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Annesa Flentje
University of California - San Francisco

Nicholas C. Heck
Marquette University, nicholas.heck@marquette.edu

Bryan N. Cochran
University of Montana - Missoula

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Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification

Annesa Flentje
Department of Psychology, The University of Montana, Missoula, Montana
Department of Psychiatry, University of California, San Francisco, California
Nicholas C. Heck
Department of Psychology, The University of Montana, Missoula, Montana
Department of Psychology, Marquette University, Milwaukee, Wisconsin
Bryan N. Cochran
Department of Psychology, The University of Montana, Missoula, Montana

Abstract

Therapy meant to change someone's sexual orientation, or reorientation therapy, is still in practice despite statements from the major mental health organizations of its potential for harm. This qualitative study used an inductive content analysis strategy (Patton, 2002) to examine the experiences of thirty-eight individuals (31 males and seven females) who have been through a total of 113 episodes of reorientation therapy and currently identify as gay or lesbian. Religious beliefs were frequently cited as the reason for seeking reorientation therapy. Frequently endorsed themes of helpful components of reorientation therapy included connecting with others and feeling accepted. Harmful aspects of reorientation therapy included experiences of shame and negative impacts on mental health. Common reasons for identifying as LGB after the therapy included self-acceptance and coming to believe that sexual orientation change was not possible. The findings of this study were consistent with recommendations by the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009), which concluded that helpful aspects of reorientation therapy could be achieved through affirmative treatment methods while avoiding potential harms that may be associated with reorientation therapy. Limitations of the findings, including a small, self-selected sample, are discussed.

KEYWORDS

LGBT, conversion therapy, reorientation therapy, reparative therapy

Sexual reorientation therapy, or interventions that are designed to change someone's sexual orientation from lesbian, gay, or bisexual (LGB) to hetersexual, continues despite the fact that homosexuality and bisexuality are not mental disorders. These interventions are controversial and possibly iatrogenic, as most major mental health organizations have noted while criticizing the practice.

Position papers on reorientation therapy from major mental health organizations clearly object to its use. For example, the American Psychiatric Association has identified reorientation therapy as potentially harmful and lacking in scientific evidence (American Psychiatric Association, 2006). The National Association of Social Workers (2007) said in a position statement that reorientation therapy "cannot and will not change sexual orientation" (paragraph 5) and encouraged social workers to refrain from reorientation practices. The Ethics Committee of the American Counseling Association has said that reorientation therapy does not meet professional standards and that counselors must not offer reorientation therapy in their occupations as counselors but may offer it only in other roles, such as pastoral counseling (Whitman, Glosoff, Kocet, & Tarvydas, 2006). The American Psychological Association conducted a review of the relevant research on reorientation therapy and adopted a resolution stating that there is not enough research evidence to support the use of reorientation therapy, that available research indicates it is unlikely that patterns of sexual attractions will be changed by reorientation therapy, and it recommends the use of "affirmative multiculturally competent treatment" approaches (American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 121). The resolution further states that the potential benefits of reorientation therapy can be achieved by therapeutic interventions that are not focused on changing sexual orientation (American Psychological Association, 2009). Despite these directives from the major mental health associations in the United States, reorientation therapy continues to be practiced by both mental health professionals and religious organizations (Exodus International, 2005).

REORIENTATION THERAPY AND SEXUAL ORIENTATION

The terms *sexual reorientation therapy, reorientation therapy, conversion therapy*, and *reparative therapy* are used to describe interventions that are meant to change someone's sexual orientation. Sexual orientation is a complex, multidimensional construct that encompasses an array of human sexual attractions, behaviors, emotions, and identities (American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Sell, 1997). Thus a single individual's sexual identity comprises that person's sexual attractions (i.e., to persons of the same sex or gender, opposite sex or gender, or more than one gender), sexual behaviors, and social connection with others who share similar sexual attractions and engage in similar behaviors. In turn, reorientation therapy is intended to alter one or more of these domains in such a way that an individual may stop (1) identifying as LGB; (2) engaging in sexual behaviors with partners of the same sex; (3) finding individuals of the same sex attractive; and/or (4) associating with people who have same-sex attractions and engage in same-sex sexual behaviors. A number of interventions, some of which may be tied to behavioral, cognitive, psychoanalytic/psychodynamic, and/or religious counseling principles, may be used during a course of reorientation therapy (Flentje, Heck, & Cochran, 2013).

To understand the emergence of reorientation therapy as a therapeutic intervention, the historical persecution and criminalization of individuals on the basis of sexual orientation must be considered as part of the context (Mogul, Ritchie, & Whitlock, 2011). One's motivation for sexual orientation change might include avoiding the real threat of prosecution for same-sex behavior, as well as other forms of societal discrimination. In addition, many major religions have historically identified same-sex behavior as a "sin," resulting in conflict for people who experience same-sex desires and a simultaneous commitment to a religious organization that decries same-sex behavior. Family pressures and internalized homophobia may also play a role in the motivation for sexual orientation change interventions. Finally, because the LGBT civil rights movement has a relatively recent history and is still ongoing, individual experiences of what it means to be gay, lesbian, bisexual, or transgender vary tremendously based on the individual's context. With all of these factors considered, the development and persistence of sexual reorientation interventions is not surprising.

Furthermore, the history of the mental health establishment's perspectives toward homosexuality also helps to explain the development of reorientation therapy. These therapies developed under the now-refuted perspective that homosexuality was a mental illness, and continued to exist through the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (DSM-II). In the third edition of the DSM, a new diagnosis of ego-dystonic homosexuality was created (American Psychiatric Association, 1980); with this diagnosis, an individual could be diagnosed if he or she was experiencing conflict with his or her same-sex sexual attraction or behavior. When homosexuality was considered a mental illness, researchers examined potential treatments for homosexuality (e.g., Cautela, 1967; Conrad & Wincze, 1976; Feldman & MacCulloch, 1965; Tanner, 1974; for a review, see Haldeman, 1991, 1994). In a revision of the third edition of the DSM, ego-dystonic homosexuality was removed (American Psychiatric Association, 1987).

Despite the shift away from clinical interventions designed to change sexual orientation after homosexuality was depathologized, Zucker (2003) described a movement that began in the early 1990s that advocated for the existence of sexual reorientation therapy, with the position that clients' wishes to change their sexual orientation should be honored by their therapists. Zucker notes that this movement was led by Socarides, a psychoanalyst, and Nicolosi, a psychologist, and coincided with the creation of the National Association for Research and Therapy of Homosexuality (NARTH) in 1992. The organized ex-gay movement began a visible media campaign in 1998 when advertisements in major newspapers began emerging, claiming that sexual orientation change was possible (Lund & Renna, 2003).

