

EXPLORING ATTITUDES ABOUT SEXUAL AND GENDER DIVERSITY

*Understanding Gender Identity, Reducing Bias,
and Building Dialogue Across Differences*

Resilience Skills for LGBTQIA+
People and People with a Different or No Label

Edited by
A. Lee Beckstead
Sulaimon Giwa
Iva Žegura
*Part of the LGBTQIA+
Peacebuilding Book Project*

Guidebooks and Personal Growth Books
found at LGBTQIApeacebuilding.com

Copyright © LGBTQIA+ Peacebuilding Book Project 2026

All rights reserved.

First edition published 2026.

Revised edition with references and endnotes published 2026.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without written permission of the author or publisher.

For permission to reproduce excerpts, use copyrighted material, translate, or adapt this work, please contact the author or publisher.

Table of Contents

Exploring Attitudes about Sexual and Gender Diversity 7

How to Approach and Use This Book 13

 Take Care of Yourself as You Read 15

Why Do Certain Attitudes about Sexual and Gender Diversity Persist?... 21

How Do We Change Harmful Attitudes? 32

Exploring Your Agreement with Certain Attitudes about Sexual and Gender Diversity 45

Understanding Attitudes and Differences about Sexual and Gender Diversity 56

 Understanding Homonegativity and Cis-Heterosexism..... 58

 Why Do Sexual and Gender Minority People Have Worse Health, on Average?..... 63

 Why Person-Centered, Affirming Identity Development Matters..... 78

 Key Ideas for Building Internal and Social Peace115

 Key Skills for Building Internal and Social Peace 116

Understanding Attitudes about Traditional Christianity, Science, and Sexual Diversity 126

 Understanding Christian Religious and Psychological Traditions and Conflicts 127

 What Do Respecting Differences, Being Authentic, and Sin Mean to You?129

 Trends in Belonging and Healing Divides..... 132

 What is Your Cultural Mindset?134

Understanding Attitudes about Gender Diversity 138

Gender Identity Has Many Parts and Many Forms	138
Different Kinds of Gender Identity	146
Different Kinds of Gender Expression	149
The Role of Context and Privilege	159
Negating Social Responses to Gender Diversity	162
Affirming Social Responses to Gender Diversity	164
Negating Personal Responses to Gender Diversity	166
Affirming Personal Responses to Gender Diversity	167
Can a Person Change Their Sexual Orientation and Gender?	169
Understanding Sexuality, Gender, and Fluidity and What Likely Cannot Change	169
Understanding Motives to Change	176
Understanding the Positive Stories about SO/GICE	178
Understanding the Negative Stories about SO/GICE	181
Moving Forward: Focusing on What We Know Helps Everyone.....	190
Harmful Beliefs and Behaviors about Sexual and Gender Diversity to Avoid.....	201
Signs of Safe and Helpful Care.....	207
Using Affirmative Skills and Actions to Reduce Minority Stress in an Assertive Way.....	211
Conclusion.....	224
Contributors' Bios	228
Endnotes	232

Exploring Attitudes about Sexual and Gender Diversity

Coauthors include A. Lee Beckstead, Matthew Nielson, Samuel Eshleman Latimer, Heather Hoffmann, and Eduardo Peres.¹

Attitudes about sexual and gender diversity vary widely across people, cultures, and communities. They range from denial, hatred, disgust, disapproval, pity, skepticism, and indifference to tolerance, acceptance, affirmation, celebration, advocacy, liberation, collaboration, and nurturing.² These attitudes involve different beliefs, feelings, reasons, actions, and results.

For example, a person could appreciate LGBTQIA+* people for what they have to go through and what they can teach us about sexuality and gender. A person can have mixed feelings about sexual and gender diversity. Someone might feel proud about one part of it and feel disgusted about another part. For example, the Netherlands became the first country to legalize same-sex marriage in 2001. National surveys^{3 4} show that about 9 in 10 adults in the Netherlands believe that gay and bisexual people should have the same rights as heterosexual people and be free to live as

* In this book, we use the term LGBTQIA+ as an umbrella term. We know these letters do not name every sexual or gender identity or experience. Some people use different words for themselves. Some people do not use labels. If you are not exclusively heterosexual and gender typical, we respectfully invite you to read LGBTQIA+ in this book as including you. Our goal is to include all people whose sexual orientation, romantic orientation, gender identity, gender expression, body, and/or relationships differ from sexual and gender norms. You may also notice other terms, such as LGBT, LGBTQ+, LGBQA, or LGB. We use these terms when describing research studies, settings, or groups that used those exact words. We also use the terms *sexual and gender minority* and *sexually and gender diverse* to describe a wide range of experiences and people without focusing on specific labels or categories.

they wish. At the same time, about one third of adults report feeling discomfort when seeing two men kiss in public. Fewer adults report discomfort when two women kiss.^{5 6}

Even with strong legal protections, Dutch sexual and gender minority (SGM) teens report higher rates of bullying than heterosexual and *cisgender** teens. National school surveys^{7 8} have found that LGBT youth are about two to three times as likely to report being bullied. They are also more likely to report being bullied by teachers or school staff. Bullying often happens in places with less adult supervision, such as changing rooms, toilets, bike sheds, parking areas, and online spaces.

In the United States, LGBT adults experience much higher rates of *violent victimization*† than non-LGBT adults. National crime data show that LGBT adults report violent victimization at about five times the rate of non-LGBT adults.^{9 10} They also report *violent hate crimes*‡ at much higher rates, with some studies¹¹ estimating about eight to nine times the rate reported by non-LGBT people. Within sexual orientation groups, gay and lesbian adults report about twice the rate of violent victimization compared with heterosexual adults, while bisexual adults report even higher rates.^{12 13} Transgender adults also face elevated risk, with national data suggesting they experience violent victimization about four times as often as cisgender adults.^{14 15}

At the same time, public attitudes in the United States have become more supportive. Recent 2026 research¹⁶ from the Public Religion Research Institute finds that about 72% of U.S. adults support nondiscrimination

* *Cisgender* is a term used for people whose gender identity, such as girl or woman, or boy or man, matches the sex they were assigned at birth, female or male. *Transgender*, *nonbinary*, and *gender-diverse* are terms used for people whose gender identity differs from the sex they were assigned at birth and/or does not fit within binary categories of female or male.

† *Violent victimization* means being harmed by crimes like assault, robbery, or sexual assault.

‡ *Violent hate-crimes* mean a violent crime occurs and the victim believes it was caused by hate or bias, such as against their race/ethnicity, gender identity, and/or sexual orientation.

Can a Person Change Their Sexual Orientation and Gender?

The question of whether someone can and should change their sexual orientation or gender is very debated and emotional. People argue about it in science, therapy, religion, families, and politics. If you have searched online for answers, you have probably seen very different messages, from “no, trying to change is harmful” to “sexual orientation and gender are flexible, and research is biased.”

Some researchers and therapists from many political views want to study sexual and gender fluidity in ways that are less influenced by politics.^{836 837} Other researchers and therapists support laws in many parts of the world that ban all sexual orientation and gender identity change efforts (SO/GICE,^{838 839} sometimes called “conversion therapy”) because of many consumers’ reports that these efforts do not work and can cause harm.

Clearly, there is a lot of tension and disagreement about whether, and how much, sexual orientation and gender can change for children, teens, and adults. The next section will try to clear up some common misunderstandings and explain the details that have added to these conflicts about SO/GICE. With this more complete and inclusive understanding, we will point out what kinds of changes in sexuality and gender identity can happen and for which groups of people.

Understanding Sexuality, Gender, and Fluidity and What Likely Cannot Change

The current scientific theory for the causes of same-sex sexual attractions involves multiple, potentially distinct, pathways, some originating prior to birth.^{840 841} These pathways may involve interactions among genetic influences, prenatal sex hormones, and immune system processes during

important periods when the brain and body are developing.^{842 843 844 845 846} This research suggests that people who experience same-sex attraction are a very diverse group, not all the same. For example, Thomas Felsina and Brendan Zietsch⁸⁴⁷ describe same-sex behavior as having “a complex poly-genetic architecture,” meaning many genes are involved in different ways for people of different sexes.

As noted earlier, current research⁸⁴⁸ suggests that sexual and gender diversity, and some traits linked to these, may be shaped before birth. However, for many people who were assigned female at birth, sexuality may not always feel fixed or the same across life. Their attractions can be more fluid and shaped by close relationships, emotions, and life experiences.^{849 850 851} This means their attractions may shift over time or in different situations, rather than staying exactly the same from birth.

Many people use identity labels that allow for attraction to more than one gender. These include bisexual, fluid, pansexual, omnisexual, mostly straight, mostly gay or lesbian, heteroflexible, queer, and other plurisexual identities. Studies^{852 853 854} suggest that plurisexual orientations are more common than strictly same-sex orientations. Most people who report attraction to more than one gender are assigned female at birth. Among people assigned male at birth, more tend to identify as heterosexual or gay than as bisexual or fluid.

Some people describe their changing attractions as natural and unplanned. They often say these shifts happen because of specific relationships or emotional connections.⁸⁵⁵ Research by Lisa Diamond⁸⁵⁶ followed nearly 100 cisgender women for 10 years who first identified as nonheterosexual. More than two thirds changed their sexual identity label at least once during that time. For some, their attractions or relationships also shifted. These patterns of change in attraction, behavior, or identity over time are often described as *sexual fluidity*.

Research^{857 858} by Meredith Chivers and her colleagues on physical arousal shows differences between people assigned female at birth and people assigned male at birth. People assigned female at birth tend to be less *category specific*. Their bodies may respond to a wide range of sexual images, regardless of the sex traits shown. However, their physical response does not always match their identity or their actual desires. Over-

all, fluid, bi, pan, and other plurisexual people often describe more flexibility in attraction across time and relationships, while monosexual people usually describe attraction focused on one gender.⁸⁵⁹

Most AMAB people tend to have more category-specific arousal: their bodies respond mostly to one gender (for example, only to men or only to women). Some people, especially AMAB people, also describe feeling physical dislike or disgust, not just lack of interest, at the idea of sex with a gender they do not prefer, though this has not been deeply studied.⁸⁶⁰

Some individuals are *sexual minorities within sexual minorities*, meaning their sexual arousal patterns are less common even compared with other sexual minorities. For example, some AFAB people are very focused on women only, some AMAB people are attracted to more than one gender, some people are attracted only to children or teens or much older adults, some are attracted to both minors and adults, some are attracted to no one, and some have specific sexual fetishes. Attraction to minors or nonconsenting adults is always a serious ethical and legal concern and must never be acted on.⁸⁶¹ People with such attractions must find ways to live with their sexual arousal in safe ways.

Some transgender and nonbinary people notice changes in their sexual desire, behavior, or identity during and after transition. One study⁸⁶² found that some trans women had lower sexual desire in the first three months of hormone therapy, while some trans men had higher desire; after about three years, desire in both groups was close to or higher than before. Other research^{863 864 865 866} suggests that changes in sexuality often relate to more self-exploration and feeling freer to be attracted to more than one gender, or to no one at all. Some people say their attractions shift a lot, and they feel more desire for a different gender than before transition, which can come with better sexual functioning, confidence, and satisfaction as their body and gender feel more “right.” Others describe these changes as more body-driven, linked to biology or smell, and some say they did not want these changes.

These experiences show that attraction and sexual identity can be fluid and flexible and expand for some people, and this fits within a plurisexual orientation, where a person can be attracted to more than one gender over time.

Gender identity can also change over time for some people, and past research gives us only a partial picture of how this happens. Earlier studies on gender fluidity looked at children who were brought to gender clinics because their parents were worried about the child's gender-related behavior and interests. Follow-up studies^{867 868} conducted by Ken Zucker, Susan Bradley, and colleagues found that most children did not continue to experience gender dysphoria in adolescence, although some did.

These older findings may not fully apply to youth today, because the children in those studies were different from many children and teens seen in clinics now, and the ways clinicians diagnosed and treated gender issues were less strict in the past.⁸⁶⁹ Many children back then were referred simply for breaking gender stereotypes or saying they wished they were “the opposite sex,” rather than having strong, ongoing, and distressing gender dysphoria. Also, before the 2000s, most minors seen in clinics were assigned male at birth; today, most youth seeking care are assigned female at birth.

In the 1960s, Richard Green^{870 871} was a psychiatrist and lawyer who conducted a 15-year study on 44 gender-nonconforming AMAB children. Their parents had brought them to clinics for what was then called “childhood gender identity disorder.” Like many clinicians of his time, Green tried to change family patterns so that parents would discourage feminine behavior and reward masculine behavior. Over time, most of these children grew up to be gay or bisexual cisgender men; a few grew up to be heterosexual or asexual cisgender men, and one continued to experience gender dysphoria and lived as a woman in adulthood. Green⁸⁷² later argued that gender variance itself should not be seen as a disorder that needs a cure.

