# The Right to Try Versus Closing of the Sexual Mind

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# The Right to Try Versus Closing of the Sexual Mind

This article contains a novel and much needed perspective regarding the growing restrictions on treating same-sex attraction. Legally prohibiting therapists from helping people, who for personal or religious reasons, want to modify their sexual attraction deprives them of their civil rights and violates the ethical principle of personal autonomy to define one's treatment goals. These restrictions are allegedly based on scientific "proof" that such therapy is ineffective at best or harmful at worst. But are the "facts" firmly established enough to warrant this unprecedented, draconian social policy that creates a new, distressed sexuality minority deprived of their right to try? We review recent research that refutes the received opinion of "born that way, can't change," methodological flaws in existing research marshalled to support this conclusion, and polemical biases that influenced professional organizations to support bans on therapy, leaving those who wish to explore change without professional help.

*Keywords*: LGBT, same-sex attraction, sexual fluidity, sexual orientation change, SAFE-T, social policy

The dazzling rate of change in the popular and scientific views of LGBTQ is unprecedented. From the dark days when LGB persons were imprisoned, they now have achieved long overdue civil rights. At the same time, the zealousness of this modern enlightenment has cast a shadow over the civil rights of others who are pained by their same-sex attractions and want the right to try to examine and modify them. With draconian irony, laws have been proposed to imprison mental health professionals for "multiple offenses" of assisting such people.

In a stunning, unprecedented act of information censorship, Google has announced that it will re-direct searches for the controversial term "conversion therapy" to LGB sites. Recently, Amazon adopted what is, in effect, a totalitarian form of "book banning" by removing from their website scholarly books by Dr. Joseph Nicolosi, Sr. on reparative or reintegrative therapy® (often confused with "conversion therapy," a vague, inapt term that is practiced more by laypersons than by certified psychotherapists, who do not convert people). These steps, ironically, undermine one of the American Psychological Association's ethical principles respecting patients' right to self-determination and autonomy. These actions have been justified by many professional societies which allege that not only "conversion therapy," but any therapeutic attempt to change a person's attraction is ineffective and even harmful.

But not so fast: A closer examination of this revolutionary and unprecedented restriction on patients and therapists, as with most radical revolutions, reveals that it is based more on political polemics than scientific facts.

So how did we get here?

Rational discussion is difficult in matters of passion, especially when the passion is sexuality. Most people, laymen and professionals alike, now believe that sexual orientation is an innate inclination, mostly genetic. Ask them if gays are born that way and the instantaneous response is, "Yes." Ask if they can change and the answer is, "No." I [R. S.] recently asked a highly regarded therapist on what she based this opinion. After a pregnant pause, she acknowledged that she had no answer.

There are many questions about what is more appropriately called "sexual orientation change efforts" (SOCE) or more recently (if awkwardly) "sexual attraction fluidity exploration in therapy" (SAFE-T). Is homosexuality primarily shaped by genes and biology, or by environment? Does same-sex attraction change spontaneously or through psychotherapy? What about the pain and depression of the now silenced minority with same-sex attractions who wish to explore their potential for change? Consider those who want

to live in line with their personal values and/or maintain their heterosexual marriage, but are now deprived of their right to try. To address these questions, let's separate facts from myths.

## Facts and Myths about Homosexuality

**Myth**: 10%, 24%, or more than 25% of Americans are LGBT.

**Fact**: Scientific studies and Gallup Polls typically found rates of LGBTQ from 1 to 5%, with a 2012 poll citing a figure of 3.5%. A 2021 poll reported 5.6%, an increase attributed mostly to Gen Z who identified as bisexual, with exclusive gays and lesbians constituting 1.5% and 1.0%, respectively.

Most educated people I asked about this said that 10% are gay, at a time when the figure was much lower. One woman put it higher, around 25%. Seventy years ago, Kinsey et al. (1948) observed that 13% of U.S. males and 7% of females were predominantly homosexual for at least three years (averaging 10%). Kinsey's methodology was widely criticized for not being representative of the general population since his respondents were drawn from prison and the underworld. Nevertheless, Bruce Voeller, director of the National Gay Task Force, in 1973 used Kinsey's data to popularize the statistic that 10% of Americans are gay, and this stuck.

