacy and harm of change-allowing sexual orientation therapy is like evaluating the efficacy and harm of marital therapy by recruiting participants only from divorce support groups, or of a major surgical procedure by examining the medical records only of patients who subsequently died. Even substantially beneficial therapies or surgeries could falsely appear to be harmful based on such partial and biased samples. Asking a sample restricted to currently-identified LGB persons who do *not* struggle with conflicts between their same-sex attractions and religious beliefs about their experience with SOCE is like asking a sample restricted to currently-identified heterosexual persons who *do* struggle with conflicts between their same-sex attractions and religious beliefs about their experience with "gay-affirming therapy" (GAT) which precludes consideration of sexual orientation change. In either case, one is likely to get a far more negative assessment of the therapy than one would obtain from a genuinely representative sample of patients who have participated in such therapy. Below I illustrate this point with reports of harm from GAT in the literature.

125) Dr. Christopher Rosik (2022), in a study titled, "A Wake-up Call for the Field of SOCE Research," found that of the 20 most prominent SOCE-critical studies since 2010, only two had attempted to include some non-LGBT persons in their samples. (p. 870). Nine studies had explicitly screened out non-LGBT persons, resulting in a sample that was 100% composed of persons who identified as either LGB or transgender at the time of the study. The remaining nine had sampled only from LGBT venues, resulting in samples that were 87% to 99% LGBT.

126) Although most SOCE-critical studies have simply ignored this problem, at least two have acknowledged the difficulty it presents for their claims. Campbell & Rogers' (2023) study of GICE among transgender youth noted briefly

among the study's "sampling issues" that "we cannot observe people for whom conversion therapy was successful" (p. 4). In their study of young adults who had undergone SOCE as adolescents, Ryan et al. (2020) stated: "study inclusion criteria called for current identification as LGBT; it is likely that this inclusion criterion excludes persons who are dissatisfied with their LGBT identity, or persons who had identified as LGBT during adolescence but not at the time of the study. Thus we acknowledge that we did not include young people whose sexual orientation may be more fluid (e.g., sexual orientation in adolescence not consistent with sexual orientation in young adulthood)" (pp. 169–170). As the 2022 APA Review of the SOCE literature acknowledged, "limitations to this and other work on adults who recall receiving change efforts as children or youth [referring to the comparative studies in group (b) of her two-group classification cited above]" "These studies are with self-identified LGBTQ individuals who may perceive their experiences differently than those who do not so identify" (Haldeman, 2022, p. 38).

127) The sample designs of Higbee et al. (2022) and Green et al. (2020) merit further mention. These studies are among those that excluded anyone who did not identify as LGBT and thus may have been more likely to benefit from change-allowing therapy, thereby structurally overstating harm. The authors in these two studies, however, went a step further to also intentionally eliminate participants who may have benefited from change-allowing therapy. Higbee et al. (2022) advised: "Although the current study's dataset includes measures of sexual attraction and behavior in addition to sexual orientation labels, we chose to only include sexual orientation in our analysis because the other variables often measure individuals who identify as heterosexual but engage in same-sex sexual activity rather than individuals with a solidified LGBQ+ sexual identity. Experiences of same-sex attraction and same-sex sexual activity tend to include substantially higher percentages of the general population than LGBQ+ self-identification" (p.

619). This decision to exclude anyone without a "solidified LGBQ+ identity" ensured the exclusion of such persons who may have benefited from SOCE by adopting a heterosexual identity while still experiencing some same-sex attraction and who may have complicated a simple narrative of harm. Green et al. (2020) reported that respondents "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'" (p. 1222). In this way, the authors intentionally removed from their study all persons who may have undergone voluntary non-coercive change-allowing therapy *precisely because* it had not been coercive. The APA (2021) claims that these openly biased sets of data present accurate information about an association between therapy and suicide. They do not.

2. Second, studies claiming harm from change-allowing sexual orientation or gender identity therapy have improperly attributed pre-existing harm to the therapy.

a) After correction for pre-existing suicidality, the strongest representative study purportedly showing higher suicide risk after change-allowing sexual orientation therapy instead showed just the opposite.

128) Blosnich et al.'s (2020) study of the relation of SOCE and early life trauma to suicide risk was based on a cross-sectional survey with retrospective measures of past experiences, including SOCE exposure. The survey was administered to a random sample of rigorously collected by the Gallup organization that was statistically representative of the U.S. LGB population. The study concluded that "[o]ver the lifetime, sexual minorities who experienced SOCE reported a higher prevalence of suicidal ideation and attempts than did sexual minorities who did not experience SOCE" (Blosnich et al., 2020, p. 1024). Specifically, the authors reported that sexual minority persons who had undergone

SOCE were 1.9 times more likely to have ever thought of committing suicide or to have made a suicide attempt, which did not result in serious injury. The APA's 2021 Resolution supporting SOCE bans cited the study multiple times (pp. 5-6), as did the related literature review in the book *The Case Against Conversion Therapy*, with the editor describing Blosnich et al. (2020) as "the first population-based study showing significant increased risk of harm from [conversion therapy]" (Hancock & Haldeman, 2022, pp. 128–129).