Decades later, researchers and clinicians^{873 874 875} at the Amsterdam Gender Identity Clinic conducted similar longitudinal follow-up studies. They found that only some children who were referred for gender dysphoria or gender-related concerns continued to experience gender dysphoria in their teen and adult years. Children with stronger and more consistent early dysphoria were more likely to continue experiencing dysphoria later.

These studies also report that a minority of adolescents who start puberty blockers later stop experiencing enough dysphoria to want further medical care. Most teens who begin puberty blockers go on to use gender-affirming hormone therapy. A smaller group later chooses surgeries, usu-

ally after age 18. Research in this area is still developing, and long-term outcomes can vary depending on the person, the timing of care, and the support they receive from family, communities, and health professionals.

These different outcomes reflect the many ways young people make sense of their gender experiences as their bodies, feelings, relationships, social environments, and understanding of themselves change over time. Because young people follow many different developmental paths, the goal should not be to ban gender-affirming care. Instead, clinicians and caregivers should avoid pushing a cisgender or transgender identity or discouraging a transgender or nonbinary identity.^{876 877} The purpose of gender-affirming care is to provide person-centered support as young people and adults explore and develop their own understanding of their sexual and gender identities, without pressure toward any particular outcome. In this way, gender-affirming care also supports the health and well-being of gender-diverse people throughout their lives.^{878 879 880}

As discussed earlier, social influences can shape how people interpret, understand, and describe their gender experiences in more than one direction. Some people who make social changes, such as changing their names, pronouns, or clothing, or medical changes, such as using hormones or surgeries, later stop, reverse, or adjust parts of their transition. Some call this *detransition*, *re-transition*, or *course correction*.^{881 882 883 884 885 886887 888}

Some people say they paused or reversed transition because they wanted to hide their trans or nonbinary identity due to discrimination, lack of care, or financial barriers. Others say that, over time, their understanding of gender and of themselves changed. At the same time, many transgender and nonbinary people continue to feel that transition supports their well-being and helps their bodies, identities, and social roles feel more aligned.

Some people who later regret their gender transition describe a “honeymoon stage” at first. They enjoyed the effects of hormones. They also felt encouraged by positive responses from others. Many said they felt a strong sense of belonging in trans, nonbinary, and gender-diverse communities. Some changed their identity from transgender to cisgender or to a nonbinary label. They say they realized that their main struggles were related to mental health concerns or internalized sexism, not gender dysphoria. They had thought that living as the other sex would be easier than living as the

sex they were assigned at birth. Over time, they found that changing their gender identity and expression did not resolve their emotional pain. They also came to understand that their idea of what makes a “real” man, woman, or trans/nonbinary person had been too narrow. They now describe having more self-awareness and acceptance of their body, their sex traits, and their own way of being a man, woman, or nonbinary person.

Some of these individuals are suing their doctors and therapists. They say they were pushed toward transition and did not get careful evaluations, good mental health treatment, or full informed consent. They wish they had been given more time, more chances to explore options, and more support to understand their own needs. They also say they wanted a clear discussion of the possible health and sexual risks before starting medical treatments.

Reports about people who stop or change their transition have increased while many more minors and young adults are identifying as transgender or nonbinary. This rise has been especially strong among those assigned female at birth who are being referred to gender clinics around the world.^{889 890 891 892} This rise began in the late 2000s and increased more quickly during the 2010s, with particularly steep growth in the mid-2010s. It is not clear how many trans and nonbinary minors mainly feel upset about their body parts related to gender and sex (how their body is seen by themselves and others as male or female), how many mainly feel upset about gender roles (rules about how boys and girls are ‘supposed’ to act), or how many feel both.

Some people consider this increase as a good sign. They believe more gender-diverse youth are coming out because there are more words and labels for gender, more public visibility, more education, more acceptance, and better access to gender-affirming healthcare.

Others are worried about this increase. They fear that some youth may be strongly affected by peers and social media, rather than taking time for deep self-reflection or having a clear biological or psychological basis for being transgender. As highlighted earlier, some critics⁸⁹³ describe this as a kind of *social contagion*, where young people are drawn toward a “trans ideology” and pushed by aggressive activists, schools, parents, and communities in ways that do not fit everyone.

Some people link this rise in trans-identifying youth to *rapid-onset gender dysphoria*, a term Lisa Littman⁸⁹⁴ introduced in 2018. She used it to describe reports from some parents who said their teens, often AFAB, seemed to develop gender dysphoria and a trans or nonbinary identity suddenly, in friend groups, and/or after engaging in affirming trans-related content. Some people who detransition also say they felt misled by cultural stories, rigid gender stereotypes, and community messages that made it seem like transition was a guaranteed cure for all their emotional pain.

Stories about misled youth are now being used in politics and law in some regions to (a) stop all teachers from sharing positive information about gender diversity or allowing social transition and (b) block all health providers from offering medical support to gender-body dysphoric minors or adults. These bans clash with earlier research, such as a 2013 Dutch study,⁸⁹⁵ that did not find that young people's psychological functioning and quality of peer relationships predicted the persistence of their cross-gender identity.

Saying that all transgender and nonbinary identities come from social contagion because some youth desist or because some people detransition dismisses and erases the experiences of many gender-diverse people. Many report that they noticed their sense of being male, female, both, or neither, and their comfort with different forms of masculinity and femininity, before they knew that transgender and nonbinary people existed. This wide range of gender identities, expressions, and levels of fluidity suggests that a single approach to gender and gender diversity will likely harm at least one group, and possibly many, of the children, teens, and adults involved.

It is also important to tell the difference between changes in parts of a person's sexual identity, sexuality, gender identity, or gender expression and changes in sexual orientation or gender-body experience and gender-role orientation. Sexual orientation involves patterns of attraction and aversion and how fixed or fluid those patterns are over time. If a person has sexual fluidity and their attractions, behaviors, or identity labels shift during their life, this does not necessarily mean their sexual orientation has changed. A person who can be attracted to more than one gender remains plurisexual, not monosexual, even if which gender they feel more attracted to changes at different times. A person's mix and degree of attrac-

tions, aversions, and fluidity also shape how they describe their sexual identity, such as bisexual with a straight lean, pansexual, mainly gay, only straight, only lesbian, asexual, and other labels.

In a similar way, if someone has gender-role fluidity and sometimes shows up as more feminine, more masculine, or a mix, depending on culture and situation, that does not by itself mean their gender has changed. Similarly, a person's experience of being more male, more female, both, or neither (their resonance or dissonance with maleness and femaleness) may stay the same, even if the labels they use for their gender identity and their gender expression shift over time as they better understand themselves.

It is also important to separate natural and chosen "changes" of sexuality and gender expression with "effectiveness of therapy to facilitate change"⁸⁹⁶ of sexual orientation, gender-body experience, and gender-role orientation. Natural fluidity is not the same thing as trying to influence change through psychotherapy or other interventions.

Understanding Motives to Change

Many people in the past and today feel that their sexual orientation or gender expression is unwanted—by themselves, by others, or both—and look for ways to change it. These efforts have included lobotomies and other brain surgeries, sex hormone treatments, aversion methods (like electric shocks or pairing nausea with same-sex images or fantasies), "orgasmic reconditioning" (fantasizing about the other sex while masturbating), talk therapy, coaching, support groups, faith-based ministries, weekend retreats, strict avoidance or abstinence, trying to suppress feelings, and religious practices. Some people try these methods because they think changing is the only way to escape stigma, suffering, and social disadvantages linked with being sexually or gender diverse.

They may feel like they do not fit in with the visible LGBTQ+ community and struggle with being "a minority within a minority," feeling lonely and different even among other sexual and gender minorities. Others seek change efforts hoping to prepare for, repair, or improve a heterosexual relationship.

Some parents and caregivers require or pressure their child to take part in these interventions.⁸⁹⁷ They may hope that this will help their child be more socially “normal,” increase the chance of having grandchildren, or reduce their fears for their child’s safety and well-being if the child is not heterosexual and gender conforming.

Some providers who focus on change may assume that the social pressure their clients feel to hide or reject their sexual or gender diversity matches the clients’ own values and therefore should be supported.⁸⁹⁸ They may skip careful exploration of why the person wants to change and what areas of empowerment they are lacking. People who have taken in negative social messages about sexual and gender diversity often experience those beliefs as “deeply held” and part of who they are. Because of this, they may not question how cis-heterosexist norms and prejudice shape their ideas and options about sexuality and gender, or how those norms affect their self-image, choices, coping, relationships, and mental health.

Each person’s reasons for wanting to change their attraction patterns or gender expression are unique and important to understand. Taking time to explore a person’s distress and motivations can open up more options to meet both short-term needs and long-term goals. These options can include better mental health, a stronger or more honest heterosexual relationship (if they choose one), less shame and loneliness, healing from trauma, and learning to be more assertive with family members and with other sexual and gender minorities.

Some SGM people who want to be only heterosexual and gender-typical may hope for several things. They may want to:

- Have a heterosexual partner and raise biological children.
- Feel normal, acceptable, and like they belong by matching their gender and sexual expression to conservative religious or moral beliefs.
- Avoid religious, social, and family consequences for not following their beliefs and rules.
- Live in line with their cultural and religious or spiritual values, traditions, and ethics.

- Avoid what they fear will be a lonely, condemned, unsatisfying, unhealthy, and disadvantaged LGBTQ+ “lifestyle.”
- Keep important current relationships and find more support, connection, and validation.
- Work through sexual abuse, trauma, and attachment problems that affect their emotions and their sexual and romantic choices.
- Feel more hope, relief, and a deeper understanding of themselves.
- Reduce or stop the harm caused by unhealthy ways of coping.

One research participant⁸⁹⁹ articulated the crux of the dilemma: “We struggle to fit in, not just into society but within ourselves.”

Understanding the Positive Stories about SO/GICE

Our review of research did not find any positive studies, either qualitative or quantitative, showing that psychotherapy can successfully change a person’s gender identity or gender expression. The studies that looked at children whose gender dysphoria later went away cannot tell us what caused those changes or how their gender identity or expression developed over time.

For sexual orientation change efforts (SOCE), a few studies⁹⁰⁰ describe that some people appreciated these programs because they fit with their conservative beliefs and helped them live according to those values. Some participants said they felt comforted when told *conversion therapy narratives* that described them as naturally heterosexual and that their same-sex feelings came from unmet emotional needs or past experiences (*I am not inherently gay and bad*). They found hope in being given “root causes” to work on, such as acting in more traditionally masculine or feminine ways, healing from trauma, and forming closer relationships with same-sex parents or friends. These ideas and efforts made some feel understood and in control.

Some reports also mentioned benefits from being part of a community with people who shared similar ideas and goals. Participants said that in these groups, they could talk openly about their feelings, sometimes for the

first time after a lifetime of secrecy and shame.⁹⁰¹ Group activities, such as talking or hugging, helped reduce shame and the tendency to think of same-sex people only one way and in a sexual way.⁹⁰² For some, this sense of belonging eased their loneliness and gave them emotional support. They no longer felt lost and alone with their struggles.

According to their own reports, some people said that sexual orientation change efforts helped them feel like they “reduced” or “lessened” their same-sex attractions and fantasies, increased their interest in other-sex relationships, improved their emotional and spiritual well-being, and helped them build nonsexual friendships with same-sex peers.^{903 904 905 906}

Overall, these personal reports show that people who feel upset or confused about their attractions need support that helps them understand their sexuality, solve their unique problems, reduce shame or mental health challenges, feel more at peace with themselves, and form safe, close relationships.

Some researchers⁹⁰⁷ think that when people report both fewer same-sex attractions and more other-sex attractions, this may happen only for people who already have the ability to feel attraction to more than one gender before starting SOCE. Coauthor Beckstead suggests that when people in SOCE programs feel accepted and supported, it might lower their shame and anxiety linked to their attractions. Feeling less guilt or fear could lead to fewer compulsive or automatic sexual reactions when they experience same-sex attraction. This may help them reduce their same-sex sexual behaviors and may also affect how they choose to describe or label their sexuality. Their pluri-, mono-, or a-sexual orientation (degrees of attractions, aversions, and fluidity) doesn’t change. But their experience of their sexual orientation changes.

A drop in sexual urges or behaviors might seem like a change in attraction, but it may actually show better self-control and a calmer ability to make choices about behavior. Their sexual behaviors, attractions, and beliefs might shift or expand, but this does not necessarily mean their basic sexual orientation, how they experience attraction, has changed.

Some individuals undergoing SOCE may recover from sexual trauma and/or develop healthier romantic relationships, such as reducing patterns of idealization and devaluation. They may interpret these changes as a

decrease in same-sex attraction, particularly if their past attractions were tied to complex, negative sexual dynamics with individuals of the same sex.