Reorientation therapy is a political, emotional, and controversial topic, and perhaps as a result of this, there is little methodologically sound empirical research on this type of therapy. Arguments have been made that reorientation therapy should be offered, if the client requests it, to honor the client's autonomy (Benoit, 2005). Individuals may seek reorientation therapy for many different reasons, including religious or cultural beliefs. This is particularly clear in a controversial study by Spitzer (2003), who studied 200 individuals who had experienced some kind of reorientation therapy and, after the therapy, maintained gains in their efforts to secure aspects of a heterosexual identity. In his study, 79% of the participants identified conflict between religious beliefs and same-sex behaviors as reasons that they wanted to change their sexual orientation. Spitzer's sample was predominantly religious, with 93% reporting that religion was very or extremely important in their lives. Spitzer concluded that sexual orientation change was possible in areas including behaviors, identity, attraction, content of fantasies, and the extent to which individuals were bothered by same-sex sexual feelings. Additionally, Spitzer reported that participants reported less depression as a result of the therapy and increased masculinity and femininity for the respective sexes. Within Spitzer's sample, 78% had spoken publicly about their sexual orientation change, and 19% directed ex-gay ministries or worked as mental health counselors.

Beckstead (2003) suggested that the widespread interpretation of Spitzer's study as proof that people can change their sexual orientation is inaccurate—that Spitzer's study, instead, shows that in rare cases people who are attracted to individuals of the same sex may be able to function in relationships with individuals of the opposite sex. Additionally, Bancroft (2003) criticized the study in many different areas, including the lack of representativeness of the sample, the strong religious beliefs of the sample, the large percentage (78%) of the sample that had spoken publicly about their orientation change, recall bias, lack of clarity about the therapy provided, and the unfounded claims of sexual orientation change. Recently, Spitzer made a public apology for his study and indicated that the claims he made in his study were inappropriate (Besen, 2012). Nevertheless, Spitzer's (2003) study stands as one of the empirical underpinnings cited by the ex-gay movement.

Scholars have considered ways of coping with the conflict that can exist between religious beliefs and sexual orientation. Diamond (2003) suggested that individuals consider modifying, if possible, or leaving practices and relationships that are not supportive of LGB identification. She also acknowledged that, relative to a person's sexual orientation, these anti-LGB practices and relationships may comprise a large and important portion of the person's overall identity. In other words, the prioritization of LGB affirmation over other important aspects of a person's identity (e.g., religious identity; relationships with family members) may be inappropriate or invalidating, even if these practices and relationships are homophobic.

As noted earlier, reorientation therapy has also received criticism for its potential harmfulness. Bancroft (2003) suggested that the individual may experience "considerable conflict and unhappiness" (p. 421) as a result of feeling that he or she needs to change his or her sexual orientation. Bancroft thoughtfully considered the potential harmfulness of his early research on behavioral reorientation techniques as potentially reinforcing homophobic beliefs. Other researchers have argued that reorientation therapy should not be practiced because there is no pathological condition that needs treatment (Tozer & McClanahan, 1999). Yarhouse and Throckmorton (2002) rebut this type of argument by pointing out that treatment is often given for non-pathological conditions, and they state that not all reorientation programs reinforce the idea that same-sex attraction is pathological.

RESEARCH ON EXPERIENCES OF INDIVIDUALS IN AND AFTER REORIENTATION THERAPY

There is a relatively limited body of research on individuals who have sought out reorientation therapy. Most of this research has focused on factors leading to the decision of individuals to enter this therapy or on the experiences of clients post-treatment. The extant literature on reorientation is summarized below.

Beckstead (2001) analyzed qualitative data from 20 Mormon proponents of reorientation therapy who reported that they had benefited from the treatment. The participants reported that being LGB was similar to having a disease and meant that their lives would consist of having multiple sexual partners, a high likelihood of contracting a sexually transmitted disease, and isolation (Beckstead, 2001). Several of the participants reported being told that they would be excommunicated from their religious communities if they were to continue to have same-sex relationships (Beckstead, 2001). Benefits of reorientation therapy included emotional relationships with persons of the same sex, increased identification with their own gender, which was a focus of treatment for many of the participants, and reduced same-sex sexual behaviors or desire; however, none of the participants reported increased sexual attraction to the opposite sex (Beckstead, 2001).

Beckstead and Morrow (2004) combined data from the 20 proponents with data from 22 individuals who had undergone reorientation therapy and reported negative outcomes to develop a model to capture the experiences of Mormon individuals who had experienced reorientation therapy. A preliminary model was subjected to a confirmatory process whereby eight additional participants with varied conversion therapy experiences and perspectives discussed the model in focus groups (Beckstead & Morrow, 2004). Beckstead and Morrow's final model, which is placed in the context of societal homophobia and heterosexism, provides a detailed overview of (1) factors and processes that may lead people to seek reorientation therapy; (2) positive and negative sexual reorientation therapy experiences; (3) post-treatment experiences and personal (identity) development; and (4) possible outcomes. Furthermore, the model specifies experiences that are unique to proponents or opponents of reorientation therapy and experiences that are shared by both groups.

According to Beckstead and Morrow's (2004) model, experiencing dissonance between same-sex attractions and religious beliefs, which can lead to disparaging self-labeling (e.g., fag, dyke, pervert), negative emotionality, and unhealthy coping behaviors, is often an impetus for seeking help from religious leaders or therapists and entering reorientation therapy. The model then suggests that both proponents and opponents of reorientation therapy experienced benefits, including finding and connecting with individuals in similar situations, having a framework by which to understand why they experienced same-sex attraction (same-sex attractions were primarily explained as occurring due to unmet same-sex emotional needs), and experiencing increased identification with their gender (Beckstead & Morrow, 2004). The model also specifies negative reorientation therapy experiences (e.g., disappointment; depression and suicidality; increased emotional distress; interpersonal and relational challenges; loss of faith), primarily voiced by opponents of the therapy, but with proponents and opponents alike indicating that they felt increasingly suicidal after feeling disappointed about "failing to sexually reorient" (p. 671, Beckstead & Morrow, 2004). Notably, eight participants (19% of the sample; four proponents and four opponents) attempted suicide after the therapy, and many participants reported having known others who had completed suicides after reorientation therapy (Beckstead & Morrow, 2004). After therapy, the model highlights a number of possible experiences that may include vacillating between different identities, disillusionment, developing or solidifying values, and eventually finding self-acceptance. Finally, the model specifies a number of possible outcomes that range from adopting a positive sexual identity (e.g., LGB, same-sex attracted, heterosexual) to finding peace, congruence, and authenticity, to continuing to experience sexual orientation–related challenges. Based on the findings, Beckstead and Morrow

(2004) conclude that the potential harms of reorientation therapy are considerable and outweigh the benefits, which could be obtained in other types of therapy.