129) However, the Blosnich et al. (2020) study's conclusions are demonstrably false, due to a blatant and disabling error in the analysis that led to them. A disabling error is a fundamental flaw in research methodology that invalidates the conclusions of the study. As noted above, any cross-sectional study claiming a causal-like temporal effect must address the possibility of reverse causation. Having discovered a correlation between SOCE participation and thoughts of suicide, and despite having asked the respondents when each of these occurred, the authors did not report time sequence and did not examine which came first: the suicidality or the treatment. When I examined the data (Sullins, 2022b), I discovered that most suicidal ideation was reported by the participants to have taken place *before* they had participated in change-allowing sexual orientation efforts. (p. 3381). Replicating Blosnich et al.'s statistical analysis after correcting to include a measure accounting for pre-existing suicidality, I found that persons who had undergone SOCE were no more likely than those who had not undergone SOCE to have thought of committing suicide or to have made a suicide attempt. Depending on other assumptions about the data, in fact, they may have been less likely. (p. 3382, Table 2). I also found that persons who had gone to SOCE following initial thoughts of suicide were less than one-fifth (0.17) as likely to have such thoughts again, compared to persons who had not experienced any intervening SOCE. (p. 3386, Table 9). These results suggest the opposite of Blosnich et al.'s (2020)

conclusion: that the causal sequence was that persons experiencing suicidal thoughts were more likely to pursue SOCE, and that such treatment was, empirically, very helpful in avoiding a recurrence of suicidality.

130) The amicus brief filed by the American Psychological Association at the U.S. Supreme Court in the *Chiles* case asserts that my study "has been widely critiqued as lacking scientific validity due to 'glaring methodological flaws.'"[2] This is false. In addition to Blosnich et al.'s response, there was exactly one methodological commentary of my 2022 replication of Blosnich et al.'s study (Rivera & Beach, 2022) —and it confirmed my critique of their study. Rivera & Beach agreed that: "Blosnich et al.'s approach failed to properly account for temporal relationships. Due to this, it is unclear if SOCE caused the increased suicidal ideation observed in the SOCE-exposed individuals" (p. 35). The APA amicus brief cites the Rivera & Beach study and quotes it as saying that my study "'failed to properly account for temporal relationships.'" (p. 29). But the portion the APA quotes was actually a criticism of Blosnich et al.'s approach. The full sentence from Rivera and Beach states, "Thus, Blosnich et al.'s approach failed to properly account for temporal relationships" (p. 35). This is a brazen misquotation in support of a misleadingly false claim. A single commentary that confirmed the methodological point I made is not accurately characterized as "widely critiqued as lacking scientific validity"[3]

131) The phrase "glaring methodological flaws" was part of a series of detailed criticisms Rivera & Beach made of the statistical methods of both Blosnich et al. (2020) and my critique, and of our use of the Generations data, which I rebutted in a responding commentary. (Sullins, 2023). In my rebuttal, I reanalyzed

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[2] Br. of The American Psychological Association, et al. as Amici Curie Supporting Respondents at 29, *Chiles v. Salazar*, 146 S.Ct. 1010 (2026), No. 24-539. Available here: www.supremecourt.gov/DocketPDF/24/24-539/370703/20250826102657442_24-539%20tsac%20American%20Psychological%20Assn.pdf

[3] *Id.*

the data to address many of their concerns, which strengthened my original results slightly.

132) In their response to my study, Blosnich et al. (2022), remarkably, insisted that the "Generations data do not allow timing of SOCE exposure" despite the presence of the following question: "About how old were you the last time you received treatment to change your sexual orientation?" Since I subtracted the average duration of SOCE from the age given in response to that question to estimate the beginning of SOCE exposure, they claimed that I used "fabricated" information. They also made a reasonable point, however, that I had understated average SOCE duration; I had estimated it to be one year, but they argued it should have been four years. This was a "fatal flaw," they claimed, because if I had used four years it would have reduced the estimate of pre-existing suicidality, restoring their finding of higher suicidality associated with SOCE.

133) In response, I recomputed the original models using four years instead of one, finding that the SOCE group still did not have higher suicidality than the non-SOCE group. I then extended the duration to six years, two years longer than they claimed was necessary, but still found that suicidality was not higher in the SOCE group. I concluded that "the findings of my study (Sullins, 2022b) continue to invalidate the conclusions of Blosnich et al. (2020), even after revising the presumed duration of SOCE upwards to the 4 years they recommend in order to reasonably 'indicate a probable pre-SOCE suicide attempt'—and even an additional two years beyond that. The conclusions of Blosnich et al. (2020) regarding the invidious harm of SOCE remain in the realm of contrived illusion, not observed reality, produced by their failure to apply the principle of causal time order, i.e., that a result cannot reasonably be attributed to a cause later in time. Their denialism regarding the Generations data's measure of SOCE timing—maintaining that the evidence either

does not exist or cannot be used to do what they themselves use it to do in their Commentary—compounds the contrivance" (Sullins, 2023, pp. 891–92).

134) Ignoring time order when assessing cause and effect for treatment outcomes is not an inconsequential problem which can be corrected by qualifying the claims that SOCE causes suicidal harm. Rather it is a discrediting logical fallacy. Rothman's widely used epidemiology text states: "[T]emporality is a sine qua non for causality: If the putative cause did not precede the effect, that indeed is indisputable evidence that the observed association is not causal" (Rothman & Greenland, 1998, p. 28). It is simply not the case that a suicide attempt made years before SOCE exposure can be a result of that future exposure.

135) I concluded my study rebutting their conclusions with this caution: "Imagine a study that finds that most persons using anti-hypertension medication have also previously had high blood pressure, thereby concluding that persons 'exposed' to high blood pressure medication were much more likely to experience hypertension, and recommending that high blood pressure medications therefore be banned. This imagined study would have used the same flawed logic as the Blosnich et al. (2020) study, with invidious consequences for persons suffering from hypertension" (Sullins, 2022b, p. 3390).

b) Other recent studies purportedly showing higher suicide risk after change-allowing sexual orientation therapy make the same time order error.