Today, things have changed, but not towards greater accuracy. According to a 2015 Gallup poll (McCarthy, 2019), the American public estimated that 23.2% of Americans are gay, 8 times higher than the 3.8% Gallup poll assessment at that time. A 2019 Gallup poll reported that a third of Americans believed that more than 25% of Americans were gay, while only 8% put the figure more accurately at or below 5%. Even with the greater acceptance of acknowledging a gay lifestyle, a 2017 Gallup poll found that 4.5% of the population identified as LBGT, rising by 2021 to 5.6%. Consistent with the Gallup polls, a 2013 study of nearly 200,000 adults by Savin-Williams & Vrangalova (2013) found that fewer than 2% of women and 1% of men endorsed being "completely homosexual."

The bottom line is that all of these figures are substantially lower than the 10% to 25% range accepted as fact. Since people are highly subjective when forming opinions about the relatively straightforward fact of the frequency of homosexuality, how much more so when it comes to obscure questions about causes and potential for change. This inflationary process can also be explained by Malcolm Gladwell's notion of a "tipping point" where an idea or trend crosses a threshold and spreads like wildfire. A scientific study conducted at Rensselaer Polytechnic Institute (2011) demonstrated that individuals will adopt a belief if only 10% of people endorse it and *two* of their last social interactions agreed with the new idea. More than scientific fact, this psychological dynamic, together with effective publicity transmitted through social media, has influenced the precipitous rate of attitude change and factual distortion.

Whether the percentage of homosexuals is 1 or 5%, this remains a significant number of people who have finally earned hard-fought civil rights and a more level playing field in the pursuit of happiness. If professionals and laypersons alike are confused as to the statistical frequency of homosexuality, they are likely to be even more so about its nature. Is being gay akin to a window treatment of black and white, or one with a gradient of grey? Is it really, as some allege, like skin color or height that is fixed? Can psychotherapy really never help in at least some cases? Let's reexamine the alleged "truths" that have shaped the way people think about the issue.

## Are Homosexuals Born That Way?

**Myth**: Homosexuality is caused primarily by biological factors, likely by a gay gene, and is thus immutable.

**Fact**: The largest study to date published in the prestigious journal *Science* (*2019)* found that 5 DNA markers were associated with sexual behavior, but none were powerful enough to predict a given individual's sexuality.

Throughout the history of psychology, the relative emphasis on biological versus environmental causes of human conditions has shifted depending on the socio-political zeitgeist. Nearly all conditions have been viewed as derived from a complex interaction of both biology and environment. Recent breakthroughs in epigenetics add to the argument against a gay gene since the activity and expression of genetic material can be altered by external factors without altering the underlying DNA sequence. Only a few medical conditions such as Huntington's disease are autosomal dominant disorders, meaning a person needs only one copy of the defective gene to develop the disease. Most conditions and traits are more complex. Based on research in the 1980s, schizophrenia was considered to be a simple case of genetic causation, but today scientists believe the causes can be mutations in as many as 120 genes as well as environmental factors.

It's hardly surprising that facts relating to emotionally charged and complex topics like sexual preference would be susceptible to distortion. Andrea Ganna and colleagues (2019), geneticists at MIT and Harvard, noted in *Science* that 25% of sexual behavior can be explained by genetics, with the majority determined by environment and culture. Leaving no ambiguity, Ganna and associates concluded, "There is no 'gay gene'." Similarly, the *American Psychological Association Handbook of Sexuality and Psychology* (Tolman & Diamond, 2014) is now saying that "born that way and can't change" is not true. Contributors to the *APA Handbook*, Rosario & Scrimshaw (2014), stated, "We are far from identifying potential genes that may explain not just male homosexuality but also female homosexuality," and Kleinplatz & Diamond (2014) observed that, "The *inconvenient* [emphasis added] reality is that social behaviors are always jointly determined by nature, nurture, and opportunity." Noting this fact to be "inconvenient" reveals the underlying political bias that filters the perception of facts, which are sometimes too compelling to distort.

Many studies have shown several environmental factors influencing the development of homosexuality. Sometimes it is a childhood family experience or parental absence or loss, especially by a same-sex parent. Sometimes it is physical and emotional abuse. Incest and developmental influences, particularly during the first six years of life and during adolescence, significantly influence the development of sexual identity later in life. The point is that familial and environmental factors influence sexual behavior—it isn't entirely driven by biology.