Some research^{908 909} has found that a type of therapy called eye movement desensitization and reprocessing (EMDR) can make certain sexual fantasies feel less intense. However, these studies did not show that people's overall sexual attractions changed. They also did not explore how much those fantasies were linked to trauma or shame, which EMDR therapy often helps to reduce.

Coauthor Eshleman Latimer hypothesizes that some individuals who discover that they are sexually fluid through other-sex sexual relationships may interpret this experience as a decrease in same-sex attraction because same-sex attraction becomes less relevant to their lives. Very few individuals describe changing from a completely same-sex orientation to a completely heterosexual orientation, with an elimination and absence of same-sex attractions.

Mark Yarhouse⁹¹⁰ researched whether people could change their sexual orientation through faith-based ministries and noted the following:

Change of identity and behavior was more likely to be reported than change of attractions, although, on average, participants did report a shift away from same-sex attraction. I think it is accurate to say, however, that most participants did not experience as much of a shift as they had hoped for and more dramatic shifts were less likely.

A “decrease” in same-sex attraction should not be seen as a clear shift on the Kinsey scale; for example, from a 6 (only same-sex attraction) to a 5 (mostly same-sex but some other-sex attraction). Still, some people describe it that way. Others say it feels more like becoming less interested in sex overall, being better able to stay celibate, or feeling less sexual excitement. For some, it also means feeling fewer romantic feelings toward same-sex people. Yet some people's romantic orientation is different from their sexual orientation, as Lisa Diamond⁹¹¹ has noted. Because people interpret these experiences in different ways, researchers and clinicians need clearer definitions for words like “explore,” “identity,” “attraction,”

“desire,” “sexual orientation,” “gender,” “aversion,” “shame,” “disgust,” “fear,” “distress,” and “change.”⁹¹²

Whether a person is attracted to one gender or more than one, a safe and helpful approach is to care for their feelings of shame, anxiety, and depression. This support helps people explore, understand, and accept their sexual orientation and gender without added shame or undeserved guilt. It also helps them make choices that fit their values, body, and life circumstances.

Developing a nonjudgmental attitude through *mindfulness* can help people respond kindly to their emotions, feel more satisfied sexually, and reduce problematic porn use.⁹¹³ Studies⁹¹⁴ ⁹¹⁵ with cisgender heterosexual adults show that mindfulness skills during sex helps people notice their body’s signals, feel less distracted or judgmental, and enjoy sex more with their partners. They often practice skills like paying attention to their breathing, focusing on their physical sensations, and gently bringing their mind back when it wanders during sexual moments. Research⁹¹⁶ with Latine sexual minorities and their families also shows that mindfulness can reduce shame and help heal from the stress and trauma linked to sexual and gender minority experiences.

Understanding the Negative Stories about SO/GICE

The kind of distress reported by many people after taking part in sexual orientation or gender identity change efforts (SO/GICE) is different from the discomfort and distress that can happen in regular therapy. In normal psychotherapy, people of all sexual orientations and genders often talk about emotions they’ve avoided, such as fear, guilt, shame, sadness, anger, and grief. This can be uncomfortable and painful and may lead some people to avoid or stop therapy. However, feeling these emotions is normal and can be helpful when supported by a trained therapist. Ethical guidelines require therapists to teach clients ways to handle and process these emotions safely.

Distress linked to using SO/GICE, on the other hand, can be described as *psychache*. This term was introduced by Edwin Shneidman⁹¹⁷ to describe

deep emotional and mental pain that can lead people to suicidal thoughts: “the hurt, anguish, soreness, aching, psychological pain in the psyche or mind. . . . that result from frustrated psychological needs.” As noted in the section on social safety, when people reject themselves, it can hurt in the brain and body in ways that feel as painful as being physically hurt.⁹¹⁸

Research^{919 920} on sexual and gender minority people shows that psychache from social rejection, internalized stigma, feeling ‘less than,’ and loneliness is closely linked with higher risk for suicide. For example, one study⁹²¹ with religious LGB young adults found that this kind of emotional pain was strongly tied to internalized heterosexism and was even stronger when people used *negative religious coping* (for example, feeling rejected and punished by a higher power and believing their identity was sinful and morally wrong).

People who say they were harmed by SO/GICE often share similar stories.^{922 923 924 925 926 927 928} Many feel rejected by others and also reject or neglect themselves. They may feel panic and deep sadness as they try to stop their sexual feelings, follow strict gender roles, and meet unrealistic expectations. Some feel like a burden or a source of shame to their family. Many describe feeling unsafe, fake, and cut off from emotional connection with others. They may hide their pain and not tell anyone what they are going through. Some blame themselves for being different and believe they are “broken” and need to “fix” themselves. Others struggle to find meaning or a sense of purpose in their lives.

In some settings, emotional, physical, and/or sexual abuse have also been reported in SO/GICE, including humiliation, physical punishment, forced nudity, sexual assault, isolation, and/or deprivation of basic needs. A United Nations report⁹²⁹ described these practices as forms of torture and cruel, inhuman treatment.

In the past, most research on sexual orientation change efforts (SOCE) focused on trying to change people’s sexual orientation. However, pressuring or shaming someone who doesn’t follow strict gender roles, such as telling them to act more “like a typical man or woman” in hopes they will feel more heterosexual, is also considered a form of SOCE.⁹³⁰

As noted earlier, research^{931 932} suggests that reinforcing strict gender ideas and rules, sometimes done in SO/GICE, can increase guilt, shame,

problems with intimacy or sexual functioning, depression, and trouble expressing emotions. This can happen among people of many identities.⁹³³

⁹³⁴ ⁹³⁵ ⁹³⁶ ⁹³⁷ For example, a 2024 study⁹³⁸ found that Black bisexual+ men who feel pressure to fit into strict ideas about how “real men” should act can end up hiding their emotions and needs. This pressure can lead to emotional shut-down, trouble showing care and affection, and worry about always needing to “win” or be successful. They may also take in negative messages about bisexuality and Black masculinity, which can turn into internal anger or shame toward themselves (internalized stigma). Over time, this mix of rigid gender roles, internalized stigma, and the need to compete or succeed can increase stress and make it harder to build close, trusting relationships.

More recent studies have examined what happens when transgender and nonbinary people face pressure from professionals—like psychiatrists, psychologists, or counselors—to identify with the sex they were assigned at birth or to stop expressing their gender identity.⁹³⁹ One study⁹⁴⁰ also included questions about religious leaders trying to influence people as children or adults, while another⁹⁴¹ asked teens and young adults if anyone had tried to make them change their sexual orientation or gender identity. Across these studies, researchers found significant associations between these change efforts and poor mental health outcomes, including suicidal thoughts and psychological distress.

Other studies⁹⁴² ⁹⁴³ describing specific harm from gender identity change efforts show that people often describe feeling *gender performative stress*, meaning they feel pushed to act out a false version of themselves to satisfy and please others’ expectations. These studies also describe people experiencing more stigma in healthcare settings, developing internalized negative beliefs about their gender, and losing hope about their future.

Some people describe initially feeling hopeful when starting SO/GICE and encouraged to believe they could change. They describe this early “honeymoon phase” as providing comfort and/or belonging.⁹⁴⁴ However, they describe their hope fading and “turning sour” when they later rejected themselves and/or were rejected from their family and religious community for not changing enough.⁹⁴⁵ Some describe feeling deceived by their provider or program,⁹⁴⁶ unprepared to build a healthy and positive life with

a stigmatized sexual or gender identity, and left without ongoing support or guidance to help them accept and live well with that identity.

Overall, these personal reports show that many people who engage in SO/GICE suffer increased shame, self-blame, worthlessness, anxiety, depression, hopelessness, sexual problems, addiction, weight gain, isolation, loneliness, suicidal thoughts, loss of faith or trust, and/or delays in personal development.^{947 948 949 950 951}

All forms of SO/GICE are a type of *identity abuse* and add to minority stress when people push themselves, or are pushed by others, to reject (“turn against”) and distance themselves (“turn away”) from their sexual and romantic orientations and gender identity. These efforts are harmful by:

- Reinforcing false beliefs, prejudice, and stigma about sexual and gender diversity
- Reinforcing patterns of self-attack and self-neglect in hopes of resolving conflicts and experiencing worth, safety, and belonging
- Limiting exploration and education about healthy ways to meet relationship needs and resolve conflicts
- Creating false hopes that lead to disappointment and pain from self-rejection, self-betrayal, and self-abandonment.

These efforts can increase feelings of powerlessness and shame, making a person’s original conflicts even worse.

As Doug Haldeman⁹⁵² explained, people who try SO/GICE often feel guilt and shame not only about being same-gender attracted and/or gender diverse but also about not being able to change. Joel Anderson and colleagues⁹⁵³ described these developmental experiences as forms of complex trauma, religious trauma, and a moral injury. These experiences can teach people to distrust their own feelings, perceptions, needs, and limits and to keep secrets, which can weaken self-worth, connection with others, and disrupt a stable sense of identity.

Many sexual and gender minority individuals who take part in SO/GICE first trust the advice of their therapist, community leaders, or parents who tell them that change is possible. Later, some become disillusioned and discouraged and realize these efforts, and the ideas behind them, do not work

for them. When SGM people “turn toward” themselves and accept that their sexual and romantic orientations and gender expression are unlikely to change and do not need to change for them to value themselves, they often begin to feel more resolved. They can then focus on how to live positively with their sexual and romantic orientations and gender expression.

Major mental health organizations warn against providing SO/GICE because these practices can cause harm by making people believe that their natural likes, dislikes, behaviors, and mannerisms are inherently “wrong.”⁹⁵⁴ These organizations emphasize that reports of harm are more important to consider than reports of benefit. When harm is reported, it becomes the responsibility of those offering SO/GICE to show scientific evidence that their methods are safe and effective for everyone who uses them.

However, some researchers and clinicians argue that studies reporting harm from SOCE are cross-sectional and do not measure psychological distress before participation. For example, Paul Sullins⁹⁵⁵ reanalyzed a study by John Blosnich and colleagues⁹⁵⁶ and found that people who chose or were referred to SOCE had higher levels of prior distress, more adverse childhood experiences, and greater lifetime suicidality than sexual minority individuals who did not participate in SOCE. In his analysis, Sullins concluded that suicidality was not increased after SOCE and may have declined for some participants, challenging claims that SOCE directly causes suicidal behavior in all cases.

Some aspects of participating in religious and/or professional SO/GICE may reduce certain forms of minority stress (such as loneliness and lack of support and perspective), while reinforcing other forms (such as internalized stigma or messages that reject LGBTQIA+ identities). The impact may depend on the person’s unique characteristics, history, beliefs, level of conflict, and the specific type of SOCE involved. Some individuals report that engaging in SO/GICE ultimately led them to greater self-acceptance after they concluded that their sexual orientation and gender expression were not changeable.

These positive outcomes and the results from Sullins’ reanalysis should not affect the position of major health organizations or the laws that ban SO/GICE. Instead, these findings highlight the need for care and cultural competence. Professionals who provide help to people who feel distress

about their sexuality or gender should respond with openness, respect, and an understanding of the full range of sexual and gender diversity. This clinical humility helps create safe spaces for each client's identity development and personal growth.

We cannot predict how a person's identity will develop over time, and pushing someone toward one identity can interrupt their natural growth. Clinicians should not use "one-size-fits-all" approaches, especially with people seeking SO/GICE, including youth who feel distress about their body, assigned sex, or gender role, and who may already struggle with high suicidality, loneliness, and emotional pain.

Research⁹⁵⁷ on gender identity change efforts also warns that helpers should focus on reducing a person's distress and supporting their mental health, rather than trying to promote or block any specific gender identity. In the next section, we will share a list of harmful behaviors and assumptions that providers, leaders, educators, parents, and caregivers should avoid when talking about or responding to gender, sexual, and faith diversity. As Sullins noted,⁹⁵⁸ wishing to be heterosexual is still common, as 1 in 10 sexual minority people in Blosnich and colleagues' U.S. nationally representative study agreed with the statement, "If someone offered me the chance to be completely heterosexual, I would accept the chance."

Current research on SO/GICE cannot show clearly whether reported positive changes or harms come from SO/GICE itself. The positive changes may come from general parts of counseling, such as working through trauma and attachment wounds, building self-acceptance and self-compassion, and feeling seen, understood, and supported. Other possible factors include personal traits of people using SO/GICE, such as natural changes in their sexual or gender feelings, a strong desire for approval, personal accountability, strict religious or community expectations, and shifts in sex drive, emotional control, sexual behavior, or beliefs about sexuality, gender, and identity.⁹⁵⁹

The 2009 American Psychological Association's (APA) report⁹⁶⁰ on SOCE concluded, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective." Because of this lack of reliable data, APA con-

cluded that insufficient evidence supports using psychological interventions to change sexual orientation. This report further concluded,

Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they have succeeded and benefited from nonaversive SOCE from those who will later perceive that they have failed or been harmed.