Shidlo and Schroeder (2002) interviewed 202 individuals who had undergone some kind of reorientation therapy and were recruited through advertisements in newspapers, online, and through e-mail Listservs. As with previous research, women were largely underrepresented, comprising only 10% of their sample. Unlike other samples, there was a representation of nonreligious individuals, with 24% of the sample identifying as nonreligious. Participants had spent an average of 26 months in reorientation treatment, ending the last treatment episode an average of 12 years before their interview (Shidlo & Schroeder, 2002). Shidlo and Schroeder reported that many of the individuals that they interviewed said that at one point in time they would have identified themselves as reoriented, but that with time they realized that this was not the case. Shidlo and Schroeder found that persons who had gone through reorientation therapy had mixed experiences with the therapy, with many reporting that they had been both harmed and helped from the same episode of therapy.

Shidlo and Schroeder (2002) developed a model for a pathway to perceived treatment failure or success. The model begins with the preentry period, which was the time during which the participant became motivated to enter treatment. Strong motivators that were reported were a search for a social group where he or she felt comfortable, religious reasons, desire to hold together a marriage and family, threatened expulsion from a religious academic institution if treatment was refused, and mood or anxiety symptoms. For the latter group that sought therapy for mood or anxiety symptoms, they reported that their therapists suggested reorientation therapy in response to their symptoms. Overall, reorientation therapy was suggested to the client by the therapist in 26% of the interventions reported.

The next phase of Shidlo and Schroeder's (2002) model was identified as the "honeymoon period," in that participants reported a sense of hope and relief at entering therapy. The model then puts forth division into two groups: persons who perceive themselves as successful and persons who perceive themselves as failing, 13% and 87%, respectively, within the sample. The authors further divide the successful group into three subgroups: "successful and struggling," which was defined by repeated same-sex sexual behaviors; "successful and not struggling," which was defined by using strategies to manage same-sex sexual urges; and "successful heterosexual shift," defined by individuals who were living actively heterosexual lives. Notably, of the eight individuals in the successful heterosexual shift phase, seven were providers of counseling to individuals who were reorienting or reoriented (Shidlo & Schroeder, 2002).

For individuals who saw themselves as not having reoriented, the honeymoon phase was followed by a time of disillusionment (Shidlo & Schroeder, 2002). At this time, the authors state that participants experienced a deadening of sexual desire, or they experienced strong feelings of same-sex sexual desire and felt disappointed in their treatment progress. The latter group often engaged in dangerous impulsive behaviors including substance use, suicidality, or unsafe sexual behaviors. From this point, Shidlo and Schroeder saw the participants as reestablishing a gay or lesbian identity with considerable residual reorientation therapy harm (n = 155) or with considerable renewal and strength (n = 21).

PURPOSE OF THIS STUDY

The present study is a departure from previous research on reorientation therapy for several reasons. First, in contrast to the controversial Spitzer (2003) study, the present study involved recruiting individuals who went through reorientation therapy and did not report a change in sexual orientation. To date, no studies have specifically focused on ex-ex-gay individuals, or those who have entered reorientation therapy at one point, then later reclaimed a gay or lesbian identity. Second, this study differs from the studies conducted by Beckstead and Morrow (Beckstead, 2001; Beckstead & Morrow, 2004) in that participants in the present study

were not recruited on the basis of one particular religious identity, and therefore may represent a broader group of individuals who went through reorientation interventions. Finally, in contrast to the model-building approach of Shidlo and Schroeder (2002), the recruitment strategy of the present study was designed to capture individuals who perceived themselves as successful, not in having achieved sexual orientation conversion, but in having reclaimed a new identity as gay or lesbian.

The purpose of this study is to thematically examine the experiences of people who have undergone reorientation therapy and have determined that an ex-gay life is not for them: ex-ex-gay (or ex-ex-lesbian) individuals. This study seeks to identify the reasons that led these individuals to seek reorientation therapy and the reasons that they later chose to claim a gay or lesbian identity. Additionally, this study aims to determine how reorientation therapy was perceived to be beneficial or harmful to the individual.

METHODS

Recruitment of Participants

Participants met inclusion criteria if they had been through any type of intervention designed to change their sexual orientation from LGB to heterosexual and currently identified as LGB. Recruitment efforts targeted several online sources over a period of approximately 12 months in 2008 and 2009. First, a notice describing the study was included in an e-mail newsletter to individuals who had registered with an ex-ex-gay Web site. The notice suggested that information about the study could be passed on to others, which created a snowball effect that resulted in additional postings about the study on at least seven other Listservs or Web sites (according to participant reports when they were asked where they heard about the study), including a Listserv for people who identify as both gay and Christian. Additionally, a description of the study was sent out to a Listserv of psychologists who are interested in lesbian, gay, bisexual, and transgender (LGBT) issues. It was anticipated that it would be difficult to find participants for this study due to low base rates of individuals who met the criteria for study participation. In addition, previous researchers had also reported difficulty in recruitment. For instance, Throckmorton and Welton (2005) spent one year recruiting participants who considered themselves reoriented or reorienting and were able to find 28 participants who met their study criteria during that time. Similarly, Spitzer (2003) spent 2 years of intensive searching to locate 200 participants and ultimately ended up recruiting many activist ex-gays. A number of factors influence the decision of an optimal sample size for reaching saturation, or the point at which additional data collection would not offer new insights or themes; however, a general recommendation for sample sizes for interview data in sexuality research was recently offered as 25–30 participants (Dworkin, 2012). Considering the uniqueness of this population, recruitment difficulties in previous research, and the goal of identifying relevant themes regarding reorientation experiences, a target goal of 30 participants was set for the present investigation.

Measures

Demographic questions

Respondents were queried about their demographic characteristics, including age, gender (including queries for male, female, transgender male to female, transgender female to male, and other), education level, income, and relationship status.

Sexual orientation

Two items were used to measure sexual orientation. One question asked the participant if he or she identifies as gay, lesbian, heterosexual, or bisexual. The Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948) was also used to measure sexual orientation both because of its simplicity and because it is a scale with which persons who go through sexual reorientation therapy may be familiar. The Kinsey Scale is a 7-point scale where responses range from 0, indicating exclusively heterosexual, to 6, indicating exclusively homosexual (Kinsey et al., 1948). Because

the focus of this investigation was on the shifts in identity that accompany an individual's self-definition as gay, ex-gay, or ex-ex-gay, the measures of sexual orientation in this study reflected LGB identity, rather than attraction or behavior.