## Is Sexual Orientation Immutable or Can It Change?

**Myth**: Once sexual orientation becomes established it cannot change, so any attempts to change are and will always be futile.

**Fact**: Sexual identity is complex and "fluid," changing to varying degrees within many individuals throughout the lifecycle.

Many gays believe they were born gay and that is why, despite efforts to change, they could not. Shattering the myth of "immutability" of sexual orientation, Diamond and Rosky (2016) published a groundbreaking 2016 study in the *Annual Review of Sex Research Special Issue* concluding that, "First, 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 attractions remain fixed over the life course."

After reviewing the genetic and neuroendocrine evidence, Diamond and Rosky (2016) concluded that the scientific "revolution" in our understanding of the human epigenome, "challenges the notion of being 'born gay,' along with the notion of being 'born' with *any* complex human trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded" (p. 366). They go further to state that even if sexual orientation were wholly determined by biology, it can still change! Humans are malleable. To wit, the growing belief that biological sex as male or female need not correspond to gender identity.

So, in principle, sexual orientation *can* change, but does it? Data from 12,000 adolescents in the 2012 *National Longitudinal Study of Adolescent Health (*Harris & Udry, 2022) showed that of the 5.7% of men and 13.7% of women who identified as "non-heterosexual," 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 100% heterosexual category. Not surprisingly, most of those changing to "100% heterosexual" began as "mostly heterosexual," accounting for 58% of the men and 74% of the women. Only 8% of the men and 26% of the women initially in the 100% homosexual group changed to a different sexual identity. Thus, a large percentage of those originally identifying as mostly heterosexual, bisexual, and mostly homosexual changed to 100% heterosexual over a 6-year period. A small, but not insignificant, percentage of those in the 100% homosexual group also changed, especially women.

Diamond and Rosky concluded that the consistency of these findings establish that it is scientifically inaccurate to describe same-sex sexual orientation as an immutable trait. So why do many consider it immutable? To their credit, these researchers acknowledged that, "Scientists themselves, (including the first author) have sometimes contributed to misconceptions about the immutability of sexual orientation by failing to challenge and unpack these misconceptions in the media, often to avoid having their statements misused by anti-gay activists." Consistent with the current review, Diamond and Rosky added with refreshing clarity, *"immutability arguments have more to do with cultural values than they have to do with science"* [emphasis added].

Yet, in a puzzling about-face, Diamond and Rosky also assert in the same article that efforts to change sexual orientation through therapy are not only ineffective but also psychologically damaging, resulting in increased depression, anxiety and suicidality. One would think a scientist who just acknowledged that she sometimes contributed to misconceptions would at least begin to question and share an obvious puzzlement. How could it be that sexual orientation, which she demonstrated to be highly fluid or mutable in the natural environment, is unequivocally intractable to change during psychotherapy for all people who are motivated enough to enter treatment? Diamond, who is openly gay, noted in her article that she herself has changed her orientation and feels she had a choice in this. But oddly, she or others somehow could never come to this choice during psychotherapy. This illogical contention is a glaring instance of the very same influence she noted regarding cultural values rather than science shaping conclusions.

The scientific discovery that orientation changes spontaneously should raise questions about the earlier conclusions that all therapy for all persons is ineffective and may be harmful. A more scientific conclusion would encourage a re-examination of the bewildering notion that sexual orientation is naturally mutable, but not by psychotherapy. Let us begin this examination.

## Can Psychotherapy Change a Person's Sexual Orientation?

**Myth**: Scientific research has proven that psychotherapy to change sexual orientation or behavior rarely or never works and is often harmful.

**Fact**: Scientific research has shown that 1/3 to 2/3 of those in psychotherapy make changes in sexual attraction and behavior, figures not vastly different than therapy for other disorders such as depression.

The most controversial topic is whether a person can change their sexual orientation and behavior, and if so, can psychotherapy help? In 2012, the idea that therapy could be helpful in changing sexual orientation was allegedly debunked. Because of its huge cultural impact, it is important to revisit the curious circumstances of this dramatic episode.