We cannot predict if or how a person's attractions or gender expression might change, and there is no proven way to make this happen. Furthermore, as noted earlier, current research suggests people are likely born with a built-in tendency toward their pattern of attraction (or lack of attraction) and any degree of fluidity. Because of this, providers should not advertise or sell services that claim to change orientation or gender, and they should not promise or try to change these parts of a client. Existing professional prohibitions and legal bans on SO/GICE are understandable and justified. This ethical decision also makes it harder to study any future versions of these practices.

The benefits reported by people engaging in SOCE can happen in other kinds of support that:

- Leave out harmful parts of SOCE, such as reinforcing prejudice and stigma, creating false hopes about change, limiting exploration of healthy options, or pushing one identity outcome
- Include helpful parts of LGBTQIA-affirming care, such as working through negative beliefs and self-hate, supporting identity exploration and development, building safe ways for self-expression, and strengthening resilience to stigma and rejection.

However, people who seek SO/GICE are often from traditional or conservative religious backgrounds and may deeply distrust LGBTQ-affirming ideas, organizations, and helpers. Asking them to attend an LGBTQ-affirming group that feels “liberal” or “secular” can feel impossible to them. It can be like telling a Catholic person whose church closed to go to a

Jehovah's Witness Kingdom Hall or a Jewish synagogue to receive communion, which would not match their beliefs or needs.

At the same time, LGBTQ-affirming groups should not be seen as the "opposite extreme" or as only supporting one sexual or gender identity. They should welcome people of all faiths and backgrounds and support each person's identity development and well-being. Their purpose should be to reduce minority stress, not to push a single identity outcome, limit options, and add more pressure and shame.

Research can help clarify these concerns and guide how support is offered. Tyler Lefevor and colleagues conducted a two-year longitudinal study⁹⁶¹ of sexual minorities who were current or former members of The Church of Jesus Christ of Latter-day Saints (LDS). The results showed no evidence that trying to change sexual orientation led to real changes in sexual attractions or aversion two years later. Instead, the study found that people who tried to change were more likely to feel depressed and have less support two years later. The researchers noted that the level of harm, and whether these efforts are always ineffective for everyone, are still being debated.

Other research with a similar group shows a more mixed pattern. A recent study⁹⁶² by Rosik, Lefevor, and Beckstead also studied sexual minorities connected to the LDS church. The researchers tested whether socially desirable responding and past efforts to change sexual orientation were linked with depression, suicidality, and well-being. They found that sexual minorities in this sample who gave more socially desirable responses also reported less depression and suicidality and greater well-being. However, this does not necessarily mean they were doing better, as socially desirable responding can involve underreporting distress or emphasizing positive self-presentation. It may also reflect coping styles, personality traits, or awareness of social expectations. In this study, past efforts to change sexual orientation were not linked to mental health outcomes.

These findings can be understood in several ways. People who are more emotionally sensitive and aware of social expectations may be more likely to give socially desirable responses. In settings where same-sex attraction is discouraged, this awareness may increase fear of rejection and lead some sexual minority individuals to try to change their sexual orientation. At the

same time, socially desirable responding may reflect coping strategies, such as aligning with valued beliefs or maintaining social belonging.

Socially desirable responding is also associated with traits such as kindness, honesty, and respect for others, which can support strong relationships and well-being.^{963 964} Although sometimes viewed as bias or linked to minority stress, it may also reflect positive social qualities.

It is also important to note that people who attempt sexual orientation change efforts are not all the same. Their experiences vary widely. Some may experience increased distress, especially when their identity conflicts and shame continue. This may lead them to try harder to stop their attractions, which can increase their hopelessness and suicide risk.⁹⁶⁵ Others may instead adjust their relationships, beliefs, and/or goals in ways that support their well-being. In this study, no clear link was found between attempts to change sexual orientation and mental health outcomes, which may reflect individual differences and unmeasured factors.

Trying to change or stop same-sex attractions is not linked to higher suicide risk for everyone. However, for some people, it may be associated with increased risk and should be approached with care. Overall, the study explained only a small portion of mental health and well-being, suggesting that many other factors play a role, including personal traits, social support, stigma, identity development, resilience, and life experiences. For counselors and other helping professionals, these findings highlight the importance of understanding each person's unique context and supporting healthy coping, safe relationships, and a strong sense of self.

Rosik, Beckstead, and Lefevor⁹⁶⁶ analyzed a separate sample of sexual minority participants and offered careful, limited recommendations rather than broad endorsement of these efforts. This study included people who had tried SOCE in the past, people who had never tried them, and people who were still involved in them. Based on this range of experiences, these researchers emphasized caution and attention to each person's unique situation rather than assuming the same needs and outcome for everyone:

Because of this ambiguity and potential for [doctor-caused] harm, therapists should not bring up SOCE or pressure a client to attempt SOCE. Therapists should also exercise caution when speaking with clients

about [the clients'] personal SOCE and should seek to promote client self-determination and autonomy surrounding SOCE by focusing instead on clients' hopes and expectations of SOCE.

In sum, the answer to the question of *whether a person can change their sexual orientation or gender* is *no*, as defined in this book. We do not have consistent scientific evidence that anyone can deliberately change their *sexual orientation* (their pattern of sexual attraction, aversion, and fluidity, or lack thereof) or *gender* (their gender-body experience and gender-role orientation). Over time, some people notice that their attractions and/or gender expression can change or feel more flexible. This is different from trying to force, stop, or control those feelings.

A person's sexual and romantic orientations, gender-body experience, and gender-role orientation most likely cannot be changed. However, a person can change some parts of their sexual, romantic, and gender experiences. This can include how they think about themselves, how they describe their sexuality and gender, how they feel about their body, how they express themselves, how they relate to others, and how they understand and share their gender identity. Next, we will share options to consider.

Moving Forward: Focusing on What We Know Helps Everyone

A lack of comprehensive, nuanced research exists on SO/GICE.⁹⁶⁷ Here are some examples:

- How are bisexual, fluid, mostly gay, mostly straight, pansexual, omnisexual, heteroflexible, and other plurisexual orientations and identities alike, and how are they different? Which orientations have more flexibility and fluidity, and which tend to stay more stable? What personal and relational factors influence changes?
- What differentiates monosexuals from plurisexuals, and genderfluid from gender-binary individuals? And from each other? What are the common factors?

- How much, if at all, does each group feel sexual aversion (degree of physical dislike or disgust about sexual contact with a person of a gender they are not attracted to).
- How much, if at all, does each group experience gender-body aversion (degree of physical dislike or disgust to specific body traits that do not match the gender a person experiences themselves to be and how they want others to relate to them)?
- How do these types of sexual and gender aversions differ from attachment insecurities, internalized bias, social anxiety, social phobia, body dysmorphia, and gender shame that are treatable with psychological and social interventions?

As Andrew Choi and colleagues⁹⁶⁸ emphasized, people who are bisexual “...experience unique psychosocial vulnerabilities and their mental health needs and social identity remain underserved and understudied, respectively.” The same could be said for the wide range of people who are gender diverse.

It may seem wise to discourage cross-gender identity in childhood, since many young people with gender dysphoria later identify with their birth sex. However, development is not easy to predict, and some children will continue to suffer with gender-body incongruence after puberty. A rejecting or discouraging response to a child’s gender diversity can be unnecessary and may cause harm. It can lead to shame and make it harder for the child to explore and understand themselves. It may also affect how they feel about other gender-diverse people. Many children who later identify with their birth sex come to this on their own, often around or after puberty. This is a time when young people better understand their sexual orientation, their changing bodies, and the difference between body traits (maleness and femaleness) and gender roles (masculinity and femininity). Puberty is also a time when some gender-diverse young people begin to notice their gender-body dysphoria.

Many questions about gender identity are left answered:

- How does puberty and sexual orientation affect gender identity development? How does gender identity affect sexual identity development and vice versa?
- How are children with early-onset gender dysphoria different and similar to teens with late-onset gender dysphoria and from teens and young adults with rapid-onset gender dysphoria who later detransition? What harms and helps each group's unique gender identity development?
- What differentiates desisters from the young people and adults who detransition and from young people and adults who continue to suffer from gender-body incongruence?
- When should we medically intervene to help gender-body dysphoric young people who will suffer short- and long-term effects from puberty, and when can they make an informed decision about later fertility, sexual functioning, physical health, and the stability of their gender identity?

When addressing a controversial topic, one conflict management strategy is to break it down into subtopics and to refrain from making general statements that do not accurately capture the nuances of a particular issue. Because strong negative reactions and complex historical narratives are associated with the word “change,” using terms like “explore,” “identity development,” and “fluidity/plurisexuality” may be less directive and misleading. These terms avoid attacking people's choices, identities, and experiences and instead encourage openness, curiosity, inclusion, collaboration, and discovery, allowing for a continuum of experiences. These terms—including separating aspects of sexuality and gender expression into identity, behaviors, and attractions⁹⁶⁹—may be a more pragmatic way to pose questions that can guide social interactions and decision-making.

One of the first steps in discussing SO/GICE may involve revising the wording of the question itself. Although acceptable in other science areas, the word “change” escalates negative emotional responses in this conversation to such an extent that it impacts humans' ability to see the data clearly and be open to other hypotheses, especially those contradicting one's conclusions. Individuals who have an automatic reaction against

change may feel angry when they think about another individual forcing someone to change who they are, or about an individual forcing themselves to change due to being misled by prejudice. This perspective hinges on historical and modern examples of individuals being pressured to change due to rejection, self-rejection, and fear of ostracization, with no options for safe expressions of their gender identity and sexual orientation.

In contrast, individuals who react strongly against the message that “change is not possible” may feel angry if they have experienced their sexuality and/or gender expression as fluid. They may perceive the message as mischaracterizing, dismissing, or ridiculing their lived experiences, conservative values, religious beliefs, and/or personal autonomy. For example, a conservative person who believes sexuality and gender expression can be aligned to fit their values or has personally experienced changes in attraction and expression (“change is possible”) may react negatively to messages claiming that “change is not possible.”

As mentioned previously, conservative or not, some individuals experience their sexual attractions expanding within the context of certain emotionally intimate relationships. The emphasis on denying change can be challenging for fluid individuals, leading to stigmatization of both them and their partner(s).

Those who tried to change and felt harmed by the process, as well as those who tried to change and found more congruence, may have encountered similar painful experiences of being misunderstood, marginalized, and misdirected. One group of sexual and gender minority individuals who underwent SO/GICE to resolve distress may have felt confusion and pain from being told that desiring someone of the same gender is wrong or told that their gender expression is wrong or both. They may have learned to hate themselves and worked to free themselves from their desires. Some of these individuals were blamed or blamed themselves for failing to change and felt “broken” because the interventions had allegedly worked for others. This added to their distress.

Another group of sexual and gender minority individuals has painful emotions from being unable to reconcile people and institutions telling them they were born gay or trans and that it is impossible to change. They felt more alone with their struggles when they read these professional

reports or met with a therapist who told them they should leave their religion and tell their spouse that their marriage is fake. This invalidation and isolation added to their distress.

The gut feeling of anger and pain, which is a primary reaction to injustice, can overpower individuals' ability to be curious and engage with themselves and others with curiosity and critical thought. Furthermore, pushing someone toward a sexual or gender identity that the person is not ready to take on or does not fit them can backfire when the person turns elsewhere for understanding, answers, and support.⁹⁷⁰

In sum, one first step forward in addressing these issues is to be open to other people's experiences with SO/GICE. Individuals invested in learning about sexual orientation and gender, and about another person's sexual orientation and gender, may be fixated on defending their own (or their group's) personal attitude and narrative about 'change.' This defensive approach is understandable given the painful historical and ongoing cultural and political wars about SO/GICE. However, acting *defensively* limits our ability to evolve narratives and expand viewpoints. Defensiveness stops us from checking our own biases and our community's biases. This blocks understanding how each side of the culture war understands sexual orientation and gender and what they need to feel accepted and calm and thrive. Repeated defensiveness, misunderstanding, and fighting leave conflicts perpetually unresolved for all sides.

A second step forward is recognizing that when individuals desire to decrease their attraction to the same sex, several principles appear reliable, regardless of one's position on the political spectrum. It is the experience of coauthor Eshleman Latimer that individuals who want to decrease their sexual attractions—and therapists who have facilitated the process—generally agree that *focusing* on reducing same-sex attraction or increasing gender conformity as the main outcome can have unintended harmful side effects.