136) In addition to Blosnich et al.'s (2020) study, the 2022 APA Review of research supporting its Resolution calling for legal restrictions on SOCE (Haldeman, 2022) also cited four other studies from 2020 to supposedly support a causal relationship between change-allowing sexual orientation therapy participation and higher suicidality: (1) Ryan et al. (2020); (2) Meanley et al. (2020); (3) Salway et al. (2020); and (4) Green et al. (2020). (pp. 33–37). Other studies often

cited for this proposition include Higbee et al. (2022), Blosnich et al. (2020), Turban et al. (2020), and Veale et al. (2021). These seven studies also failed to consider or adjust their results for the presence of pre-existing suicidality or other psychological distress, thereby misstating an association of change-allowing sexual orientation therapy with suicidal risk. Because all of them measured only lifetime suicidality and/or lifetime sexual orientation therapy participation without specifying which came first, none of them can tell us whether the therapy led to increased suicidality or—as I found when I re-examined Blosnich et al.'s data—whether instead pre-existing suicidality increased recourse to therapy.

137) Some of the studies acknowledged the problem of reverse causation—i.e. of pre-existing stress leading to the therapy—although they then dismissed or ignored it when asserting a causal effect of SOCE or GICE to the point of recommending a legal ban. For example, Turban (2020) stated: "Limitations [of this study] include its cross-sectional study design, which precludes determination of causation. It is possible that those with worse mental health or internalized transphobia may have been more likely to seek out conversion therapy rather than non-GICE therapy, suggesting that conversion efforts themselves were not causative of these poor mental health outcomes" (p. 75). Green et al. (2020) used a survey administered by the Trevor Project (2019). A later version of the same survey, using the same methodology, acknowledged in its report: "Because this is a cross-sectional study, we cannot determine the chronology of events. While we measured suicidal thoughts and behaviors in the past year, we measured life-time exposure to conversion therapy. It is possible that some respondents were referred to conversion therapy as part of treatment after a suicide attempt" (Trevor Project, 2026). Salway et al. (2020) acknowledge: "We are unable to know whether SOCE preceded the psychosocial health outcomes identified by participants" (p. 507). Ryan et al. (2020) stated: "We cannot rule out the possibility that those who were most

maladjusted as young adults retrospectively attribute parental behaviors during adolescence as attempts at changing their sexual orientation; we also cannot rule out the possibility that well-adjusted LGBT young adults may be less likely to recall experiences related [to] SOCE" (p. 170). Veale et al. (2021) admitted the study could not "rule out alternative causal hypotheses of causation in different directions" (p. 482).

138) The disabling problem of unaddressed reverse causation affects other recent quantitative studies of SOCE and mental health, including the recent study of lifetime sexual orientation therapy recall by Tran et al. (2024). The authors of this study acknowledged that the inability to "account[] for mental health problems prior to conversion practice exposure" is "a potential threat to the validity of studies examining the conversion practice-mental health relationship," including their study. (2024, App'x p. 2). In a supplemental analysis, the authors statistically 'modeled the effect that a control measure for pre-existing suicidality would have on their results, finding that, within the statistical margin of error, it reduced the observed relationship between SOCE and suicidality to zero. (Tran et al., 2024, App'x p. 9, Suppl. Table 4). This finding confirms that, as in Blosnich et al.'s (2020) study, the apparent association between sexual orientation therapy and subsequent suicidality in this study was spurious due to ignoring the presence of substantial suicidality prior to participating in SOCE.

139) The idea that suicidality may lead to participation in change-allowing sexual orientation therapy rather than the other way around has also been corroborated by a recent study of post-SOCE suicide risk among LGB persons in Korea. Like Blosnich et al. (2020), Lee et al. (2021) found an elevated risk of lifetime suicidality among persons exposed to SOCE in a sample of over 2,000 sexual minority Koreans. However, they also found that the elevated risk of suicidality was the same, within limits of statistical uncertainty, for persons who had been advised

to undergo SOCE but had not done so. (p. 430, Table 2). Since those who did not undergo SOCE had the same elevated risk as those who had undergone it, this finding is not consistent with the idea that SOCE caused the higher suicidality but is consistent with the idea that prior higher suicidality may have prompted both the referrals and the SOCE attempts.

140) Another review by Forsythe et al. (2022) estimated the likelihood of suicide attempts following SOCE from Ryan et al.'s (2020) study of SOCE exposure among 245 LGBT young adults aged 21–25 years. Several features of this study render its findings unsuitable for generalization to all LGB persons. First, this study did not measure suicide attempts after SOCE, but lifetime suicide attempts. Taking pre-existing suicide attempts as an indicator of harm from SOCE, as Forsythe et al. do, risks blaming a treatment for the problem that prompted the treatment, like attributing a heart attack to the corrective surgery that follows it. Second, Ryan et al.'s (2020) study did not include any persons who voluntarily underwent SOCE, as is the case with all change-allowing sexual orientation therapy and with the therapy at issue in this case. It only included parent-initiated SOCE, which exacerbates the problem of pre-SOCE suicide if you think that parents are more likely to seek therapy for suicidal children. Third, Forsythe et al. (2022) further inflate the estimate of SOCE harm by an improper analytical choice. Ryan et al.'s (2020) study reported two lifetime suicide rates related to SOCE: 48% for SOCE itself, and 63% for SOCE when combined with "external conversion efforts," meaning direct attempts by parents or caregivers "try to change your sexual orientation (i.e., to make you straight)" apart from therapy. Such direct attempts likely reflect higher levels of family conflict, which are known to increase mental health struggles for adolescents. Ryan et al. (2020) clearly report them as associated with higher suicidality than that due to SOCE alone. Notwithstanding the fact that SOCE could not possibly have caused these external efforts by family, Forsythe et

al. multiply the higher percentage (63%) by 190,695 to estimate suicidal harm from SOCE. By this one choice they unjustifiably inflated the projected cost and quality of life estimates from SOCE due to suicidality by almost a quarter (24%)—even assuming the 48% figure is accurate, which, for the reasons I have described, it likely is not.

c) Prominent SOCE-critical scholars have not shown with representative data that LGB persons suffer higher risk of harm for an indefinite period after SOCE.