In 2003, Robert Spitzer (2003a), considered the father of modern psychiatry who spearheaded the 1973 decision to remove homosexuality as a disorder, conducted a landmark study interviewing those who underwent therapy to modify their sexual orientation. He found that the majority of 200 mostly religious individuals reported that therapy helped them shift from predominantly homosexual to predominantly heterosexual. Reports of complete change were uncommon, and more women than men reported change (consistent with the finding of women's greater sexual orientation fluidity noted earlier). Spitzer found the reports to be credible. This study became pivotal in the culture wars, initially cited as supporting therapy change efforts. But in 2012, Spitzer (2012) repudiated the study and apologized for his original interpretation of the results. Thereafter, the opponents of therapy to change sexual orientation have cited his reinterpretation as proof that therapy cannot change gays.

The reason Spitzer gave for the 2012 reversal was that the study relied on self-reports. Consider the difference between Spitzer's (2003b) reply to 26 commentaries and his later repudiation. In 2003 he referred to a positive assessment of his study: "Wakefield says the study 'usefully moves questions about orientation change from the political to the scientific domain and opens them to fresh critical scrutiny, hopefully inaugurating overdue scientific examination of issues currently highly politicized'." In addition to questioning self-reports, others opined that because of selection "bias" of participants who were highly motivated religious individuals (mostly Christian), the results could not be generalized.

Spitzer initially defended and clarified this study by changing the term from "reparative therapy," which implies disorder, to "reorientation therapy," a more neutral term indicating an individual's dissatisfaction with his or her orientation. He noted that the inspiration for the study was the American Psychiatric Association's (2000) Position statement on therapies focused on attempts to change sexual orientation, indicating a courageous effort to fulfill the APA's guidelines. When he discussed the ongoing project with colleagues, he met anger and disbelief that he believed what former gays said about themselves. Spitzer reasonably opined that it made no sense to believe former gays only when they say they have not changed, and discredit those who say they have. He noted sensibly enough that although some response bias may have occurred, this would not explain *all* the reported positive changes.

The vast majority of psychological research both before and after Spitzer have used self-reports, including those that question the effectiveness of therapy to change sexual orientation or claim that it causes harm. Psychology remains in part the study of minds, and access to minds often relies on what people tell us they are experiencing. Methods are available to detect distortions and lies. What gays and former gays report should not be

uncritically accepted, but neither dismissed wholesale. Note that even objective phallometric studies that directly measure erection can be "faked" by enhancing or suppressing one's arousal responses. Yet such studies are not dismissed outright.

The proper scientific response to a retrospective interview study is to note the limitations of the data, interpret and generalize the results within those limitations, and suggest future directions and improvements for research on the topic. In his 2003 response to critics, Spitzer reframed the research question from, "Can some gays change their sexual orientation?" to, "Contrary to conventional wisdom, do some ex-gays describe changes in attraction, fantasy, and desire that are consistent with true changes in sexual orientation?" Instead of a wholesale repudiation, the study, as one commentator opined, was useful in shifting questions about sexual orientation from the political to the scientific domain and hopefully inaugurating a scientific examination of these highly politicized issues. Instead, further investigation into how sexual orientation can change was met with silence. The closing of the sexual mind has been firmly fixed.

Why then did Spitzer publish a repudiation? The original article, published in a reputable journal, *Archives of Sexual Behavior,* was given multiple peer reviews using conventional standards of evaluation. Alice Drucker, former professor of bioethics at Northwestern University, described a conversation with Ken Zucker, editor of the *Archives.* He told her that he advised Spitzer that since the varied scholarly commentaries were positive, negative, and mixed, the controversy alone did not merit retraction. Spitzer's initial change in the interpretation of the data is not normally the thing that causes an editor to "expunge the scientific record." Zucker went on to say, "You can retract data incorrectly analyzed; to do that, you publish an erratum. You can retract an article if the data were falsified. As I understand it, he's [Spitzer] just saying ten years later that he wants to retract his *interpretation* [emphasis added] of the data. Well, we'd probably have to retract hundreds of scientific papers with regard to re-interpretation, and we don't do that."

Despite the popular press, the *Archives* never *retracted* his article but published Spitzer's brief 2012 note, in which he walked back from his earlier belief that the reports of change in any of 200 former gays were credible. He now wrote that there was no way of determining if any of the participant's claims of change were valid, and apologized for harm that gays may have experienced undergoing therapy. This extreme flip-flop is more characteristic of a politician vying for votes from opposing constituencies than of a scientific researcher. Again, the dominance of politics over science.