Questions about therapy experiences

Several items queried the participants' experiences with reorientation therapy. These questions included number of episodes of therapy, the length of therapy, the modality of therapy, the designation of the person(s) who provided the therapy, and the setting of the therapy. If the participant had experienced more than one episode of reorientation therapy, these questions were asked for each episode.

Furthermore, participants were asked about reorientation experiences via the following questions: "What were your reasons for seeking reorientation therapy?"; "How did this therapy episode help you in the short term?"; and "How did this therapy harm you in the short term?" Similarly worded items were used to assess the long-term helpfulness and harmfulness of each therapy episode. Participants' reasons for LGB identification following therapy were assessed by asking: "What were your reasons for identifying as gay, lesbian, or bisexual after reorientation therapy?"

Procedure

Due to concerns that the data could be compromised if an open survey was offered to anonymous parties, participants were asked to contact the principal investigator via e-mail or telephone to participate in the study. After contact was made, the investigator mailed the individual a paper survey and a separate form and envelope to request an incentive of $15. This method was meant to prevent the same individual from completing the survey multiple times, with contact with the principal investigator being the deterrent.

Analyses

An inductive content analysis strategy (Patton, 2002) was used to analyze participants' responses to the open-ended survey questions. Verbatim responses were printed for the research assistants (research assistants were either advanced undergraduate students [*n* = 5] or graduate students who had obtained MA degrees [*n* = 2]), who collaborated with the principal investigator to identify core themes in the responses and develop an open coding system (Strauss & Corbin, 1998) serving as both developers and coders. During this process, the developers were instructed to read all responses one or more times and to mentally note any themes that began to emerge. The code developers were then instructed to reread all responses and identify specific themes that could be captured using a short phrase or sentence. The developers were not limited in the number of potential themes they could identify. Once complete, the developers met to share their themes. Generally speaking, the most prominent themes were discussed first, and often the principal investigator would ask the theme developers to specify portions of responses that would be included under each theme category.

This process continued until a consensus had been reached about the themes that were present in the responses. Once a consensus had been reached either three research assistants (one of whom had a MA degree) or two research assistants and the principal investigator coded each of the responses. Responses were counted as resonating with a particular theme if at least two out of the three coders identified the theme as present in the specific response. Frequencies of responses that were classified as a particular theme were then tallied, and themes that occurred at least twice are reported. Fleiss's Kappa was calculated as a measure of agreement among raters. Kappa coefficients within this study ranged from .53–.71, in the *moderate* to *substantial* agreement range (as defined by Landis & Koch, 1977).

RESULTS

Participants

Relevant sample characteristics are reported here for convenience; sample characteristics are also reported in Flentje, Heck, and Cochran (2013). Thirty-eight people participated in the study; their demographic information is reported in Table 1. Participants indicated that they had continually identified as lesbian or gay for between 13 months and 23 years (M = 7.09 years, SD = 5.62) since their last episode of reorientation therapy. When asked about their current religious identification, respondents indicated that they identified with Protestantism (n = 26), no religion (n = 4), Judaism (n = 2), Greek/Eastern Orthodoxy (n = 2), Catholicism (n = 1), Buddhism (n = 1), or were undecided (n = 1). The group who identified as Protestant further identified with the following churches or denominations: nondenominational (n = 5), Methodist (n = 5), United Church of Christ (n = 2), Baptist (n =2), Episcopal (n = 2), Quaker (n = 2), Lutheran (n = 2), Metropolitan Community Church (n = 1), Evangelical (n = 1), Presbyterian (n = 1), Christianity "emergent" (n = 1), Golden Rule Christian (n = 1), and the Reformed Church of America (n = 1).

TABLE 1 Demographic Information (N = 38)

Demographic variable	*n*, % (or *M*, *SD*, if applicable)
Age *M* (*SD*, range)	37.37 (11.98, 20 – 66)
Sex (*n*, %)	
Male	38 (81.6%)
Female	7 (18.4%)
Sexual orientation	
Gay	38 (81.6%)
Lesbian	7 (18.4%)
Sexual orientation: Kinsey scale[a]	
Predominantly homosexual, only incidentally heterosexual	16 (42.1%)
Exclusively homosexual	22 (57.9%)
Race (*n*, %)	
Caucasian	33 (86.8%)
African American	1 (2.6%)
Latino/Latina	1 (2.6%)
Asian/Pacific Islander	1 (2.6%)
Multi Racial	2 (5.3%)
Education (*n*, %)	
Some college	1 (2.7%)
4-year college degree	11 (29.7%)
Some graduate school	6 (16.2%)
Graduate/professional degree	19 (51.4%)

[a]Participants only endorsed these two categories for sexual orientation.

Reorientation Experiences

Participants provided information about multiple episodes of reorientation therapy when applicable, with 38 participants providing information on 113 episodes. Participants reported that 7.1% of episodes were inpatient, 50.4% were outpatient, and 42.5% were classified as "other." Responses to what was meant by "other" varied considerably and included things such as telephone or e-mail therapy, online support groups, conferences, and retreats. Characteristics of reorientation episodes are summarized briefly in Table 2. In-depth details of reorientation experiences are reported in Flentje, Heck, and Cochran (2013).

TABLE 2 Characteristics of Reorientation Therapy Episodes

Participant intervention experiences	Range	*M (SD)*	*Mdn*
Age at first reorientation intervention	11–52	23.18 (8.62)	20
Total number of hours in reorientation interventions	12–3000	487.20 (639.72)	200
Number of different reorientation episodes	1–9	3 (2.10)	2.5
Length of intervention episodes in weeks[a]	1–240	40.54 (42.64)	26
Professional designation of intervention provider[b]	*n*	%	
Religious leader	50	22.1%	
Religious individual without leadership duties	48	21.2%	
Licensed counselor	38	16.8%	
Pastoral counselor	29	12.8%	
Peer counselor	21	9.3%	
Marriage and family therapist	18	8.0%	
Psychologist	11	4.9%	
Social worker	6	2.7%	
Psychiatrist	5	2.2%	

[a]This and the following categories are calculated for all reorientation episodes (participants reported on multiple episodes), 113 total for the study.
[b]Participants could endorse multiple professional designations for providers, resulting in 226 total responses to this question.