For example, there is a difference between focusing on building deeper romantic and emotional intimacy in an other-sex relationship than tracking consistently how attracted one is to other-sex individuals in general and trying to avoid any feelings toward those of one's same sex. Many individuals who are male-identified in other-sex or mixed-orientation rela-

tionships who grew up attracted to the same sex tend not to claim that they are attracted to all women and no men. Instead, they describe being sexually attracted to their female partner and possibly other women, only to the extent that they are emotionally connected to those women. Moreover, some report that they are still sexually attracted to men. This emotional/romantic/sexual bisexuality/fluidity can be similar for many female-identified and nonbinary individuals in mixed-orientation relationships.

Focusing on sex therapy may help couples understand how to increase or enjoy their eroticism or at least understand their own and their partner's erotic desires, limits, and needs, and explore win-win options.

The third point we might all agree on is that we currently do not know of any intervention that can reliably and validly change a person's sexual orientation (their predisposed attractions, aversions, and degree of fluidity) or their experience of their gender-body and gender-role orientation (their resonance and dissonance with male and femaleness and cultural gender roles). Any intervention that is assumed effective on one person or sexual orientation or gender identity should also work on all other non-heterosexual sexual orientations and gender identities.

Research⁹⁷¹ on pedophilic and hebephilic attractions similarly finds recommendations to focus on limiting sexual fantasizing about minors, managing effectively their sexual behaviors and sex drive, changing cognitive distortions, and learning relapse-prevention strategies, rather than trying to change attractions or condition sexual preferences toward adults.

Given this lack of evidence and potential for harm, it is unethical and consumer fraud⁹⁷² for therapists to use any intervention with the hope, promise, or even exploration of changing a client's sexual orientation or gender-body experience or gender-role orientation.

A fourth focus moving forward is reducing shame, self-hatred, anxiety, depression, trauma, attachment insecurities, and social phobias, as these factors can constrain or amplify the intensity and felt experience of attractions, arousals, desires, and motivations. This focus may include interventions aimed at reducing unsafe or incongruent sexual behaviors. Therapists can encourage clients who express an interest in SO/GICE to use evidence-based methods to reduce their distress and enhance self-determination, such as developing mindfulness, self-acceptance, and self-

compassion; examining negative beliefs about the self and gender and sexual diversity; strengthening social support; and resolving past trauma.

Some interventions have synergistic or adjunctive benefits (for example, improving emotional regulation, developing self-worth, and building friendships). Any improved mental health occurs on a spectrum associated with many gender and sexual variables that allow for more choice from a secure sense of self, rather than as a categorical shift from exclusively homosexual to exclusively heterosexual. The focus should be on improving mental health and functioning and being open to whether it affects the person's sexuality and understanding of their gender identity.

The fifth area we may agree on is that some interventions and assumptions are clearly harmful (for example, using shame or aversive cognitive and behavioral methods; reinforcing messages and prejudice that LGBTQ+ individuals are pedophiles or gay/lesbian/queer relationships are inherently unhealthy and dysfunctional). If individuals engage in coercive or unrealistic attempts to change their attractions or use any strategy that increases self-hatred, this can lead to harmful mental health outcomes.

However, we should not generalize too quickly regarding harm and sexuality and gender. If a person attempts to reduce their attraction to a sexual perpetrator or someone they find distressing, it may or may not be helpful, with possible unintended side effects. If a person works to increase their desire for their heterosexual spouse, including increased sexual and romantic attractions, it may or may not be helpful and may depend on the methods and the person's innate fluidity.

Sixth, we hope these ideas help many SGM groups. This includes people who do not want to act on certain sexual urges and desires, such as fetishes or attractions to people who cannot give legal or ethical consent. Instead of trying to change a person's sexual orientation, therapy can focus on parts of their sexuality that can grow and develop. These include a person's beliefs, values, motivations, goals, self-acceptance, self-knowledge, relationship skills, behaviors, social identity, sense of purpose, life satisfaction, safe outlets of self-expression, and commitment to consensual sexual and romantic relationships.

Some clients believe their life experiences, including trauma, have shaped their attractions or behaviors. They may come to therapy hoping

for some change. Talking through these experiences and using trauma-informed interventions may help them better understand and relate to their sexuality. Some clients may not yet know how strong or lasting their attractions are, or if their feelings change over time. Anxiety, depression, or trauma can also affect desire, fear, or insecurity. Therapists who support people with stigmatized sexualities should talk about the wide range of sexual and romantic orientations and identities. It is also important to discuss minority stress and how stigma has limited what we know and understand about this diversity.

Seventh, given the definitions we noted previously, a person cannot change their gender but could change aspects of their *gender identity*, which we use as an umbrella category similar to a person's sexual identity. A person could explore and reconsider their views about gender norms and expectations, along with their judgments about their own gender experiences, sex characteristics, body, gender expression, and sense of self. People can figure out and understand their gender identity by knowing their gender-body experience (their resonance and dissonance with maleness and femaleness). They can figure out and understand their gender-role orientation by thinking about which gender roles, activities, ways of being and expressing themselves feel right and most natural and comfortable to them and which do not (their resonance and dissonance with masculinity and femininity, as defined by their culture).

Aspects of gender identity that a person can change include their internalized gender-based stigma, gender evaluations, gender-role expectations, and gender social label. As noted previously, gender-role incongruence, gender shame, and internalized stigma can be treated with psychological and social interventions, while gender-body incongruence may require medical considerations.

Eighth, we have more in common than we think. Rosik and colleagues,⁹⁷³ in another analysis of their diverse sample, found 13 interventions that were rated as helpful to all subgroups regardless of identity and faith in addressing their sexual orientation distress:

- Identify your authentic needs and learn to meet them in healthy ways.

- Accept your sexual feelings (or lack thereof) nonjudgmentally and make decisions based on your values.
- Learn strategies to reduce anxiety, depression, shame, and other mental distress.
- Learn how to act more assertively rather than passively, codependently, passively aggressive, or aggressively.
- Learn how to connect on a deep emotional level with others, regardless of gender.
- Express who you are, rather than holding yourself back, so others can understand you.
- Affirm your own gender expression and ways of being masculine and feminine.
- Work through traumatic memories from physical, emotional, and/or sexual abuse.
- Help others who are distressed about their sexual attractions and gender.
- “Come out” and tell others about your sexual and gender diversity.
- “Demystify” same-sex and queer individuals by identifying with them to make them no longer “exotic” and seeking out relationships that are more authentic and mutual.
- Accept both your sexuality and your faith or spirituality, see both as complementary, and find ways to integrate them.
- Learn how others have accepted or made peace with their same-sex attractions and gender diversity while still choosing to live their values.

For non-LGBTQ-identified participants, surrendering to a Higher Power and limiting sexual fantasizing were rated consistently helpful in reducing distress with their sexual orientation. For LGBTQ-identified participants, affirming and enjoying their attractions was rated consistently helpful. Getting angry, punishing, or shaming oneself or using other aversive methods when sexually attracted and pairing sexual fantasies with negative consequences were rated consistently harmful, regardless of sexual orientation or identity.

Normative and non-normative models of sexual and gender development are still being developed. Experts do not agree on every detail. Because of this, providers should practice scientific humility and stay curious about each client's unique experience. Providers should continue learning and seek consultation from professionals with different viewpoints. If needed, they should refer clients to specialists in sexual and gender diversity who do not treat these identities as problems, deficiencies, or defects.

A treatment approach that focuses only on averages and statistics is not a good fit for this group. People have different sexual and romantic orientations and gender expressions, and they respond to life in different ways. When too much focus is placed on what is "normal" or average, people whose experiences are less common will be ignored or invalidated. This can increase minority stress.

Sexual and gender identity development calls for care that supports each person's unique path rather than fixed expectations. Providers should stay open, person-centered, and curious and use interventions that improve health and well-being. Each client's sexual orientation, romantic orientation, gender-body experience, gender-role orientation, and identity growth should be approached as a unique human experience and new territories to discover.

Alfred Kinsey and colleagues⁹⁷⁴ put it this way:

Only the human mind invents categories and tries to force facts into separated pigeon-holes. The living world is a continuum in each and every one of its aspects. The sooner we learn this concerning human sexual behavior, the sooner we shall reach a sound understanding of the realities of sex.

Pause and Reflect

- What are your thoughts and feelings about this section? Did anything strongly match your life or the lives of people you know? Did anything not fit?
- What are the most important ideas you are taking from this section, *Can a Person Change Their Sexual Orientation and Gender?*
- Is there one idea, skill, or behavior from this section that you want to practice? How do you hope it could help you and others respond to bias or harmful messages about sexuality and gender?

Harmful Beliefs and Behaviors about Sexual and Gender Diversity to Avoid

David Matheson once provided SOCE and now speaks out against it. Based on what he observed as a provider and what he experienced in communities offering SOCE, he created a list of harms. He has given us permission to publish this list.^{* 975 976}

The first four kinds of harm describe things that providers do. We call these *harmful provider actions*. A provider is a helper, such as a therapist, counselor, coach, group leader, retreat leader, religious leader, politician, community leader, teacher, parent, caregiver, or guardian. When we use the word “provider,” we mean anyone in one of these helping roles. When we use the word “client,” we mean the person the provider is meant to support and care for. For parents and caregivers, this includes their own children and other children in their care.

We hope this list helps providers understand what to avoid when working with people who are sexually and gender diverse. We also hope it supports people who have been hurt or pressured to change who they are. Finally, we hope it helps people who seek help for questions, concerns, or stress related to their sexual orientation or gender expression recognize and avoid harmful provider behaviors.

Predatory Harm

This kind of harm can happen in any type of care, not just in SO/GICE. It occurs when a provider has hidden goals or their own motives and manip-

* For a longer list of helpful and harmful practices, including harms that LGBTQ-affirming providers may also cause, visit: https://reconciliationandgrowth.org/wp-content/uploads/2025/02/RGP-Declaration_02-2025.pdf

ulates, exploits, and uses a person to get what they want at the other person's expense. The provider may seek status, fame, money, sexual gratification, or emotional comfort for themselves, instead of focusing on caring about the client's safety, needs, limits, and well-being.⁹⁷⁷

Warning signs of predatory harm include:

- The provider asks for gifts, extra money, or favors that are just for them and not part of your normal payment.
- The provider wants private meetings, calls, or messages that feel secret, flirty, or wrong. They might tell you not to tell anyone what happens in your sessions.
- The provider talks a lot about their own feelings or problems instead of focusing on you or shares personal details that do not help your care.
- You leave sessions feeling used, unsafe, confused, exploited, manipulated, or like something is “off,” even if you cannot say exactly why.
- The provider suggests that you owe them love, sex, or special loyalty, or says your relationship is “more than professional.”
- The provider asks sexual questions that do not fit your treatment, touches you without your permission or in ways that feel wrong, or includes nudity in sessions.

Hurtful Methods Harm

Some of these methods are specific to SO/GICE, and some are not. This harm includes:

- Using painful or shaming methods to push someone to change or conform.
- Using words, stories, or activities that make someone feel fear, suspicion, guilt, shame, or ongoing stress.

- Teaching or repeating hurtful beliefs about LGBTQIA+ people (for example, saying that being gay is a mental illness, a “dangerous lifestyle,” or a sign of being “broken”).
- Blaming the person’s character, effort, or motivation when change does not happen.
- Cutting off, rejecting, abandoning, or excluding someone because of choices that a group calls “wrong,” even when those choices do not cause physical harm.
- Using methods that cause clear and immediate pain, discomfort, anxiety, or distress to force someone to obey or to change.

False Premise Harm

This type of harm is unique to SO/GICE and may result from a provider:

- Using methods, processes, techniques, or pharmacological or homeopathic substances that are falsely believed to change sexual orientation or gender identity, are ineffective or wasteful of time and money, and/or cause short or long-term distress (for example, not considering that suppressing sexual or gender feelings may result in resentment, irritability, lying, dissociation,⁹⁷⁸ or impulsive behaviors later).
- Creating or reinforcing expectations and promises and suggesting that treatment will result in change or a person will outgrow their feelings and desires.
- Continuing to dig and look for “causes” and attempting “cures” and refusing to accept failure of therapeutic approach due to a belief that sexual and gender diversity must be fixed and is curable.⁹⁷⁹
- Sharing false, misleading, or unproven claims and information about LGBTQIA+ people, relationships, health, or culture. For example, saying that full affirmation always leads to “sexual addiction” or a shorter life⁹⁸⁰ or suggesting directly or indirectly that certain gender roles, clothing, hobbies, or behaviors will help a person be more heterosexual, cisgender, or healthier.