141) In 2022, I published a study that compared the LGB respondents on the Generations data by SOCE exposure (Sullins, 2022a). This comparison revealed that "[t]he SOCE group was statistically indistinguishable from the non-SOCE group" (p. 1) on any of 9 measures of current psychological or behavioral harm. Seven of those measures were (1) substance abuse, (2) alcohol dependence, (3) self-harm, (4) suicide ideation, (5) suicide planning, (6) suicide intentions, and (7) suicide attempt. (p. 1). Substance abuse and alcohol dependence were measured by validated scales responsive to criteria of the APA's Diagnostic and Statistical Manual. I also found that there was no significant difference between the two groups on the Kessler scale of psychological distress or their own self-rated mental health. (Sullins, 2022a, p. 7, Table 2). The Kessler scale is a 24-point scale designed by Harvard Medical School (Kessler et al., 2003) that asks survey questions about six symptoms of mental illness "to identify persons with a high likelihood of having a diagnosable mental illness and associated functional limitations" (Pratt et al., 2007, p. 2). In sum, I could find no evidence that having been exposed to change-allowing sexual orientation therapy resulted in higher levels of psychological distress.

142) In a commentary responding to my argument, Meyer & Blosnich (2022) asserted, "suicide morbidity, if it occurred, would have been more proximal to the

initial SOCE exposure" (p. 2). "[M]ost suicidality reported among people exposed to SOCE," they noted from a confirming study, "occurred *during* the period they were exposed to SOCE" (p. 2, emphasis in the original). Meyer & Blosnich's response strongly confirmed that the evidence does not show that SOCE induces subsequent or lifelong suicidal harm upon those exposed to it.

143) Meyer & Blosnich's (2022) assertion that there is no persistent risk following a non-proximal period of time after SOCE, for example, contradicts the claim of Green et al. (2020) that young persons "who reported undergoing SOGICE were more than twice as likely to report having attempted suicide" in the past year. (p. 1221). It also contradicts the claim of Turban et al. (2020) that "[r]ecalled lifetime exposure [to GICE] was associated with severe psychological distress during the previous month;" and the main finding of Ryan et al. (2020), which found that previous SOCE exposure was associated with higher current depression; and the main finding of Meanley et al. (2020), which found previous SOCE exposure to be associated current negative psychosocial conditions, including depression and PTSD. The disparity in findings could be due to the fact that, while Meyer & Blosnich (2022) were acknowledging results from a rigorous representative sample, the other studies cited in this paragraph were reporting on nonrandom convenience samples recruited from LGBT community sources, which are susceptible to bias.

E. SOCE research has understated the possibility of sexual orientation change and overstated harm by focusing on male experience to the detriment of women.

144) A significant weakness of SOCE research—both SOCE-critical and pro-SOCE studies—has been its almost complete neglect of the unique experience of women. The 2009 APA Task Force Report observed that "[t]he majority of participants in research studies on SOCE have been Caucasian men," and that although some samples had included women, "these studies do not examine if there

are potential differences between the concerns of men and women" (p. 45). Quantitative SOCE research since 2009 has not improved in this respect. The SOCE-critical studies by Meanley et al. (2020) and Salway et al. (2020), and the pro-SOCE studies by Karten & Wade (2010), Pela & Sutton (2021), Sullins (2024), and Sullins & Rosik (2025) all examined samples of only men. I am not aware of any comparable studies since 2009 that examine samples only of women. Studies that have included both men and women have usually included more men than women and have not reported differences by sex, so that the findings reflect largely the experience of men.

145) This neglect is consequential for accurate knowledge about the effects of SOCE because strong research has shown that the sexuality of men and women are very different, particularly with regard to minority sexual orientation. For example, compared to men, women on average have been found to be much more fluid in changing sexual orientation. (Diamond & Rosky, 2016).

146) To examine whether this and other differences may also be observed in the context of change-allowing sexual orientation therapy, I recently examined a sample of 129 men and 54 women who reported a change from homosexual to heterosexual orientation. Ninety-eight of them had done so with the aid of change-allowing sexual orientation therapy. (Sullins, 2026). I found that women changed sexual attractions more readily than men: 88% of the women, but only 38% of the men, experienced a shift from primarily homosexual to primarily heterosexual attraction. (Sullins, 2026, p. 13, Table 4). Women also reported significantly higher psychological benefits than men from changing sexual orientation and a greater improvement in positive psychological outcomes when undergoing therapy. (p. 18, Table 8). Change-allowing sexual orientation therapy strongly improved depression outcomes for women in this sample but did not significantly improve depression outcomes for men. (p. 16, Table 7).

147) On the question of restrictions on change-allowing sexual orientation therapy, these results suggested: "The strong confirmation in these data that women undergoing [sexual reorientation therapy] experience more change and higher psychological benefit than do men suggests that assessments of therapy outcomes that rely on data comprised entirely or wholly of men, … will inevitably understate the effectiveness and psychological benefit of SRT" (p. 24).

F. Advocates of censoring counseling and psychotherapeutic speech risk harm to patients by ignoring patients' religious convictions and identities.

1. SOCE-critical research has minimized the importance of deeply held religious convictions that conflict with same-sex orientation to the persons who experience them.

148) Some have suggested that when an individual experiences distress over his or her religious beliefs and LGB identity, the individual should find new, LGB-affirmative beliefs. (Ginicola & Smith, 2011; McCann et al., 2020). Others have also called for prohibiting, not just conversion therapy, but the dissemination of the religious teachings that are seen to underlie conversion therapy. Salway (2020) included prayer and Bible reading among the "discredited methods" of SOCE that should be "eradicated" (Salway et al., 2020, p. 503). Goodyear et al. (2022) set forth a "demand for … policy efforts to … address the structural determinants … [that] permit and drive SOGIECE," including "religious discourses surrounding the acceptability of [LGB] "lifestyles" (p. 15).