Reasons for Seeking Reorientation Therapy

A total of 36 participants provided responses regarding their reasons for seeking reorientation therapy, and eight distinct themes emerged. The theme "religious beliefs" was the most frequently identified theme within the responses (n = 29, 80.6%). The "religious beliefs" theme represented answers about specific religious beliefs (e.g., "I had been taught that God would punish me as a gay man") that led participants to see an LGB identity as incompatible with their religious belief system. Consistent with this theme, 100% of participants reported that they had been part of a religious or spiritual community that held negative beliefs about LGB people. Additionally, there was a "desire for a 'normal' heterosexual life" (n = 14, 38.9%). Responses that were coded for this theme indicated that the participants wanted to be married and have children and families, and again saw these desires as incompatible with being LGB. A complete listing of the themes that emerged and the frequency of their occurrences can be found in Table 3.

TABLE 3 Reasons for Seeking Reorientation Therapy: Themes That Emerged

Theme	Frequency	Example
Religious beliefs	29 (80.6%)	"Being gay was a sin and I couldn't be a Christian and gay."
Desire for a "normal" heterosexual life	14 (38.9%)	". . . I wanted to live a "normal" life, married with children- it was my dream."
Family acceptance/rejection	14 (38.9%)	"Wanted to be 'normal' so that my family and parents would love me again."
Religious community acceptance/rejection	11 (30.6%)	"I wished to continue actively in my church which I could not continue to do in that church as a gay man."
Mental health (depression, guilt, fear)	10 (27.8%)	"I felt defective, abnormal, depressed, and self-hatred toward myself and wanted to change."

Social stigma	7 (19.4%)	". . . social stigma of being perceived as queer, deviate, effeminate"
In a straight marriage or family	4 (11.1%)	"I was married with 4 kids."
Being gay associated with negative or risky health behaviors	3 (8.3%)	"... fear of the 'gay lifestyle' (i.e., disease, promiscuity, loneliness, drug/alcohol abuse)."

Perceived Helpfulness of Therapy

All of the participants (N = 38) provided responses regarding short-term and long-term helpfulness for each of the reorientation therapy episodes that they experienced, and 16 themes emerged from those responses (percentages are reported according to the percent of the total of the 113 therapy episodes that they were reporting). The most commonly occurring themes for short-term helpfulness of reorientation therapy included providing a "sense of connectedness, support" (21 occurrences, 18.6%) and that the participants "felt accepted, not alone" (15 occurrences, 13.3%). For both of these themes, it appeared that there was a benefit to the social aspect of being able to share experiences with people who felt similarly conflicted about same-sex attractions. After these two themes, the third most frequently occurring theme was that the therapy was not helpful in the short term (14 occurrences, 12.4%). It should be noted that although this seems to be a counterintuitive response (e.g., participants indicated that a "helpful" aspect of the therapy was that it was "not helpful"), the statements here reflect the participants' responses to the question and were coded accordingly. Suicide was explicitly mentioned in six responses (5.3%). In these cases, participants indicated that their therapists or being in therapy had helped them to deal with suicidal feelings or encouraged them to not act on suicidal impulses. When considering long-term helpfulness, the most frequent theme was that the episode of therapy did not provide long-term help (35 occurrences, 31.0%). The next most frequently occurring themes were that the therapy "solidified gay identity" (13 occurrences, 11.5%) and provided a "sense of connectedness, support" (12 occurrences, 10.6%). The complete list of themes that emerged regarding ways in which participants had found reorientation interventions to be helpful and the frequency of the occurrences of these themes are noted in Table 4.

TABLE 4 Themes in the Helpfulness of Each Reorientation Episode

Theme	Frequency	Example
How did this episode of therapy help you in the short term?		
Sense of connectedness, support	21 (18.6%)	"I found peers, support, love, and friendship. I had a free place to discuss my struggles. They helped me get through crisis situations."
Felt accepted, not alone	15 (13.3%)	"It helped me realize I wasn't alone in my 'struggle.'"
Didn't help	14 (12.4%)	"This therapy did not aid me in the short term."
Hope (explicitly stated or implicit)	12 (10.6%)	"Therapy made me feel empowered over my own life, both in regards to my sexual orientation and the rest of my life in general. I would almost always leave each therapy session feeling great about myself and optimistic . . . It made me feel good in the short term."
Family or relationship issues	10 (8.8%)	"Gave me skills/tools and increased my self evaluation of areas in my life that could perhaps be improved–-e.g., mother/father– son relationships, relationships/friendships with male peers, self esteem issues."

Mental health or other health issues addressed	9 (8.0%)	"Again, by providing a place where I didn't feel alone in my struggles, thereby staving off suicide and deeper depression."
Safe place to talk, be honest	6 (5.3%)	"Gave me an opportunity to talk about being homosexual for the first time in my life."
Helped to talk about same-sex attractions with family or community	5 (4.4%)	"It helped me to finally admit to others, including my parents, that I had same sex attractions."
Strengthening or reconciliation of faith	4 (3.5%)	"It helped to establish that I was a person of worth and to focus on God partnering with me."
Aided the coming out process	3 (2.7%)	"In settling the upset emotions of the coming out process."
Solidified a gay identity	2 (1.8%)	"Helped me to accept I was not straight"
Trauma issues dealt with	2 (1.8%)	"I was elated and felt my childhood memories of trauma were healed."
How did this therapy help you in the long term?		
Didn't help	35 (31.0%)	"This therapy has not aided me in the long term."
Solidified gay identity	13 (11.5%)	"It reinforced the fact that I was made gay and that it was not a lifestyle or a circumstances choice."
Sense of connectedness, support	12 (10.6%)	"I had a group of friends/acquaintances that I could talk to openly and honestly without fear of judgment. They understood me."
Strengthening or reconciliation of faith	7 (6.2%)	"I realized God's love was bigger than my homosexuality. I was His, and no power could negate that fact."
Felt dissatisfaction with reparative therapy	6 (5.3%)	"Showed me that ex-gay ministries/mentality was cult-like and destructive, overall, by proffering false hopes and promoting further/more rigid thinking and self condemnation."
Mental health or other health issues addressed	5 (4.4%)	"He recognized I was really depressed and connected me with medical professionals who diagnosed my depression and supplied antidepressants–-possibly saving my life."
Family or relationship issues	4 (3.5%)	"Opened up some opportunities for growth with my dad and family. Built the relationship levels with my parents to share about my homosexuality later in life. Allowed me to stop blaming my parents for my situation."
Safe place to talk, be honest	4 (3.5%)	"She is, to this day, the only therapist I've felt safe being honest with."
Aided with the coming out process	3 (2.7%)	"Started me on the road to come out."
Learned repressive techniques	3 (2.7%)	"It taught me a certain measure of self-control and made me aware of my abilities to deny sexual desires."
Met a partner or lover there	3 (2.7%)	"Met my future first gay lover."
Gained skills	2 (1.8%)	"Gave me skills"
Helped to talk about same-sex attractions with family or community	2 (1.8%)	"It began the ongoing journey of accepting my sexual orientation and sharing this with friends or family when I have a certain comfort level with them."
Trauma issues dealt with	2 (1.8%)	"I learned a lot about myself and was able to come to terms with some abuse and neglect from my past."