- Referring clients to books, talks, videos, podcasts, or online material that insult LGBTQIA+ people and their relationships, deny their worth, or say that being LGBTQIA+ is a defect or a mental problem.
- Claiming to “protect” a person by warning them not to explore their sexual identity, gender expression, or same-gender romantic or sexual relationships.

Provider Error Harm

This type of harm is not unique to SO/GICE. It happens when providers make mistakes that are hurtful, based on false ideas, or even predatory. This harm can come from:

- Poor decisions by well-trained providers.
- Mistakes in care by providers who do not have enough training.
- A provider’s own health or well-being being in bad shape and compromised.
- Providers not knowing or following basic ethics, not checking for the impact of minority stress and trauma, not checking for depression, anxiety, or suicidal thoughts, and not watching how clients react to therapy and changing the plan when needed.

Treatment failure can happen to most, if not all, providers. Because of this, it is important to determine the criteria to evaluate competence from incompetence⁹⁸¹ and when a provider is doing their best and when they are not providing safe and competent care. Changing and improving treatment plans that are not helping may reduce treatment failure and help prevent harm from providers. Authentic apologies from providers can be healing. This is why it is good practice for all providers to ask often how clients feel about therapy and about the provider’s methods and approach.

All four of these *harmful provider actions* can add to another group of harms, called *client challenges and needs*. This distress includes the client’s mental health struggles and coping patterns that help in the short term but also cause problems over time. These challenges can be present before

and during treatment. They can be shaped by a mix of factors, including personal traits, natural temperaments, and life experiences, along with stress from stigma, identity conflict, trauma, lack of safe options, and social pressure.

These challenges can make it more difficult for people to live as their full, healthful, and authentic selves, and often play a key role in why they seek help. These challenges do not come from SO/GICE. Many people already experience them before engaging in SO/GICE. Because of this, it is usually impossible to know exactly where each challenge or harm began. The key point is that providers must avoid the harmful actions listed earlier and take care not to add to or worsen a client's existing struggles and needs.

Delayed Resolution

This type of harm occurs when a provider's actions delay a person from exploring, discovering, understanding, and accepting their sexual orientation, romantic orientation, gender-body experience, and gender-role orientation and pursuing what supports their health and well-being. The harm happens when a client remains stuck in patterns that do not fit their sexual orientation, romantic orientation, or gender identity, or that do not meet their healthful needs.

As a result, their ability to make informed choices, reduce or resolve inner conflicts, and meet their emotional and relationship needs may be delayed. These delays can cost time and money and may leave people feeling stuck, tired, frustrated, irritable, or depressed.

Self-Negation

Self-negation is a form of mental and emotional harm. This can affect anyone involved in SO/GICE. It may happen through a provider's words or actions and when a provider goes along with or strengthens a person's self-rejection and harsh beliefs about themselves. These harms can include providers:

- Undermining a person's self-worth, self-respect, confidence, and self-trust.
- Adding to or reinforcing thoughts of shame, self-blame, undeserved guilt, doubt, inadequacy, deficiency, depression, anxiety, loneliness, and hopelessness.
- Encouraging distrust of therapy, spirituality, or both.
- Encouraging a person to shut down and avoid feelings or hide authentic emotional needs or parts of their personality.
- Reinforcing beliefs that a person is wicked, evil, or beyond redemption, or that they deserve negative eternal consequences (for example, "I was taught that the divine would punish me for being a gay man"⁹⁸²).
- Reinforcing beliefs that a person's life does not matter or that they are condemned and meant to suffer.

Many people who seek SO/GICE already carry painful beliefs about themselves. If providers do not help a person examine these beliefs with care, the person's distress may grow worse.

People who feel they have "failed" at SO/GICE may have been taught not to identify as LGBTQIA+ and may not have learned how to live well as a LGBTQIA+ person. They may not have developed skills to respond effectively to stigma and rejection or to build a positive and meaningful life as a sexual or gender minority person. When people feel like a failure and a burden, feel alone and without hope, and/or feel cut off from themselves, the risk of suicide can rise.⁹⁸³ As one person said, "I came to the place of trying to kill myself because I didn't want to be labeled a homosexual."⁹⁸⁴

Self-Harm and Self-Neglect

This type of harm happens when people hurt themselves. It can grow from internalized stigma, shame, painful self-rejection, self-neglect, and ongoing pressure to change and meet unrealistic expectations from family, religion, culture, and society. These self-harms can include avoiding people and responsibilities, not meeting important needs, talking harshly to one-

self, and engaging in risky or addictive behaviors, such as sexual behaviors that feel self-violating, alcohol or drug abuse, self-injury, or thoughts of suicide or suicide attempts.

Collateral Damage

These harms affect people close to the person engaging in SO/GICE, especially spouses and children, because of the harms the person experiences. Delays in personal resolution and the financial strain of taking part in SO/GICE may increase distress, delay family resolution, and create financial burdens. Some people may also develop more negative feelings toward their parents when providers of SO/GICE suggest that “bad parenting” caused their sexual or gender diversity.⁹⁸⁵

Signs of Safe and Helpful Care

To help balance these harms, it can be useful to learn the signs of safe and supportive care. These signs can help you recognize when a provider is working to reduce distress and supporting health and well-being rather than adding to pain. Safe and effective care also recognizes that many people carry past trauma and live with multiple, overlapping aspects of identity. These may include race or ethnicity, culture, disability/ability, religion or faith, financial situation, gender, and sexuality. These experiences can shape both sources of stress and sources of strength.

The following are some signs of supportive and respectful care:

- The provider clearly says they will not try to change your sexual orientation or gender identity. They also stay open to how your identity may grow or change over time.
- Your gender expression and sexuality are respected and named the way you choose.
- You are treated as a whole person. Your full identity is respected, including how your sexuality, romantic style, and gender connect

with your ethnicity, culture, faith or purpose in life, disabilities/abilities, way of thinking, family, and community.

- The provider works to create emotional and physical safety. They help you build your own sense of safety and check in about what helps you feel safe during sessions.
- After most sessions, you feel safer, calmer, or more hopeful or understood.
- The provider listens with care. They ask questions to understand you and your experiences and do not judge, shame, or blame but focus on helping you understand and resolve your distress.
- You can say, “This is not helping,” and the provider works with you to make changes together.
- The provider asks about depression, anxiety, trauma, self-harm, and thoughts about suicide in a caring and supportive way.
- The provider names minority stress, stigma, prejudice, discrimination, and rejection as real problems. They do not treat these as your fault or something you are making up.
- The provider understands that harm and well-being can come from many places and may affect people differently based on their identities and life experiences.
- The provider supports your right to explore your identity, relationships, culture, spirituality, and community at your own pace.
- You are never pressured to hide, deny, or fight any part of who you are.
- The provider uses accurate and up-to-date information about LGBTQIA+ health and lives across diverse communities.
- Your spiritual, cultural, sexual, romantic, and family values are explored with care and respect to understand you and your needs. They are not used against you.
- The provider welcomes your feedback and checks in about how therapy feels and whether it is helping.

One important part of supportive and effective care is using approaches that reduce shame. Shame can grow when people are treated as if something is wrong with who they are. It often comes from unrealistic expecta-

tions and false or harmful messages. Shame may be used to pressure people to comply or change. As described in the previous social safety section, shame can create a sense of social threat that can lead to self-rejection and painful stress responses in the mind and body.

Supportive providers work to reduce this kind of stigma and harm. They understand that shame and punishment do not lead to lasting or meaningful change. Instead, they help clients feel respected and valued while teaching skills clients need to address their challenges. Research⁹⁸⁶ shows that approaches based on dignity, respect, and empowerment are more effective in reducing distress and helping people address problems.

For example, people who are struggling with faith may benefit from practices that help them feel loved and accepted by the divine or a higher power. Some may understand this as being a child of God or gods, while others may think of themselves as stardust and part of the universe or connected to something greater than themselves. These practices can remind people that they have worth and value that do not depend on performance or expectations.

Supportive providers also help reduce shame by appreciating a client's efforts and strengths. They may explain how harsh self-beliefs, unfair expectations, and self-rejection can affect mental and physical health, and help clients learn kinder ways to relate to themselves. Learning self-compassion⁹⁸⁷ can help people notice and gently replace shame and other self-disempowering patterns. As noted earlier, these skills may include noticing self-rejecting thoughts, speaking to yourself with the same kindness you would offer a close friend, and remembering that many people go through similar struggles.

We hope this section helps you think about what you need and don't need when you face stress or pain related to sexual or gender diversity. What patterns did you notice that may help keep your mind, body, and spirit safe and strong? As you review the signs of harm and the signs of good care, take time to check in with yourself and be curious about your feelings and needs. Use this information to find support that respects your dignity and helps you understand and resolve your distress with sexual and gender diversity.

Pause and Reflect

- What are your thoughts and feelings about this section? Did anything strongly match your life or the lives of people you know? Did anything not fit?
- What are the most important ideas you are taking from this section, *Harmful Beliefs and Behaviors about Sexual and Gender Diversity to Avoid*?
- Is there one idea, skill, or behavior from this section that you want to practice? How do you hope it could help you and others respond to bias or harmful messages about sexuality and gender?
- If you disagree with LGBTQIA-affirmative interventions, how would your approach to sexual and gender diversity address the above concerns of harm and client experiences and needs? What would you say are signs of safe and helpful care?

833. Vaillancourt, T., Hymel, S., & McDougall, P. (2003). Bullying is power: Implications for school-based intervention strategies. *Journal of Applied School Psychology*, 19(2), 157–176. https://doi.org/10.1300/J370v19n02_10
834. Pu, Y., Budge, S. L., & Xu, W. (2025). The bright side of gender nonconformity among Chinese cisgender LGQ individuals: Life satisfaction, positive sexual identity, and interpersonal resources. *International Journal of Sexual Health*, 1–18. <https://doi.org/10.1080/19317611.2025.2577731>
835. Richards, C., Bouman, W. P., Seal, L., Barker, M. J., Nieder, T. O., & T’Sjoen, G. (2016). Non-binary or genderqueer genders. *International Review of Psychiatry*, 28(1), 95–102. <https://doi.org/10.3109/09540261.2015.1106449>
836. Bailey, J. M., Vasey, P. L., Diamond, L. M., Breedlove, S. M., Vilain, E., & Epprecht, M. (2016). Sexual orientation, controversy, and science. *Psychological Science in the Public Interest*, 17(2), 45–101. <https://doi.org/10.1177/1529100616637616>
837. Rosik, C., Beckstead, A. L., & Lefevor, G. T. (2025). Associations between health, identity labeling, sexuality changes, and engagement status of sexual orientation change efforts. *Journal of Open Inquiry in the Behavioral Sciences*. Researchers.One. <https://researchers.one/articles/25.01.00002v1>
838. Haldeman, D. C. (Ed.). (2022). The case against conversion “therapy”: Evidence, ethics, and alternatives. American Psychological Association. <https://doi.org/10.1037/0000266-000>
839. American Psychological Association. (2021). Resolution on sexual orientation change efforts. <https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf>
840. VanderLaan, D. P., Skorska, M. N., Peragine, D. E., & Coome, L. A. (2023). Carving the biodevelopment of same-sex sexual orientation at its joints. *Archives of Sexual Behavior*, 52(7), 2939–2962. <https://doi.org/10.1007/s10508-022-02360-1>

841. Folkierska-Żukowska, M., & Dragan, W. Ł. (2025). Biodevelopmental correlates of sexual orientation in men: Evidence from a Polish sample. *Archives of Sexual Behavior*, 54(8), 2825–2838. <https://doi.org/10.1007/s10508-024-03018-w>
842. Blanchard, R. (2018). Fraternal birth order, family size, and male homosexuality: Meta-analysis of studies spanning 25 years. *Archives of Sexual Behavior*, 47(1), 1–15. <https://doi.org/10.1007/s10508-017-1007-4>
843. Breedlove, S. M. (2017). Prenatal influences on human sexual orientation: Expectations versus data. *Archives of Sexual Behavior*, 46(6), 1583–1592. <https://doi.org/10.1007/s10508-016-0904-2>
844. LeVay, S. (2016). *Gay, straight, and the reason why: The science of sexual orientation* (2nd ed.). Oxford University Press.
845. Sadr-Bazzaz, M., & Vasey, P. L. (2025). Birth order and sibling sex ratio predict same-sex sexual attraction in Iranian cisgender and transgender adult males and females. *Archives of Sexual Behavior*, 54(8), 3111–3126. <https://doi.org/10.1007/s10508-025-03249-5>
846. Skorska, M. N., Blanchard, R., VanderLaan, D. P., Zucker, K. J., & Bogaert, A. F. (2017). Gay male only-children: Evidence for low birth weight and high maternal miscarriage rates. *Archives of Sexual Behavior*, 46(1), 205–215. <https://doi.org/10.1007/s10508-016-0829-9>
847. Felesina, T., & Zietsch, B. P. (2025). Emerging insights into the genetics and evolution of human same-sex sexual behavior. *Trends in Genetics*. Advance online publication. <https://doi.org/10.1016/j.tig.2024.12.005>
848. Xu, Y., Norton, S., & Rahman, Q. (2019). Early life conditions and adolescent sexual orientation: A prospective birth cohort study. *Developmental Psychology*, 55(6), 1226–1243. <https://doi.org/10.1037/dev0000704>
849. Diamond, L. M., Alley, J., Dickenson, J., & Blair, K. L. (2020). Who counts as sexually fluid? Comparing four different types of sexual fluidity in women. *Archives of Sexual Behavior*, 49(7), 2389–2403. <https://doi.org/10.1007/s10508-019-01565-1>