The editor of *Atlantic Magazine*, Steve Stossel, reported a visit to Spitzer's home by Gabriel Arana, who as a teen underwent "reparative therapy" and attributed his depression and suicidality to the treatment. Presumably moved by his story, Spitzer asked Arana, an editor at *The American Prospect,* to publish a retraction of his paper, "So I don't have to worry about it anymore." This request was not sensible, which Spitzer should have known, because only the journal that published an article can retract it. For a decade Spitzer remained silent; at the time of his interview with Arana, he was 80 years old with advanced Parkinson's disease, from which he died a few years later. In his brief repudiation, he merely said he felt his critics were essentially correct. This occurred at a time when the gay rights movement was mounting intense pressure on society to conform to their politically correct ideology, and of course, much of this was directed at Spitzer. He asked to end the meeting with Arana because he felt "weary."

A single study, regardless of the author's questionable later views, should not have become a socio-scientific tipping point

contributing to the closing of the sexual mind. The 2009 APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009) noted that there was only a small number of studies, mostly done before 1981, on therapy to change sexual orientation, but nevertheless concluded that it was “unlikely” that psychotherapy could change sexual orientation. Given that the Task Force reported that the studies showed between 1/3 and 2/3 of participants experienced varying degrees of change in aspects of their sexual attractions and behaviors, why would they conclude that change was “unlikely” rather than at least possible in some cases? The report noted that the more stringent the studies, the lower the rate of change, but this would still leave a sizeable percentage of participants that experienced some change. Note that the introduction of the section of the report entitled Research on Adults Who Undergo Sexual Orientation Change Efforts clearly states that “*Because of the lack of empirical research in this area, the conclusions must be viewed as tentative”* [emphasis added]. Tentative results should not form the basis of revolutionary social and medical policy.

Why did the Task Force make sweeping conclusions that went beyond the data and their own caveat that the conclusions must be viewed as tentative? Consider the fact that 5 of the 6 Task Force members were LGB identified, all 6 were unsympathetic to sexual orientation change therapy, and none were religious. When asked about why no religious psychologists were included, Clinton Anderson, the Director of APA’s LGB Concerns Office, defended the decision: “We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don’t fit into our worldview” (Yarhouse, 2009, p. 74). Revealing political bias rather than scientific objectivity, the selection criterion held that only those who held fundamentally positive perceptions of homosexuality were acceptable. Presumably, the committee comprised of 83% gay members held such positive views. A fair court of law would not stack the jury by admitting those who held a clear positive view of a position while excluding those who did not. It would strive to at least balance the members with equally opposing or more neutral views. The committee member’s uniform identity and associated beliefs introduced a glaring confirmatory bias that inevitably influenced the design, outcome and interpretations of the investigation (Jones et al., 2010). Note that the Task Force’s selection bias was knowingly established from the outset and never questioned, whereas the many religious individuals in Spitzer’s study were dismissed by critics—and later by him—as lacking credibility.

Given the small number of studies and limited funding for sexual orientation change studies, together with the longstanding, post-Spitzer fallout for even conducting such research, we simply do not know enough for broad, sweeping conclusions that therapy is unlikely to help. Consider psychotherapy outcome research that evaluates the “efficacy” or effectiveness of treatment for disorders such as depression or anxiety. A 2018 study by Hengartner and Plöderl (2018) published in *Frontiers in Psychiatry* reported that most studies used “poor methods” and the few high-quality studies yield “remarkably lower effect sizes” than the studies of lower quality. (Note that this is the same finding that the APA Report observed with sexual orientation change studies of varying quality.) They draw a stark conclusion about *therapy in general*, *including pharmacotherapy,* even for this widely accepted treatment of depression:

> Some evidence suggests that when efficacy is estimated based exclusively on unbiased high-quality trials, effects of psychotherapy could fall below the threshold for clinical relevance (Cuijpers et al., 2014). Recently, some

> psychotherapy researchers hence raised the controversial point that effects of both psychotherapy and pharmacotherapy for depression may entirely reflect a placebo effect (Cuijpers and Cristea, 2015). (p. 256)

What would happen if the same stringent criteria used for evaluating and excluding sexual orientation change studies are applied to psychotherapy research in general? The empirically based cognitive-behavioral therapy and medication therapies for depression (two of the most thoroughly researched over decades and reputably effective treatments) would need to be discouraged and potentially outlawed, an unlikely or nonsensical step.