Perceived Harmfulness of Therapy

All of the participants responded to questions regarding short- and long-term harms for each therapy episode they experienced, and 17 themes emerged (percentages are representative of the percent of the total number of episodes experienced among the sample, *N* = 113). The most frequently identified short-term harms resonated with themes that represented "mental health (depression, anxiety)" and "shame, guilt, self-hatred," each with 17 occurrences (15.0%). Additionally, 17 episodes (15.0%) were identified as not being harmful in the short term. In the long term, participants identified that 24 episodes (21.2%) were not harmful. As with the question on helpfulness, these seemingly counterintuitive responses were the participants' verbatim answers to the question about harmfulness. The next most frequently cited long-term harm was "shame, guilt, and self-hatred" (21 occurrences, 18.6%). Suicide was specifically mentioned as a harmful aspect of reorientation episodes (four occurrences in both the short and long term, 3.5%). Identified themes and the number of occurrences of these themes are in Table 5.

Reasons for Identifying as LGB

Thirty-six participants provided responses when queried about their reasons for identifying as LGB after reorientation therapy, and eight distinct themes

TABLE 5 Themes in the Harmfulness of Each Reorientation Episode

Theme	Frequency	Example
How did this therapy episode harm you in the short term?		
Mental health (depression, anxiety)[a]	17 (15.0%)	"It was fear inducing–-horrible. Almost like an exorcism performed on me. I had panic attacks and anxiety."
Shame, guilt, self-hatred	17 (15.0%)	"I felt shame about my urges/attractions."
Didn't harm	17 (15.0%)	"It probably did no harm in the short term. Finally getting to talk to someone was very calming."
False hope	13 (11.5%)	"It complied with my errant thinking that it was okay for me to get married, even though this was going on, that it would all work itself out and the situation would improve somehow–-it fostered false hope."
Suppressing, not being honest, secrecy	10 (8.8%)	"Didn't face the problem. Tried to suppress to please the counselor."
Isolation, distance or loss of relationships	8 (7.1%)	"Isolation from family and friends."
Inaccurate or bad view of LGBT people	7 (6.2%)	"I was told many incorrect and untrue things about LGBT people . . . reinforced the idea that LGBT people are sick and evil."
Blamed parents, damage in relationship with parents	6 (5.3%)	"It also caused me to attempt to fit my past experiences into a reparative therapy model of attractions, which led me to begin blaming my parents for things they were not responsible for."
Delayed coming out or pursuing relationships	6 (5.3%)	"Also in the short term my experience with therapy delayed my ultimate coming out by about 2–3 years, which I view as short term in the grand scheme of things."
Financial cost	5 (4.4%)	"I didn't make much money and it was difficult to afford."
Can't change, failure, worthlessness	4 (3.5%)	"Also made me feel inadequate because my faith was too weak for me to change."

Distrust	2 (1.8%)	"The pastor counseled me in private and later told the whole church all we had spoken in private. It was a painful breach of trust."
Fear of going to hell	2 (1.8%)	"Constantly second guessing myself thinking I was going to hell."
Loss of faith in God or spirituality	2 (1.8%)	"Caused me to stop believing in God for a time."
Loss of time	2 (1.8%)	"The summer after I concluded ex-gay therapy was when I had my first relationship. However, the entire school year after that summer was a social black hole–-I literally recall nothing of what transpired that year. To some degree I don't think I was ready to come out as gay, yet I knew I wasn't going back to therapy. It was a very strange year, I don't remember pursuing anyone of either gender romantically and it almost feels like my 'lost year.'"
How did this therapy episode harm you in the long term?		
Didn't harm	24 (21.2%)	"Didn't. Was able to see what a load of crap it was."
Shame, guilt, self-hatred	21 (18.6%)	"It led me to more introspection and greater self-loathing. Every activity I performed had to be scrutinized for possible demonic overtures."
Loss of faith in God or spirituality	12 (10.6%)	"It caused me to feel separated from God and condemned to hell."
Mental health (depression, anxiety)[a]	10 (8.8%)	"In spite of the therapist's efforts, my depression grew worse under his care rather than growing better. I began cutting, secured a gun license in my state, and almost killed myself."
Blamed parents, damage in relationships	8 (7.1%)	"Based on this man's advice and others in his organization, I spent a lot of money and told my father that our relationship made me gay–-I regret these things."
Isolation, distance or loss of friendships	8 (7.1%)	"I was not comfortable with myself and that was making people around me uncomfortable too. As a result, I was left behind by almost everyone, except my family."
Financial cost	6 (5.3%)	"Expense/debt of treatment."
Delayed coming out or pursuing relationships	5 (4.4%)	"Delayed accepting myself."
False hope	5 (4.4%)	"It created in me the false image that I could change my sexuality. I was kept in this lie for more than 12 years, trying to change it."
Career or academic consequences	4 (3.5%)	". . . it distracted me from my true course, i.e., from continuing in college (which I eventually went back to) pursuing my career and hobbies, friends through these interests, etc."
Distrust	4 (3.5%)	"Made me distrust sharing this with other counselors."
Inaccurate or bad view of LGBT people	4 (3.5%)	"Exposed me to a lot of very miserable gay people who I thought were representative of all gays."
Can't change, failure, worthlessness	3 (2.7%)	"Contributed to shame and self-hatred because my orientation never changed–-not even a little. I felt like a failure."
Suppressing, not being honest, secrecy	3 (2.7%)	"I learned things that fed my anonymous sexual behavior. This ended up creating a cycle of shame and secrecy that would become very hard to break."
Fear of going to hell	2 (1.8%)	"I still struggle with the fact that I am not going to hell."