850. Dickenson, J. A., Diamond, L. M., King, J. B., Jenson, K., & Anderson, J. S. (2020). Understanding heterosexual women's erotic flexibility: The role of attention in sexual evaluations and neural responses to sexual stimuli. *Social Cognitive and Affective Neuroscience*, 15(4), 447–465. <https://doi.org/10.1093/scan/nsaa058>
851. Katz-Wise, S. L., Ranker, L. R., Gordon, A. R., Xuan, Z., & Nelson, K. M. (2022). Sociodemographic patterns in retrospective sexual orientation identity and attraction change in the Sexual Orientation Fluidity in Youth Study. *Journal of Adolescent Health*, 72(3), 437–443. <https://doi.org/10.1016/j.jadohealth.2022.10.015>
852. Savin-Williams, R. C. (2016). Sexual orientation: Categories or continuum? Commentary on Bailey et al. (2016). *Psychological Science in the Public Interest*, 17(2), 37–44. <https://doi.org/10.1177/1529100616637618>
853. Gallup. (2024, March 13). LGBTQ+ identification in U.S. now at 7.6%. Gallup News. <https://news.gallup.com/poll/611864/lgbtq-identification.aspx>
854. Pew Research Center. (2023, June 23). 5 key findings about LGBTQ Americans. <https://www.pewresearch.org/short-reads/2023/06/23/5-key-findings-about-lgbtq-americans>
855. Diamond, L. M. (2016). Sexual fluidity in males and females. *Current Sexual Health Reports*, 8(4), 249–256. <https://doi.org/10.1007/s11930-016-0092-z>
856. Diamond, L. M. (2009). *Sexual fluidity: Understanding women's love and desire*. Harvard University Press.
857. Chivers, M. L., Rieger, G., Latty, E., & Bailey, J. M. (2004). A sex difference in the specificity of sexual arousal. *Psychological Science*, 15(11), 736–744. <https://doi.org/10.1111/j.0956-7976.2004.00750.x>
858. Chivers, M. L., Seto, M. C., & Blanchard, R. (2007). Gender and sexual orientation differences in sexual response to sexual activities versus gender of actors in sexual films. *Journal of Personality and Social Psychology*, 93(6), 1108–1121. <https://doi.org/10.1037/0022-3514.93.6.1108>

859. Slettevold, E., Holmes, L., Gruia, D., Nyssen, C. P., Watts-Overall, T. M., & Rieger, G. (2019). Bisexual men with bisexual and monosexual genital arousal patterns. *Biological Psychology*, 148, 107763. <https://doi.org/10.1016/j.biopsycho.2019.107763>
860. For more information, read Beckstead, A. L., Metzler, S. C., Buspavnick, P., Morgan, E., & Cooper, M. A. (2024). Develop your sexual/gender self-knowledge. In A. L. Beckstead, J. Cheng, S. Giwa, M. A. Yarhouse, & I. Žegura (Eds.), *Feel secure in yourself: A guidebook for LGBTQIA+ people and those with a different label or no label*. Bloomsbury.
861. B4U-ACT. (n.d.). Our mission. <https://www.b4uact.org/about-us/our-mission>
862. Defreyne, J., Elaut, E., Kreukels, B., Fisher, A. D., Castellini, G., Staphorsius, A., den Heijer, M., Heylens, G., & T'Sjoen, G. (2020). Sexual desire changes in transgender individuals upon initiation of hormone treatment: Results from the longitudinal European Network for the Investigation of Gender Incongruence study. *Journal of Sexual Medicine*, 17(4), 812–825. <https://doi.org/10.1016/j.jsxm.2019.12.020>
863. Auer, M. K., Fuss, J., Höhne, N., Stalla, G. K., & Sievers, C. (2014). Transgender transitioning and change of self-reported sexual orientation. *PLOS ONE*, 9(10), e110016. <https://doi.org/10.1371/journal.pone.0110016>
864. Lindley, L., Anzani, A., & Galupo, M. P. (2022). Gender dysphoria and sexual well-being among trans masculine and nonbinary individuals. *Archives of Sexual Behavior*, 51(4), 2049–2063. <https://doi.org/10.1007/s10508-021-02242-y>
865. Katz-Wise, S. L., Williams, D. N., Keo-Meier, C. L., Budge, S. L., Pardo, S. T., & Sharp, C. (2017). Longitudinal associations of sexual fluidity and health in transgender men and cisgender women and men. *Psychology of Sexual Orientation and Gender Diversity*, 4(4), 460–471. <https://doi.org/10.1037/sgd0000246>
866. Lawrence, A. A. (2005). Sexuality before and after male-to-female sex reassignment surgery. *Archives of Sexual Behavior*, 34(2), 147–166. <https://doi.org/10.1007/s10508-005-1793-y>

867. Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. Guilford Press.
868. Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry*, 12, 632784. <https://doi.org/10.3389/fpsyt.2021.632784>
869. Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M.-L., Jamieson, A., & Pickett, S. (2018). A critical commentary on follow-up studies and “desistance” theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, 19(2), 212–224. <https://doi.org/10.1080/15532739.2018.1456390>
870. Green, R. (1987). *The “sissy boy syndrome” and the development of homosexuality*. Yale University Press.
871. Green, R. (2008). Childhood cross-gender behavior and adult homosexuality: Why the link? *Journal of Gay & Lesbian Mental Health*, 12(1–2), 17–28. https://doi.org/10.1300/J529v12n01_03
872. Green, R. (2018). *Gay rights, trans rights: A psychiatrist/lawyer’s 50-year battle*. Agenda Publishing.
873. Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, 16(4), 499–516. <https://doi.org/10.1177/1359104510378303>
874. Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52(6), 582–590. <https://doi.org/10.1016/j.jaac.2013.03.016>
875. Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(12), 1413–1423. <https://doi.org/10.1097/CHI.0b013e31818956b9>

876. de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59(3), 301–320. <https://doi.org/10.1080/00918369.2012.653300>
877. Reconciliation and Growth Project. (2025, February). Declaration on avoiding harm in work related to sexual orientation and gender identity. Reconciliation and Growth Project. https://reconciliationandgrowth.org/wp-content/uploads/2025/02/RGP-Declaration_02-2025.pdf
878. D’Angelo, R. (2024). Supporting autonomy in young people with gender dysphoria: Psychotherapy is not conversion therapy. *Journal of Medical Ethics*, 51(1), 3–9. <https://doi.org/10.1136/jme-2023-109282>
879. Newhook, J. T., Winters, K., Pyne, J., Jamieson, A., Holmes, C., Feder, S., Pickett, S., & Sinnott, M.-L. (2018). Teach your parents and providers well: Call for refocus on the health of trans and gender-diverse children. *Canadian Family Physician*, 64(5), 332–335.
880. Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., ... Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health*, 23(Suppl. 1), S1–S259. <https://doi.org/10.1080/26895269.2022.2100644>
881. Expósito-Campos, P., Salaberria, K., Pérez-Fernández, J. I., & Gómez-Gil, E. (2023). Gender detransition: A critical review of the literature. *Actas Españolas de Psiquiatría*, 51(3), 98–118.
882. Irwig, M. S. (2022). Detransition among transgender and gender-diverse people—An increasing and increasingly complex phenomenon. *Journal of Clinical Endocrinology & Metabolism*, 107(10), e4261–e4262. <https://doi.org/10.1210/clinem/dgac356>
883. Jorgensen, S. C. J. (2023). Transition regret and detransition: Meanings and uncertainties. *Archives of Sexual Behavior*, 52(5), 2173–2184. <https://doi.org/10.1007/s10508-023-02626-2>

884. Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, 50(8), 3353–3369. <https://doi.org/10.1007/s10508-021-02163-w>
885. Lomax, J., & Butler, C. (2025). Narratives of adults registered female at birth who started a medical transition and later detransitioned. *Archives of Sexual Behavior*, 54(6), 1671–1686. <https://doi.org/10.1007/s10508-025-03083-9>
886. MacKinnon, K. R., Kia, H., Gould, W. A., Ross, L. E., Abramovich, A., Enxuga, G., & Lam, J. S. H. (2024). A typology of pathways to detransition: Considerations for care practice with transgender and gender diverse people who stop or reverse their gender transition. *Psychology of Sexual Orientation and Gender Diversity*, 11(3), 231–244. <https://doi.org/10.1037/sgd0000678>
887. Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender identity 5 years after social transition. *Pediatrics*, 150(2), e2021056082. <https://doi.org/10.1542/peds.2021-056082>
888. Vandebussche, E. (2022). Detransition-related needs and support: A cross-sectional online survey. *Journal of Homosexuality*, 69(9), 1602–1620. <https://doi.org/10.1080/00918369.2021.1919479>
889. Expósito-Campos, P., Gómez-Balaguer, M., Hurtado-Murillo, F., & Morillas-Ariño, C. (2023). Evolution and trends in referrals to a specialist gender identity unit in Spain over 10 years (2012–2021). *Journal of Sexual Medicine*, 20(3), 377–387. <https://doi.org/10.1093/jsxmed/qdac034>
890. Fielding, J., & Bass, C. (2018). Individuals seeking gender reassignment: Marked increase in demand for services. *BJPsych Bulletin*, 42(5), 206–210. <https://doi.org/10.1192/bjb.2018.30>
891. Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisé, L., Schorkopf, M., Suomalainen, L., & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. *Nordic Journal of Psychiatry*, 74(1), 40–44. <https://doi.org/10.1080/08039488.2019.1667429>

892. Pang, K. C., de Graaf, N. M., Chew, D., Hoq, M., Keith, D. R., Carmichael, P., & Steensma, T. D. (2020). Association of media coverage of transgender and gender diverse issues with rates of referral of transgender children and adolescents to specialist gender clinics in the UK and Australia. *JAMA Network Open*, 3(7), e2011161. <https://doi.org/10.1001/jamanetworkopen.2020.11161>
893. Wright, C. (2025, October 29). Evidence backs the transgender social contagion hypothesis. *The Wall Street Journal*. <https://www.wsj.com/opinion/evidence-backs-the-transgender-social-contagion-hypothesis-4093787>
894. Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE*, 14(3), e0214157. <https://doi.org/10.1371/journal.pone.0214157>
895. Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52(6), 582–590. <https://doi.org/10.1016/j.jaac.2013.03.016>
896. As Richard Sprott, PhD, described when he reviewed another book in this book project.
897. Glassgold, J., & Ryan, C. (2022). The role of families in efforts to change, support, and affirm sexual orientation, gender identity, and gender expression in children and youth. In D. C. Haldeman (Ed.), *The case against conversion “therapy”: Evidence, ethics, and alternatives* (pp. 89–107). American Psychological Association.
898. Green, R.-J. (2003). When therapists do not want their clients to be homosexual: A response to Rosik’s article. *Journal of Marital and Family Therapy*, 29(1), 29–38. <https://doi.org/10.1111/j.1752-0606.2003.tb00380.x>
899. On page 666 in Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients’ experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist*, 32(5), 651–690. <https://doi.org/10.1177/0011000004267555>