149) The insistence by SOCE-critical psychologists that persons seeking to alter their sexual orientation are denying their core identity fails to credit, or perhaps does not understand, that, as one secular counseling author put it, "Many of these individuals [seeking change-oriented therapy] do not identify with their sexual orientation at all but rather highlight their values and their religious beliefs as their primary identity" (Ginicola & Smith, 2011, p. 306). Many SOCE-critical

scholars, themselves not very religious, advise therapists to challenge the "non-affirming" religious beliefs of those troubled by same-sex attraction without seeming to understand that it is this "non-affirmation" of the client's religious beliefs, not a lack of gay affirmation, that threatens the core identity of such persons. Indeed, Beckstead and Morrow (2004) reported that *all* of their sample of 50 very religious same-sex-attracted Mormons seeking change-allowing sexual orientation therapy "were willing to give up their sexual identities in return for religious and societal rewards because, as they stated, they felt their sexual identities were peripheral to their religious identities" (p. 663). In a companion study, Beckstead (2002) elaborated further: "Because of the high stakes involved of losing family, friends, community, religious support, and eventually 'eternal exaltation,' participants felt that 'being gay' was not a valid choice for them" (p. 97).

150) The expectation of gay-affirmative therapy that they could adopt a gay identity prompted sample members to frustration and despair. One commented: "People think … we can change our beliefs…. I don't have the desire, and I really don't know that I would have much of the ability to change some of my basic fundamental beliefs … because of the way they give my life coherence" (Beckstead and Morrow, 2004, p. 663). Another recounted his disappointment with his gay-affirmative therapist: "I tried to explain the conflict to her between religion, my personal values, [and my same-sex attractions]... and she just kind of said, 'Well, I don't see what your problem is. Just pick one.' She didn't seem much help. She just didn't quite get it" (Beckstead, 2002, p. 97). Beckstead commented that this exchange "seems to articulate the frustrations expressed by all participants" (p. 97). Before beginning change-oriented therapy, faced with the prospect of "being gay" (p. 97; quotation marks in the original, indicating a quote from the participants themselves)—that is, having to affirm an identity or lifestyle of same-sex behavior that they believed would bar them from eternal blessedness—"[a]ttempting suicide

was seen as the only solution for 8 participants. Dan, for example, wrote, 'I felt like I couldn't continue to live in such pain. My alternatives seemed to be either to end my life or to straighten my life out.'" (p. 98).

151) Weiss et al.'s (2010) in-depth qualitative study of internet postings by persons who had undergone change-allowing sexual orientation therapy also reported traces of harm from gay affirmation among those who had experienced conflict between their religious convictions and same-sex attractions. The researchers examined internet groups of persons who had not ("ex-gays") and who had reverted ("ex-ex-gays") to an LGB identity after change-allowing sexual orientation therapy. A small proportion of comments in both groups (2 of 16 for the ex-ex-gays, 15 of 85 for the ex-gays) mentioned past thoughts of suicide. The two comments among the ex-ex-gays may have reflected the difficulty of resisting a gay identity, but for the larger ex-gay group, the authors reported: "The majority of respondents that reported being suicidal stated that it was the prospect of being gay [] that led them to thoughts of suicide, rather than the struggle of trying not to be gay" (Weiss et al., 2010, p. 306).

152) Dr. Douglas Haldeman, editor of the APA book *The Case Against Conversion "Therapy*," (Haldeman, 2022) has nevertheless previously written of respecting the religious conflict presented and experienced by those seeking SOCE: "In some circumstances, it is more conceivable, and less emotionally disruptive, for an individual to contemplate changing sexual orientation than to disengage from a religious way of life that is seen as completely central to the individual's sense of self and purpose" (Haldeman 2002, p. 262). "[G]ay-affirmative therapists need to take seriously the experiences of their religious clients, refraining from encouraging an abandonment of their spiritual traditions in favor of a more gay-affirming doctrine or discouraging their exploration of conversion treatments. Many religiously oriented individuals have reported that their therapist ignored or

attempted to devalue the spiritual aspects of their identity in the interest of facilitating their 'coming out.'" (p. 263).

153) Unfortunately, many SOCE-critical advocates commenting on therapeutic protocols simply refuse to acknowledge or respect the priority that religious conviction holds in the identity of such individuals. For example, two academic advocates wrote recently, "[Sexual orientation conflict] may result from an understanding of religious scripture … which identifies same-sex attractions as immoral, sinful, perverse, and repugnant. The underlying source of conflict then is not their attractions, but rather the oppressive beliefs that dictate the existence of certain populations of individuals as wrong.… Failure to confront and challenge these negative ideas may perpetuate them and bring harm to the client *or others*" (Ginicola & Smith, 2011, p. 318, emphasis added). These authors' rejection and condemnation of their (hypothetical) clients' religious convictions is express. Instead of supporting and affirming a religious client's goals, they are willing to jeopardize that client's psychological well-being by using the client's desire for counseling to "confront and challenge" the client's deeply held personal beliefs which contradict the authors' own personal beliefs. They are even willing to risk client harm for the good of what they perceive to be the interests of "others"—a position difficult to square with professional ethics.

2. <u>Dr. Yarhouse's method of therapy for highly religious persons with same-sex attraction does not render SOCE unnecessary.</u>

154) Citing Dr. Mark Yarhouse (joined by assorted co-authors), it is sometime argued that there are therapeutic methods for highly religious persons that render the use of change-allowing therapy unnecessary.