By improving the scientific rigor of psychological research, the field risks being hoisted on its own petard. Instead of a politically motivated movement to defund research or make it illegal to provide therapy for depression, the scientifically informed direction would be to encourage innovative treatments to improve them and evaluate them more stringently. It is unlikely that even a single psychologist, let alone an entire mental health association would advocate prohibiting future treatments of depression on the basis of the research noted above. In fairness, the same standards of evaluation and social policy should be applied to both depression and sexuality. The reason sexual orientation change therapy is shunned while depression treatment is not is the socio-political zeitgeist deems depression to be abnormal and bad and homosexuality to be a normal variant of sexuality and in that sense, good. But this is not the view of *those distressed by it*, and this disenfranchised group deserves a voice.

A more scientifically accurate conclusion would be that, given the paucity, limited quality, and low replication rates of research, we cannot yet determine definitively if and what type of therapy to change sexual orientation is effective or not. As with depression, there are studies of varying degrees of rigor, as well as many credible case reports. Only more research will delineate an as yet to be determined percentage and types of people who can be helped, even with the current state of the art.

## Does Sexual Orientation Change Therapy Cause Harm?

**Myth**: Scientific research has shown that therapy to change sexual orientation causes harm to many who have tried to change, including but not limited to depression and suicidality.

**Fact**: There is currently no credible scientific evidence to determine whether such therapy harms people more than other therapies and whether the therapy itself caused the harm. Rather, there are reports by some who failed to change that felt harmed and attributed various forms of harm to the treatment.

People who are deeply conflicted about same-sex attraction prior to therapy often suffer from confusion, anxiety, guilt, depression, and suicidality. It is plausible that if the person wanted to change and the therapy did not help, they might feel despair if unable to accept their attraction. But as I [C. R.] observed, research indicates that 5–10% of adults in all forms of therapy report being worse off after the therapy and 20% or more of children and adolescents in psychotherapy evince deterioration rates (Rosik, 2014; see also Lambert, 2013). Also, those asserting harm use drop-out rates from SOCE as indications that the dropouts felt they were “harmed.” The appropriate scientific approach to this issue, as I [C. R.] observed, would be to place the question of harm in the broader context of all therapies, establishing a base rate against which alleged SOCE harm can be evaluated.

Another point I [C. R.] noted that limits the interpretation of the anecdotal data about harm is the failure to differentiate between good and

bad SOCE. There are likely differences between well-designed treatments administered by professionals and undefined therapies by non-professional counselors or church members without training who may induce shame and guilt.

A recent study on SOCE by Blosnich and colleagues (2020) purporting harm caused by SOCE has become an influential "fact" supporting the dangers from which people should be protected. However, this study was seriously flawed by a major omission that experienced researchers should have been aware of. The study failed to take into account the levels of suicidality and distress that the individuals had *prior to* undergoing the treatment. The Blosnich study used an existing dataset (the Generations survey) available to other scholars. Oddly, Blosnich and colleagues did not take into account data concerning the subjects' pre-SOCE distress in their study design even though such information was available in their same dataset. These researchers nevertheless purported to find that SOCE had "insidious associations with suicide risk" and "may compound or create . . . suicidal ideation and suicide attempts." Note that "insidious associations" is a rhetorical rather than a scientific statement, while "may compound or create" describes a hypothesis that should be tested, not a scientific finding.

But there is more: Puzzled by this omission, Donald Sullins (in press) reanalyzed the same data, but took into account the pre-"SOCE" distress levels of the study participants. This reanalysis revealed a very different reality. While the effect of controlling for pre-SOCE suicidality was larger for adults than for minors, Sullins reported:

> After controlling for pre-existing conditions, there no longer remained any positive associations of SOCE with suicidality in the Generations data. Where there was a significant association, suicidality following SOCE was reduced, not increased.