[a]Suicide was mentioned specifically regarding four (3.5%) episodes of therapy in reference to short-term harm and four (3.5%) episodes of therapy in reference to long-term harm; these responses were given by two different participants in the study.

emerged. These themes and their frequency of occurrence are reported in Table 6. The most frequently occurring themes included “acceptance of and being honest about being gay or lesbian” (*n* = 15, 41.7%), “I couldn’t change my sexual orientation” (*n* = 14, 38.9%), and the experience of a “religious integration with LGB” (*n* = 9, 25.0%). When considering the theme of “religious integration with LGB” it is important to note that 100% (*n* = 37, 1 participant declined to answer this series of questions) of participants had been part of a religious community that held negative beliefs about LGB people, and 97.3% (*n* = 36) of participants had left these religious communities. Of the participants who had left their religious communities, 61.1% (*n* = 22) did so after reorientation therapy.

TABLE 6 Reasons for Identifying as LGB After Reorientation Therapy

Theme	Frequency	Example
Acceptance of and being honest about being gay or lesbian	15 (41.7%)	“. . . I decided that the change I needed to experience was accepting myself.”
I couldn’t change my sexual orientation	14 (38.9%)	“The realization that therapy did not get rid of sexual orientation; it only ‘treated the symptoms.’”
Religious integration with LGB identity	9 (25.0%)	“This is how I was made–-and God made me–-so I was okay as is, in His image.”
Desire for or finding intimacy or a relationship	7 (19.4%)	“I fell in love with another Christian woman.”
Deterioration of mental health	6 (16.7%)	“The chaos in my life since the therapy, my life had become something close to hell.”
Exhausting to be ex-gay, gave up	5 (13.9%)	“. . . it was because I was simply exhausted from 13 years of suppressing my natural urges.”
Ex-gay example falling from grace	2 (5.6%)	“A prominent ex-gay individual was caught using a restroom in a gay bar and made a lame excuse for being there.”
Being gay or lesbian is not associated with negative, risky, or stigmatized health behaviors	2 (5.6%)	“. . . I decided it would be OK to ‘try out’ a same-sex relationship provided it wasn’t all the horrible things my church and my therapist said it would be.”

DISCUSSION

Sexual reorientation therapy remains a controversial area of practice; there are widespread concerns that reorientation therapy is harmful, and recent studies (e.g., Spitzer, 2003) that are cited to support the effectiveness of reorientation therapy have been heavily criticized on methodological grounds. The results of this study are not intended to resolve this controversy; rather, the results illuminate the experiences of individuals who have undergone reorientation therapy and identify as LGB.

The results of this study are consistent with previous research in several ways. First, the sample comprised mainly Caucasian and male individuals, which was similar to participant demographics from other studies (Schaeffer et al., 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Throckmorton & Welton, 2005). Second, participants’ motivations for seeking reorientation therapy and the delivery of therapy were driven by religious and heteronormative beliefs. Specifically, religious beliefs and desires to have or maintain a heterosexual lifestyle, which includes marriage and children, were the most commonly cited reasons for

entering reorientation therapy, a finding that is consistent with previous research (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002; Spitzer, 2003; Tozer & Hayes, 2004). Although previous research suggests that mental health professionals (e.g., psychologists, pastoral counselors) are often identified as the most common providers of reorientation therapy (Shidlo & Schroeder, 2002; Spitzer, 2003), the most frequent providers reported by participants were individuals with a religious affiliation, while very few psychologists, psychiatrists, and social workers were identified as the participants' providers of reorientation therapy. On the other hand, the fact that any mental health professionals were identified as providers of reorientation therapy is inconsistent with the statements made by virtually all major mental health organizations that such practices are ineffective and possibly unethical.

With respect to perceived helpfulness of reorientation therapy, participants endorsed feelings of acceptance, connection, hope, and support. Beckstead and Morrow (2004) reported that most of their participants derived a sense of belonging and were provided with hope as a result of treatment, and as Shidlo and Schroeder (2002) pointed out, conversion therapy "may offer a powerful social component as part of the treatment" (p. 252). In the long run, many participants acknowledged that treatment would not help them to become heterosexual; rather, treatment helped to solidify aspects of their sexual identity and integrate (or reconcile) this identity with their religious beliefs. Furthermore, 97.3% of participants reported that they had left religious communities that held negative beliefs about LGB individuals, with 61.1% of these individuals doing so after reorientation therapy.

Once again, acceptance of one's sexual orientation and a realization that sexual orientation could not be changed were the most frequent themes identified in participants' reasons for leaving reorientation therapy and identifying as gay or lesbian. In sum, these findings echo the results of Shidlo and Schroeder (2002) and suggest that for some, reorientation therapy was very much part of the process by which they came to accept their own sexual orientation and to feel freed to identify as gay or lesbian.

There are many reasons that individuals who have undergone reorientation therapy might be motivated to identify beneficial aspects of the experience. Studies of psychotherapy outcome have repeatedly identified "common factors" of all forms of therapy that are beneficial components of the experience, and one of the most consistent of these factors is the therapeutic alliance (Wampold, 2010). Even though participants in our study later reclaimed an identity that was opposite of the intended goal of reorientation therapy, many of these individuals were likely to have experienced a good working relationship, or alliance, with treatment providers they encountered in the process. The psychological theory of cognitive dissonance (Festinger, 1957), in which individuals are motivated to justify their decisions through modifying their interpretation of the outcome, may also apply to reorientation therapy. Individuals who have invested a great deal of time, money, and effort into the process of reorientation therapy may be motivated to find benefits of the experience to explain such an investment of resources. Finally, an individual undergoing reorientation therapy may experience a mitigation of shame or internalized homophobia by attempting to overcome unwanted aspects of his or her identity. Although the ultimate result of reorientation therapy could be an increase in shame through the process, as some of the participants in this study noted, temporary amelioration of shame may occur while one is attempting to become heterosexual.

Participants' perceptions of how reorientation therapy was harmful in this study were consistent with the results of Shidlo and Schroeder (2002). These include increased psychological distress that centered on depressed mood, increased anxiety, and suicidality. Many of the responses resonated with a theme of "shame, guilt, and self-hatred." While client deterioration as a result of treatment is considered harmful (Lilienfeld, 2007), additional themes (e.g., "not harmful," "financial costs," "loss of time") that emerged from the participants' responses reflect opportunity costs, or the harm that is derived from receiving ineffective or suboptimal treatments (Lilienfeld, 2002). The varying responses to questions of helpfulness and harmfulness could indicate that a person's unique background, psychosocial history, and preconceived notions about

reorientation therapy may affect his or her perceptions of helpfulness and harmfulness. Additionally, the variability in interventions that exists among providers of sexual reorientation therapies (see Flentje et al., 2013) further complicates matters when attempting to discern how and why differences in perceptions of helpfulness and harmfulness might arise.

Implications

The results reported herein are not only consistent with previous research but also have important practical implications that warrant attention. Perhaps the largest implication of this study involves the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). The results of this study support the report's conclusions, which indicate that the helpful components of reorientation therapy could be obtained through other treatments, while minimizing the potential for harm that appears in the reports of participants who have undergone reorientation therapy.