155) But Yarhouse, who co-authored one of the methodologically strongest studies of SOCE-mediated sexual orientation change, strongly affirms that some persons can change sexual orientation through SOCE. "Those involved in the

change attempt reported an average decrease in attraction to the same sex," he writes. (M. Yarhouse, 2010, p. 9). At the six- to seven-year follow-up, 23% of the participants reported changing from homosexuality to heterosexuality and 30% of the participants reported a reduction in their same-sex attraction, which "suggested that the average changes made were able to be sustained over time" (M. Yarhouse, 2010, p. 9). Yarhouse rejects the idea "that no one can experience change in sexual orientation and that those who have made that claim have lied," a position he terms *cynical pessimism*. (Yarhouse, 2010, p. 23) (emphasis in the original).

V. Research and publication on SOCE has been corrupted by pervasive and explicit ideological bias.

156) In October of 2024, Dr. Johanna Olson-Kennedy, a leading advocate of the administration of puberty blockers and cross-sex hormones to minors, and lead Principal Investigator in a multi-year, multi-million-dollar NIH-funded cohort study of the effect of puberty blockers on the mental health of children suffering from gender dysphoria, told *The New York Times*—apparently without embarrassment—that her team had withheld data obtained by that study from publication because it did *not* show mental health improvements, and she feared that that data would be "weaponized"—that is, used to argue against the treatments that she advocates. (Ghorayshi, 2024). Unfortunately, Dr. Olson-Kennedy's unabashed manipulation of the published scientific record to serve ideological and political goals exemplifies the distorted and unreliable nature of the wider scientific evidence base relevant to contentious "culture war" issues today.

157) In the prior sections of my report, I have cited peer-reviewed publications sufficient to demonstrate that sexual orientation is, for many people, not immutable; that the Minority Stress Theory as an explanation for the poor average mental health of LGB individuals is unproven and contradicted by important evidence, and that there is considerable evidence of benefit, and little

evidence of harm, from change-supporting therapy provided to willing patients in service of personal goals chosen by those patients. Nevertheless, as I have also noted, the majority of studies and publications in this area must be categorized as "SOCE-critical," seeking to contradict one or another of these points. Therefore, it is important for the court to understand how pervasively the available scientific record and ostensibly scientific voices have been compromised by ideology with respect to sexual orientation change and therapies that contemplate and support such change.

A. The social science academy has become a self-policing "tribal moral community" that "distorts and undermines" objective science.

158) In the past two decades, careful independent research has presented evidence that the bias against ideas perceived as conservative or religious has undermined objective scientific studies in most social science fields, and especially in psychology. Jonathan Haidt, Ph.D, at New York University has documented, with concern, the "near-total absence of conservatives [in American social science academia]," which has "allowed a tribal moral community to develop in many fields. Those who don't share the same sacred [politically liberal] values must either hide, leave, or live stigmatized lives with stunted career prospects" (Haidt, 2011).

159) Dr. Haidt is not wrong. The absence of conservatives in social science departments that Haidt found is not accidental. Inbar and Lammers (2012) asked a representative sample of 292 academic psychologists and found that 66% said that they would choose a liberal over a conservative job candidate with equal qualifications. (p. 501, Table 2, results recalculated to show percentages by Jussim, 2020, p. 3). The authors concluded that among psychologists, "Hostility toward and willingness to discriminate against conservatives is widespread" Similarly, Jussim (2012) identified fourteen mechanisms of liberal privilege in academic psychology that, he concluded, collectively result in liberal bias so great that it "distorts and

undermines the objectivity and validity of the 'science' that social psychology and other social sciences ultimately produce" (p. 504).

160) Research funding has been similarly restricted to serve pre-determined liberal policy goals. As with hiring, Inbar and Lammers (2012) also found that 77% of their academic psychologist sample stated that if a grant proposal took a "politically conservative perspective," that "would negatively influence" their decision whether to award the grant. (pp. 500–501, Table 2, results recalculated to show percentages by Jussim, 2020, p. 3). And indeed, in 2009 Jones and Yarhouse, introducing a study of sexual orientation change under treatment, noted that such studies had been common prior to the 1970s, but that "there has been a steady decline of such published studies in the last several decades as the professional political climate has made such research professionally threatening [and] research funding and other support for such research has evaporated" (Jones & Yarhouse, 2009, p. 2).

B. <u>The published scientific record is further skewed by censorship at multiple levels.</u>

161) As Dr. Olson-Kennedy's actions and statements illustrate, if research is done which produces results that may support "conservative" conclusions or contradict the narrative or policy goals approved by the monolithic "tribal moral community" described by Professor Haidt, researchers may simply withhold those results from publication, whether because the researcher shares those "tribal" goals (as in the case of Dr. Olson-Kennedy), or for fear of living "stigmatized lives with stunted career prospects" (Haidt, 2011, p. 4)

162) Those who do attempt to publish narrative-contradicting scientific results then face the hurdle of unapologetic censorship through what is supposed to be a scientific, ideologically neutral, peer-review process. Again, 77% of surveyed academic psychologists stated that if an article supported a conservative

perspective, that would negatively influence their decision as a peer reviewer as to whether to accept the paper for publication. (Inbar and Lammers 2012, p. 501, Table 2, results recalculated to show percentages by Jussim, 2020, p. 3).

163) Not even survival of peer review and actual publication ends the gauntlet of censorship. Instead, recent years have seen a drumbeat of ideologically motivated demands for "retraction" of peer-reviewed, published studies, and in some cases compliance by the publisher.

164) Famously, in 2001, the eminent psychiatrist Robert Spitzer—hailed at his death as "the most influential psychiatrist of his time" (Frances, 2016)—published evidence that some persons reported successful SOCE-assisted change from homosexual to heterosexual orientation, identity, or behavior. (Published as Spitzer, 2003) A furor of angry denunciation by LGBT activists followed (Hausman, 2001), and scholars accused study participants—without evidence—of exaggerating or lying. (Drescher & Zucker, 2006). LGBT activists called for the study to be retracted, asserting that the findings would be harmful to LGBT persons personally and politically. The paper was not retracted.