For the most part the observed reduction in suicidality is not small, especially for those who received SOCE treatment as adults. Following SOCE, the odds of suicide ideation were reduced by two-thirds (AOR of .30) for adults and by one-third (AOR of .67) for minors. Suicide attempts were reduced by four-fifths (AOR of .20) for adults following SOCE, though they were not reduced for minors. Minors undergoing SOCE were only about half as likely to attempt suicide after initial thoughts or plans of suicide, and no less likely after an initial suicide attempt, compared to their peers who did not undergo SOCE. On the other hand, adults who experienced SOCE intervention following suicidal thoughts or plans were 17–25 times less likely to attempt suicide. Sullins concluded, "Blosnich et al. are simply mistaken: as the evidence in the present paper shows, controlling for pre-SOCE suicidality emphatically contradicts their conclusion."

Sullins's reanalysis controlling for pre-SOCE distress is of great importance because no fewer than a half dozen recent studies of SOCE suffered from the same oversight. Hence, this literature is insufficient to support any general prohibition on therapies that work with a client's goal of exploring their sexual attraction fluidity potential. More generally, the glaring oversight by established scientists adds compelling support to the current contention that research on this highly charged issue is marred by selective interpretive biases resulting in distortions of fact that inform vital social policy.

The 2009 APA Task Force concluded that research was lacking to determine the likelihood of SOCE was being harmful:

> We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear

> indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. (APA, 2009, p. 42)

It is unlikely that research over the past decade, especially considering the methodological flaws noted above, represents strong policy-changing evidence. Yet recent statements and resolutions by the APA have taken a more hostile tone toward SOCE (Dispenza et al., 2021) and have lost any pretense to measured objectivity, preferring talk-therapy bans to the conduct of ideologically neutral and diverse research. Tellingly, however, the APA's more recent statements about SOCE are blind to the issues that Sullins has exposed for all to see. In fact, recent APA guidelines and resolutions cite the Blosnich study as support for the contention that SOCE elevates the risk of suicide, whereas Sullins's reanalysis indicates the reality is exactly the opposite, that SOCE reduced suicidality.

## Back to the Future: Homosexuality or "Homosexualities"

The gay rights movement won a hard-fought battle to increase awareness and acceptance of sexual diversity. Ironically, this was achieved partially through a retreat from diversity to the view that homosexuality is a monolithic phenomenon and that research studies would apply to all homosexuals and all forms of therapy. This reverses the groundbreaking work of Kinsey in 1948 who introduced the idea that sexual orientation was not binary, but a continuum on a 7-point scale with 0 representing "exclusively heterosexual" and 6 "exclusively homosexual" with most people falling somewhere in between. In 1978 Bell and Weinberg (1981), researchers at the Kinsey Institute, published *Homosexualities: A Study in Diversity Among Men and Women*, challenging the stereotype that all homosexuals were isolated, unhappy, and dysfunctional. Instead, they proposed subtypes that ranged from the unhappy "dysfunctional" and "asexual" subtypes to the "closed couples" who lived together in stable, committed relationships, akin to the heterosexual, monogamous ideal of that time. They recommended that rather than referring to "homosexuality" we should use the term "homosexualities" and differentiate amongst these various subtypes.

This more differentiated and accurate view is consistent with general psychological thinking that the study of most phenomena should distinguish among subtypes. It's time to restore Bell and Weinberg's concept of "homosexualities" to allow scientific investigations to explore what subtypes of homosexuality in which cultural and religious groups will respond to which forms of therapy—and vice versa. Presumably, those with 100% homosexual orientation who want to change will respond less completely to therapy or will need a more intensive, longer-term therapy, or perhaps one not yet devised. Many conditions such as agoraphobia and manic depression eluded successful outcomes for decades until the development of cognitive therapy, medication, and more recently, brain stimulation.

How did this regression in socio-scientific and public thinking occur? The highly charged and high-stake cultural struggle around sexuality, as noted earlier, encourages emotional reasoning. This in turn contributes to magnification in perception and global, non-differentiated, all-or-none thinking. Recently an Israeli minister whose comment that he knew of people with "homosexual tendencies" who were helped by therapy sparked a firestorm of controversy calling for his

resignation. Homosexual tendencies could range from those with occasional homoerotic thoughts and feelings that have never been acted upon to people with such tendencies that have lived in same-sex relationships for decades. Today's zeitgeist allows no differentiation of these degrees and subtypes, ruling out exploration of how and to what extent SOCE therapies can help some along the continuum.