Specifically, the most frequently identified helpful components of reorientation therapy (a sense of connectedness with others or acceptance) could be achieved through other, less stigmatizing, treatment methods. Within this vein, it is important to increase the availability of alternatives to reorientation therapy, especially in communities and treatment centers that may offer or promote reorientation therapies. Silverstein (2003) pointed out that ex-gay organizations have attractive and easy-to-use Web sites, and that other therapy options are not well publicized. This means that persons who are concerned about their sexual orientation, or family who are concerned about the sexual orientation of their children or teens, may find these Web sites and see them as a viable, and perhaps the only, option. On this front, mental health organizations should continue to work to increase the visibility of therapy options that are affirming of LGB identities.

It is also important to consider this study's clinical implications. Phillips (2004) raised the importance of appreciating the complexity of sexuality when working with clients who experience both same-sex attraction and religious promotion of non–gay friendly values. It may be tempting to suggest that a client change or leave religious communities that are anti-LGB; however, this suggestion may be harmful to both the client and the therapeutic relationship. Alternatively, affirmative and client-centered interventions may help clients come to this conclusion on their own or help clients develop positive coping skills to navigate homophobic environments and relationships (American Psychological Association, 2009). Miville and Ferguson (2004) noted that for some individuals, religion may not be optional, and in respecting client diversity and autonomy, it is important to value both the client's religious and sexual identity (Haldeman, 2004), even if these may seem to be in conflict with one another.

Haldeman (2004) recommended a therapeutic approach that focuses on the client; such an approach may not necessarily advocate for openness about one's sexual orientation, nor would it advocate for a change in sexual orientation, but instead it would integrate the client's own values into his or her sexual orientation, thereby finding some resolution between the conflicted aspects of the client's identity. Haldeman's recommendation is supported in the findings of this study, in that a frequently cited reason for identifying as gay or lesbian was an integration of religious beliefs and sexual orientation.

The results indicate that the "desire for a 'normal' heterosexual life," including children, marriage, and families, is a common reason for seeking reorientation therapy. A therapist who is approached by a client who wishes to change his or her sexual orientation may want to be aware of this motivation and should attempt to find a way to explore alternatives to traditional marriage and family structures with his or her clients. The results also suggest that suicidal ideation was addressed in the context of reorientation therapy, and some participants found this to be beneficial. Even if suicidality is not a result of participation in reorientation therapy, this helpful component of the therapy could be addressed within the context of an affirmative approach to sexual orientation. In their review of the literature, Haas et al. (2010) concluded that there is a large body of literature

indicating LGB individuals have increased rates of suicide risk. Two participants within this study perceived a link between reorientation interventions and an increase in suicidal ideation or behaviors. If suicidality is caused or exacerbated by participating in reorientation therapy, the case for abandoning the therapy and adopting an affirmative, client-centered approach is strengthened. This is particularly important given that LGB people are presumed to already be at higher risk for suicidal ideation (Haas et al., 2010). Therapists should inquire about current and past suicidality, especially when treating clients who have been through reorientation therapy. When confronted with a client who is expressing interest in changing his or her sexual orientation, a treatment provider should be keenly aware of the potential for suicidality, as this theme occurred both in the helpful and harmful components of reorientation therapy episodes.

Future Directions

This study also points to the need for future research. There were several instances of participants reporting reorientation episodes that were helpful because these episodes involved participants' feeling supported, accepted, or hopeful or because these episodes helped to resolve family or relationship challenges and mental health issues. Future research could assess the psychological health and wellbeing of individuals with varying levels of motivation for seeking reorientation therapy in an effort to approximate the prevalence of psychological disorders and suicidality among individuals who are highly motivated to seek this form of treatment. Next, future research could examine the helpfulness of non-reorientation-focused therapies in persons who are presenting for treatment wanting to change their sexual orientation. This could evaluate whether or not the helpful components of reorientation therapy could be achieved through other means with this population and could help determine the effectiveness of affirmative, client-centered interventions in treating individuals who are highly motivated to change their sexual orientation.

Similarly, future research could build on other findings regarding the perceived harmfulness of reorientation therapy episodes. Areas of perceived harmfulness of reorientation therapy that warrant future research include the consequences of the shaming or suppression aspects of reorientation therapy, the loss of or damage to important relationships, and the delays experienced prior to coming out.

Limitations

This study has several limitations that should be noted in the interpretation of the results. First, due to the design of this study, no conclusions can be made regarding causality, and causal inferences regarding the potential benefits and potential harm experienced by persons who undergo reorientation therapy cannot be made. Longitudinal research would be required to examine the relationship between reorientation therapy and psychological functioning in a scientifically rigorous way. However, longitudinal research or a randomized controlled trial may be unethical and difficult or impossible to conduct, given that a review of the scientific evidence for sexual orientation change efforts (SOCE), which includes reorientation therapies, concluded that "enduring change to an individual's sexual orientation as a result of SOCE was unlikely. Furthermore, some participants were harmed by the interventions" (American Psychological Association, 2009, p. 54).

A second important limitation of this study involves the reliance on participants' retrospective self-reports, which may not accurately reflect behavior or experience. For some participants, reorientation therapy episodes were more than a decade prior to this study; thus, it is possible that some information that was provided was incorrect or distorted. Next, the participants for this study were self-selected volunteers, and there is no way to know if the results would generalize to individuals who were exposed to the recruitment information and decided not to participate. In addition, the measures of sexual orientation used in the study focused primarily on identity and did not include the dimensions of attraction and behavior emphasized in the definition of sexual orientation provided by Sell (1997). Given that some recent research has identified different findings when

measuring sexual orientation identity, attraction, and behavior, future research with this population could incorporate a more multidimensional conceptualization of sexual orientation.

Finally, the inductive/open coding analysis (Patton, 2002) that was used to analyze the results represents a preliminary step toward developing or replicating a theoretical model meant to capture the reorientation experiences of ex-ex-gay and lesbian people. However, the results of the inductive/open coding analysis are promising, given their similarity to the results of Shidlo and Schroeder (2002) and Beckstead and Morrow (2004). Despite these limitations, this study has provided important information about the motivation for seeking reorientation therapy, the perceived helpfulness and harmfulness of reorientation therapy, and the reasoning behind identifying as LGB after treatment.

FUNDING

This research was supported by the Roy Scrivner Grant of the American Psychological Foundation. The results reported herein do not necessarily reflect the views of the American Psychological Foundation.

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