165) A decade after the study was published, a gay activist visited Dr. Spitzer, now age 80 and suffering from Parkinson's (Dr. Spitzer died just three years later), at his home to talk about the study and his personal unhappy experience with SOCE. (Arana, 2012). Dr. Spitzer, "afraid that the 2001 study [sic] would tarnish his legacy and perhaps hurt others" (Arana, 2012), published an apologetic letter rejecting his earlier conclusions, and asserting that there was "no way to determine" whether the study participants who reported successful change through SOCE were engaging in "self-deception or outright lying" (Spitzer, 2012). Study participants reacted by vigorously and publicly rejecting the accusation that their survey responses had been false. (Armelli et al., 2012). Because the data had

not changed and the article's analysis had not been discredited, the journal refused to retract the article. (Arana, 2012).

166) In a prominent recent case, a widely published researcher, Professor Michael Bailey of the Northwestern University Department of Psychology, published a survey-based study of the recently reported phenomenon of "rapid onset gender dysphoria" among adolescents in a respected peer-reviewed journal. (Diaz & Bailey, 2023). After an ideologically driven campaign demanding retraction of the article and the firing of the journal's editor-in-chief, and despite a letter signed by more than 2000 fellow academics, clinicians, and researchers opposing any such retraction, the publisher did retract the paper, the academic conglomerate Springer Nature, informed the authors that they would be overruling the editor and retracting the paper due to a newly invented technical requirement. Bailey easily refuted the pretext, pointing out that if the journal applied the new requirement consistently it would have to retract dozens of other studies as well. No error or fraud in the data was ever alleged, and the paper has since been republished with minor changes in another peer-reviewed journal. (Bailey, 2023; Diaz & Bailey, 2023).

167) I myself have undergone similar experiences. My peer-reviewed study showing that SOCE did not increase suicide (Sullins, 2022b) attracted calls for retraction, included one instigated by the same Dr. Lauren Beach who had organized the letter attacking Mayer and McHugh's review. (Rivera & Beach, 2022). As already noted above, the alleged flaws in the paper were rebutted in an analysis that only strengthened the original findings. (Sullins, 2023). Another commentary objected to the publication of my study as "egregiously problematic" and "unethical" because, *even if true*, the resulting scientific knowledge might impede political advances for LGBT causes. Evidence of success and benefits from therapy in

support of changes in any aspect of sexual orientation, this commentary asserted, should not even be permitted to be discussed. (Strizzi & Di Nucci, 2022, p. 866).

168) Again, while respected and tenured (or retired!) professors such as Dr. Bailey, Dr. McHugh, and myself can survive ideologically based attacks and retractions, the risk is simply unbearable for graduate students and untenured junior faculty. This deters—probably as an intended result—research that might contradict ideologically driven narratives. This further biases the available science.

169) The eminent psychologist Nicholas Cummings, past APA president and recipient of the organization's Gold lifetime achievement award for contributions to psychological science, recounts in his co-edited volume "Destructive Trends in Mental Health: The Well-Intentioned Path to Harm," how the field of psychology became captured by political correctness which degraded treatment for persons with psychological struggles which did not fit the liberal narrative. "Psychological practice is replete with examples in which political correctness has altered the treatment process, sometimes for the better but often for the worse" (Wright & Cummings, 2005, p. 13).

170) Dr. Cummings' views on conversion therapy were informed by both his scientific research and his clinical experience with persons seeking therapeutic help for their experience of same-sex sexual attraction and/or homosexual or bisexual identity. For 21 years he was Chief Psychologist for the Kaiser Permanente health care system in San Francisco, California. In a sworn affidavit submitted in other litigation, Dr. Cummings reported that during that time "I personally saw over 2,000 patients with same-sex attraction, and my staff saw another 16,000.… Many of these patients sought therapy "to resolve relationship issues" or to "come to grips with their homosexual identity" But some "sought therapy … to change their homosexual orientation," and of these, "hundreds were successful" (Cummings, 2013, p. 5). As Dr. Cummings reported elsewhere, of the approximately 16,000

patients who sought therapy to address their felt "conflicts over [their] homosexuality, two thirds were helped while one third "were not helped much" Of those for whom therapy was "successful," about 80% were helped to lead "saner" homosexual lives, while 20% were able successfully to reorient their sexual orientation. (Throckmorton, 2007). These results contradict the hypotheses that sexual orientation is immutable and that therapy that allows such change as a goal is deceptive and harmful.

171) Dr. Cummings' 2013 sworn affidavit concludes: "Attempting to characterize all sexual reorientation therapy as 'unethical' violates patient choice.… Rather, it is unethical for a professional, or a professional organization like the APA, to prevent a patient from seeking help to change his or her sexual orientation if that is the psychotherapeutic treatment the patient desires.… Accusing professionals who provide treatment for fully informed persons seeking to change their sexual orientation of perpetrating a fraud … serves only to stigmatize the professional and shame the patient" (Cummings, 2013).

C. Pronouncements of professional associations, and particularly the APA, represent ideology rather than science.

172) SOCE critics often point to the position statements, reports, and resolutions of the APA. However, multiple respected voices have recognized that in recent decades, the APA has become a voice for particular ideological positions, rather than for accurate and unbiased science.

173) In 2001, legal scholar Professor Richard Redding observed: "Organized psychology's advocacy efforts have historically supported liberal political agendas, with the profession becoming increasingly politicized as APA's advocacy efforts have expanded. Table 1 presents the policy positions adopted by the APA Council of Representatives since 1990 reflecting political views on contentious social issues in

the so-called culture wars. All are liberal. Many of these policies lack sufficient scientific foundation[.]" (Redding, 2001, p. 208).