## Right to Try: Implications for Policy

A disordered adjustment arises when unwanted same-sex attractions conflict with a person's core identity and cause them distress. An open-minded and compassionate understanding can comprehend the intense conflict of a married person who wants to remain so, or a religious person dedicated to following his or her understanding of God-given laws. This emotional disorder does not need to be considered a specific sexual disorder, avoiding any implication of the normality or abnormity of gay life. Indeed, psychology previously allowed those with "ego-dystonic" homosexual attraction, whose attraction caused distress because it conflicted with their core identity, to make an informed choice of the goals of therapy to be decided by the client and therapist. The current diagnosis of "adjustment disorder" is broad enough to accommodate same-sex attraction that is unwanted and causes distress. A renewed and truly liberal view of diversity demands this inclusion.

Not only did the gay-rights movement achieve acceptance of diversity, but it also expanded civil rights to sexual minorities that had been marginalized, stigmatized and silenced. In her recent Ted Talk promoting "sexual fluidity," "Why the 'Born This Way' Argument Doesn't Advance LGBT Equality," Diamond offered that holding onto the scientifically incorrect position that sexual orientation is immutable is not justified, not necessary for legal cases, and is actually harmful to the struggle for civil rights of those sexual minorities that are based on choice. Even if sexual orientation is changeable by choice, she concluded, respecting the civil rights of these minorities is simply the right thing to do.

Consider again the pain, depression and potential suicidality of those for whom same-sex attractions or behaviors are tantamount to the "death" of their strongly held psychosexual identity, whether religiously or otherwise informed. To conclude that it is unethical or perhaps soon to be illegal for therapists to offer any form of SOCE to any person is an egregious and harmful deprivation of their civil rights.

Recall that according to the APA Report, credible research on SOCE pretty much ceased after 1981, since homosexuality was no longer considered an illness after 1973 unless it caused distress, and was totally removed in 1986. As noted earlier, conditions such as obsessive-compulsive disorder, manic-depressive disorder and agoraphobia, previously intractable, are now treatable with improved techniques. Note that even the best treatments may yield only a 2/3 success rate, with some relapse potential. It is logically impossible to conclude that any future therapies could not be developed that could assist some same-sex attracted persons in developing their heterosexual potential. The failure to explore this is a value-laden, not scientific, decision–a reversal of the past discrimination against gays that now does so against those who want to change.

Let us say that it was demonstrated definitively (which as we have shown, it has not) that no existing therapy to change sexual orientation has yet reached the level of quality found acceptable by the APA. Consider an analogy to medical conditions for which there is no approved treatment. The Right to Try Act, signed into law in 2018 and adopted in 38 states, allows people with life-threatening illnesses who have unsuccessfully tried all

FDA approved therapies to have "expanded access" to try certain unapproved experimental therapies. This is aptly termed "compassionate use." Let us not allow what is tentative science at best and emotional polemics at worst to deprive those deeply pained by unwanted sexual feelings of their autonomy and civil right to determine their treatment goals. Instead, let us expand access to include and respect the right to try of this newly threatened sexual minority.

## Conclusion

The gay spectrum is an ever expanding "rainbow," evinced by the growing inclusiveness of the acronym to LGBTQIA (Lesbian, Gay, Bisexual, Transsexual, Queer, Intersexual, Associates). The nearly 80% acceptance rate of gays and legally established gay rights represents an unprecedented change in social attitudes that should reassure the movement that their place in society is secure. Now that homosexuality is accepted, homosexual advocacy groups, politicians and the general public can add another hue to the rainbow, opening the sexual mind to a more dispassionate discussion of the development of sexual orientation and scientific investigation to identify who can and who cannot be helped by which forms of existing or yet to be developed therapies. What we need now is for sexuality experts to step forward to decry the politicizing of science. Let us welcome a world where the gay community can rest assured that while they remain who they are, they should allow others who need professional help to become who they are, equally convinced they are and must be. It is time to honor ethical requirements of autonomy, self-determination, respect and dignity of those who are suffering and encouraging their "right to try." This too is a basic human and civil right.

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