174) Elson et al. (2019), examining critiques of the scientific accuracy of several APA resolutions, observed that "policymakers and the general public may assume that such statements reach objective conclusions," but that is often not the case. "A common criticism," they note, is that "statements … cited only studies supporting a particular adopted narrative and failed to consider those that yielded conflicting evidence" As a result, such statements "tend to be more definitive than is warranted by the underlying science" (pp. 12–13). Other critics (O'Donohue & Dyslin, 1996) have warned: "By its failure to insist upon compelling evidence before making political positions [the APA] may be seen as a quasi-disguised political organization rather than as a scientific and professional organization" (p. 4).

175) In 2021, the prominent psychologist and scholar Christopher Ferguson, a former member of the APA's Council of Representatives, publicly resigned from the APA because of the organization's prioritization of ideology over science. His resignation letter, titled "The American Psychological Association no longer represents good science or clinical practice" (Ferguson, 2021), expressed the following concerns: "Within my own area of research, the APA has grossly distorted the evidence on [several controversial issues], where the nuances of a complicated and controversial field are flattened into a definitive but ideological stance. [Clinical guidelines] are not grounded in science and often conflict with scientific data. I worry that these policy statements may do actual harm to clients … and may actually discourage many … from seeking treatment they could benefit from" "Ultimately, it is my perception … that the APA does not function either as a science or clinical organization. Rather, it appears to sway with the political currents"

176) The APA's elevation of ideology over science perversely flows back to further distort the published "scientific" literature. It has become all too common in SOCE-critical studies to cite resolutions of the APA and other professional associations as evidence of a "consensus" that all forms of change-allowing therapy or support are harmful. This is, at best, out of place; at worst, it provides cover for assertions not actually established by a study's results. Policy statements are not scientific evidence. A premise of the scientific method is that truth is not based on authority but on evidence—and the recognition that evidence must be permitted to challenge pronouncements from authorities, no matter how respected.

177) The APA's bias against research that leaves room even for the *possibility* that some individuals may experience change in sexual orientation and benefit from therapy in support of that goal is a matter of explicit policy. In 1985 the APA's Committee on Lesbian, Gay, and Bisexual Concerns ("LGB Concerns Committee") established a Task Force on Non-Homophobic Research, which produced detailed guidelines ("the Guidelines") on avoiding research determined to be "heterosexist," defined as "conceptualizing human experience in strictly heterosexual terms and consequently ignoring, invalidating, or derogating homosexual behaviors and sexual orientation, and lesbian, gay, and bisexual relationships and lifestyles" (Herek et al., 1991, p. 957). The Task Force's Guidelines were published as a series of screening questions for research studies in the 1991 article titled, "Avoiding Heterosexist Bias in Psychological Research" (Herek et al., 1991). These guideline questions are available on the APA website (www.apa.org/pi/lgbt/resources/avoiding-bias), and their contents are vigorously enforced by the LGB Concerns Committee.

178) By the definition above, the mere hypothesis that some persons may benefit from moving towards more heterosexual identity, behaviors, and/or relationships, rather than a homosexual identity and behaviors, is *prima facie*

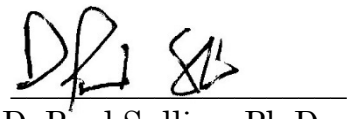
heterosexist. The notion that sexual orientation may change was also excluded by a terminology rule. In a concurrent document, an APA committee urged the use of the term "sexual orientation" rather than "sexual preference," since "[t]he word *preference* suggests a degree of voluntary choice that is not necessarily reported by lesbians and gay men and that has not been demonstrated in psychological research" (LGB Concerns Committee, 1991, p. 973). The Guidelines' position that a hypothesis that voluntary change is possible on one or more axes of sexual orientation must be *excluded from research* (and hence from testing) because a sense of "choice" has "not necessarily [been] reported" by (unspecified) "lesbians and gay men" and "has not been demonstrated" is incompatible with science. Where propositions "have not necessarily been reported" and have "not been demonstrated," then science would seek to determine definitively whether or not they are true.

179) Research that could look for benefit from therapies in support of desired change was not just implicitly excluded by these restrictions on theory and terminology, but was explicitly and emphatically prohibited: "Psychological research intended to prevent development of homosexual or bisexual identity, or to change or 'cure' a homosexual or bisexual orientation once it has developed, is [a] dramatic example of heterosexist bias" (Herek et al., p. 958). The Guidelines add: "Aside from the general failure of conversion therapies in most cases, the ethics of such attempts are highly questionable" (p. 958).

180) With this 1991 policy the APA officially and pre-emptively took a position on several empirical questions related to SOCE that it was to declare, almost 20 years later, lacked sufficient research to be able to come to a scientific conclusion. In 1991, the APA asserted that SOCE was a "general failure ... in most cases," (Herek et al., 1991, p. 958), but the APA's subsequent SOCE Task Force Report (2009) concluded that "research on SOCE ... has not answered basic

questions of whether it is safe or effective" (Glassgold et al., 2009, p. 90). Both of these statements cannot be true. If there was not enough research in 2009 to tell how often efforts to change any aspect of sexual orientation succeeded or failed, there emphatically could not have been enough research to tell in 1991.

181) Since empirical support was lacking to make such a statement, we must conclude that in 1991, the APA was making a statement about the possibility of change and the beneficence of therapy in support of desired change based on ideology rather than science. Following the APA's imposition of that perspective on psychological research, it is no accident that since 1991 not a single study that did not take a strong SOCE-critical approach has been published in any APA journal. In this way, too, ideology has biased scientific research and the scientific record.



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