900. For a review, see American Psychological Association. (2009). Appropriate therapeutic responses to sexual orientation. <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>
901. Flentje, A., Heck, N. C., & Cochran, B. N. (2014). Experiences of ex-gay individuals in sexual reorientation therapy: Reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality*, 61(9), 1242–1268. <https://doi.org/10.1080/00918369.2014.926763>
902. Vásquez, D. A., Newman, J. L., Frey, L. L., Caze, T. J., Friedman, A. N., & Meek, W. D. (2014). Relational health and masculine gender-role conflict in the friendships and community relationships of bisexual, gay, and straight men. *Journal of LGBT Issues in Counseling*, 8(2), 124–145. <https://doi.org/10.1080/15538605.2014.895662>
903. Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Hyde, D. C., & Crowell, K. A. (2015). Sexual orientation change efforts among current or former LDS church members. *Journal of Counseling Psychology*, 62(2), 95–105. <https://doi.org/10.1037/cou0000011>
904. Karten, E. Y., & Wade, J. C. (2010). Sexual orientation change efforts in men: A client perspective. *Journal of Men's Studies*, 18(1), 84–102. <https://doi.org/10.3149/jms.1801.84>
905. Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86(3, Pt. 3), 1071–1088. <https://doi.org/10.2466/pr0.2000.86.3c.1071>
906. Stanus, W. E. (2018). The lived experience of men in reparative therapy (Master's thesis). Trinity Western University.
907. Vasey, P. L., & Rendall, D. (2003). Sexual diversity and change along a continuum of bisexual desire. *Archives of Sexual Behavior*, 32(5), 453–455. <https://doi.org/10.1023/A:1025699511081>
908. Allen, A., McKillop, N., Katsikitis, M., & Millear, P. (2023). The effects of bilateral stimulation using eye movements on sexual fantasies with follow-up. *Journal of Behavior Therapy and Experimental Psychiatry*, 79, 101826. <https://doi.org/10.1016/j.jbtep.2022.101826>

909. Bartels, R. M., Harkins, L., Harrison, S. C., Beard, N., & Beech, A. R. (2018). The effect of bilateral eye-movements versus no eye-movements on sexual fantasies. *Journal of Behavior Therapy and Experimental Psychiatry*, 59, 107–114. <https://doi.org/10.1016/j.jbtep.2018.01.001>
910. On page 236 in Yarhouse, M. A. (2019). *Sexual identity and faith: Helping clients achieve congruence*. Templeton Press.
911. Diamond, L. M. (2003). What does sexual orientation orient? A biobehavioral model distinguishing romantic love and sexual desire. *Psychological Review*, 110(1), 173–192. <https://doi.org/10.1037/0033-295X.110.1.173>
912. For a review, read Beckstead, A. L. Metzler, S. C., Buspavanich, P., Morgan, E., & Cooper, M. A. (2024). Develop your sexual/gender self-knowledge. In A. L. Beckstead, J. Cheng, S. Giwa, M. A. Yarhouse, & I. Zegura (Eds.), *Feel secure in yourself: A guidebook for LGBTQIA+ people and those with a different label or no label*. Bloomsbury.
913. Pareek, S., Jain, G., & Gupta, R. K. (2023). Efficacy of mindfulness meditation as a therapeutic tool in problematic pornography consumption. *Sexual Health & Compulsivity*, 30(4), 365–379. <https://doi.org/10.1080/26929953.2023.2270620>
914. Leavitt, C. E., Lefkowitz, E. S., & Waterman, E. A. (2019). The role of sexual mindfulness in sexual wellbeing, relational wellbeing, and self-esteem. *Journal of Sex & Marital Therapy*, 45(6), 497–509. <https://doi.org/10.1080/0092623X.2019.1572680>
915. Pepping, C. A., Cronin, T. J., Lyons, A., & Caldwell, J. G. (2018). The effects of mindfulness on sexual outcomes: The role of emotion regulation. *Archives of Sexual Behavior*, 47(6), 1601–1612. <https://doi.org/10.1007/s10508-017-1127-x>

916. Li, M. J., DiStefano, A. S., Thing, J. P., Black, D. S., Simpson, K., Unger, J. B., Milam, J., Contreras, R., & Bluthenthal, R. N. (2019). Seeking refuge in the present moment: A qualitatively refined model of dispositional mindfulness, minority stress, and psychosocial health among Latino/a sexual minorities and their families. *Psychology of Sexual Orientation and Gender Diversity*, 6(4), 408–419. <https://doi.org/10.1037/sgd0000338>
917. On page 51 in Shneidman, E. S. (1993). *Suicide as psychache: A clinical approach to self-destructive behavior*. Jason Aronson.
918. Eisenberger, N. I., Lieberman, M. D., & Williams, K. D. (2003). Does rejection hurt? An fMRI study of social exclusion. *Science*, 302(5643), 290–292. <https://doi.org/10.1126/science.1089134>
919. Peterson, A. L., Bender, A. M., Sullivan, B., & Karver, M. S. (2021). Ambient discrimination, victimization, and suicidality in a non-probability U.S. sample of LGBTQ adults. *Archives of Sexual Behavior*, 50(3), 1003–1014. <https://doi.org/10.1007/s10508-020-01888-4>
920. Wolford-Clevenger, C., Frantell, K., Smith, P. N., Flores, L. Y., & Stuart, G. L. (2018). Correlates of suicide ideation and behaviors among transgender people: A systematic review guided by ideation-to-action theory. *Clinical Psychology Review*, 63, 93–105. <https://doi.org/10.1016/j.cpr.2018.06.009>
921. Miles, J. R., Frantell, K. A., & Bourn, J. R. (2018). Internalized heterosexism, religious coping, and psychache in LGB young adults who identify as religious. *Psychology of Sexual Orientation and Gender Diversity*, 5(3), 303–312. <https://doi.org/10.1037/sgd0000274>
922. Baams, L., Grossman, A. H., & Russell, S. T. (2015). Minority stress and mechanisms of risk for depression and suicidal ideation among lesbian, gay, and bisexual youth. *Developmental Psychology*, 51(5), 688–696. <https://doi.org/10.1037/a0038994>
923. Feinstein, B. A. (2020). The rejection sensitivity model as a framework for understanding sexual minority mental health. *Archives of Sexual Behavior*, 49(7), 2243–2258. <https://doi.org/10.1007/s10508-019-1428-3>

924. Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology*, 51, 101579. <https://doi.org/10.1016/j.copsyc.2023.101579>
925. Grigoreva, D., & Szaszko, B. (2024). Minority stress and psychological well-being in queer populations. *Scientific Reports*, 14, 27084. <https://doi.org/10.1038/s41598-024-78545-6>
926. Michaels, C., Choi, N. Y., Adams, E. M., & Hitter, T. L. (2019). Testing a new model of sexual minority stress to assess the roles of meaning in life and internalized heterosexism on stress-related growth and life satisfaction. *Psychology of Sexual Orientation and Gender Diversity*, 6(2), 204–216. <https://doi.org/10.1037/sgd0000320>
927. Pachankis, J. E., Mahon, C. P., Jackson, S. D., Fetzner, B. K., & Bränström, R. (2020). Sexual orientation concealment and mental health: A conceptual and meta-analytic review. *Psychological Bulletin*, 146(10), 831–871. <https://doi.org/10.1037/bul0000271>
928. Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review*, 66, 24–38. <https://doi.org/10.1016/j.cpr.2018.03.003>
929. United Nations Human Rights Office of the High Commissioner. (2020, July 8). UN expert calls for global ban on practices of so-called “conversion therapy.” <https://www.ohchr.org/en/press-releases/2020/07/un-expert-calls-global-ban-practices-so-called-conversion-therapy>
930. American Psychological Association. (2021). Resolution on gender identity change efforts. <https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>
931. Robinson, C. M., & Spivey, S. E. (2007). The politics of masculinity and the ex-gay movement. *Gender & Society*, 21(5), 650–675. <https://doi.org/10.1177/0891243207306384>
932. Sullivan, T. S. (2018). Conversion therapy ground zero: Interrogating the production of gender as a pathology in the United States (Doctoral dissertation). California Institute of Integral Studies.

933. Sánchez, F. J., Blas-López, F. J., Martínez-Patiño, M. J., & Vilain, E. (2016). Masculine consciousness and anti-effeminacy among Latino and White gay men. *Psychology of Men & Masculinity*, 17(1), 54–63. <https://doi.org/10.1037/a0039465>
934. Sánchez, F. J., Westefeld, J. S., Liu, W. M., & Vilain, E. (2010). Masculine gender role conflict and negative feelings about being gay. *Professional Psychology: Research and Practice*, 41(2), 104–111. <https://doi.org/10.1037/a0015805>
935. Szymanski, D. M., & Carr, E. R. (2008). The roles of gender role conflict and internalized heterosexism in gay and bisexual men's psychological distress: Testing two mediation models. *Psychology of Men & Masculinity*, 9(1), 40–54. <https://doi.org/10.1037/1524-9220.9.1.40>
936. Szymanski, D. M., & Ikizler, A. S. (2013). Internalized heterosexism as a mediator in the relationship between gender role conflict, heterosexist discrimination, and depression among sexual minority men. *Psychology of Men & Masculinity*, 14(2), 211–219. <https://doi.org/10.1037/a0027787>
937. Vásquez, D. A., Newman, J. L., Frey, L. L., Caze, T. J., Friedman, A. N., & Meek, W. D. (2014). Relational health and masculine gender-role conflict in the friendships and community relationships of bisexual, gay, and straight men. *Journal of LGBT Issues in Counseling*, 8(2), 124–145. <https://doi.org/10.1080/15538605.2014.895662>
938. Del Pino, H. E., Steers, W. N., Lee, M., McCuller, J., Hays, R. D., & Harawa, N. T. (2022). Measuring gender role conflict, internalized stigma, and racial and sexual identity in behaviorally bisexual Black men. *Archives of Sexual Behavior*, 51(2), 1019–1030. <https://doi.org/10.1007/s10508-021-01925-w>
939. Veale, J. F., Tan, K. K. H., & Byrne, J. L. (2022). Gender identity change efforts faced by trans and nonbinary people in New Zealand: Associations with demographics, family rejection, internalized transphobia, and mental health. *Psychology of Sexual Orientation and Gender Diversity*, 9(4), 478–487. <https://doi.org/10.1037/sgd0000537>

940. Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, 77(1), 68–76. <https://doi.org/10.1001/jamapsychiatry.2019.2285>
941. Green, A. E., Price-Feeney, M., Dorison, S. H., & Pick, C. J. (2020). Self-reported conversion efforts and suicidality among US LGBTQ youths and young adults, 2018. *American Journal of Public Health*, 110(8), 1221–1227. <https://doi.org/10.2105/AJPH.2020.305701>
942. Tillewein, H., & Kruse-Diehr, A. J. (2023). The impact of sexual orientation conversion therapies on transgender individuals. *Psychology & Sexuality*, 14(3), 360–374. <https://doi.org/10.1080/19419899.2023.2188485>
943. Mammadli, T., Call, J., Whitfield, D. L., Holloway, B. T., & Walls, N. E. (2024). Understanding harms associated with gender identity conversion efforts among transgender and nonbinary individuals: The role of preexisting mental well-being. *International Journal of Transgender Health*, 25(1–2), 1–23. <https://doi.org/10.1080/26895269.2024.2333531>
944. Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice*, 33(3), 249–259. <https://doi.org/10.1037/0735-7028.33.3.249>
945. Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences with conversion therapy: The need for a new treatment approach. *The Counseling Psychologist*, 32(5), 651–690. <https://doi.org/10.1177/0011000004267555>
946. *Ferguson v. JONAH*, No. L-5473-12 (N.J. Super. Ct. Dec. 18, 2015).
947. American Psychological Association. (2009). Appropriate therapeutic responses to sexual orientation. <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>
948. American Psychological Association. (2021). Resolution on gender identity change efforts. <https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>

949. American Psychological Association. (2021). Resolution on sexual orientation change efforts. <https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf>
950. Haldeman, D. C. (Ed.). (2022). The case against conversion “therapy”: Evidence, ethics, and alternatives. American Psychological Association. <https://doi.org/10.1037/0000266-000>
951. Anderson, J. R., Jones, T. W., Power, J., Jones, T. M., Despott, N., Pallotta-Chiarolli, M., & Gurtler, P. (2025). Mental health practitioners’ knowledge of LGBTQA+ conversion practices and their perceptions of impacts on survivors. *Journal of Homosexuality*. Advance online publication. <https://doi.org/10.1080/00918369.2024.2319615>
952. Haldeman, D. C. (2025). Helping LGBTQ+ clients recover from conversion therapy or non-affirming care experiences. In N. A. Livingston, B. A. Feinstein, & M. Paz Galupo (Eds.), *Addressing minority stress and enhancing resilience with diverse LGBTQ+ clients* (pp. 89–113). Springer. <https://doi.org/10.1007/978-3-031-92836-9>
953. Anderson, J. R., Jones, T. W., Power, J., Jones, T. M., Despott, N., Pallotta-Chiarolli, M., & Gurtler, P. (2025). Mental health practitioners’ knowledge of LGBTQA+ conversion practices and their perceptions of impacts on survivors. *Journal of Homosexuality*. Advance online publication. <https://doi.org/10.1080/00918369.2024.2319615>
954. Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., Meyer-Bahlburg, H. F. L., Pleak, R. R., & Tompkins, D. A. (2012). Report of the American Psychiatric Association Task Force on treatment of gender identity disorder. *Archives of Sexual Behavior*, 41(4), 759–796. <https://doi.org/10.1007/s10508-012-9975-x>
955. Sullins, D. P. (2022). Sexual orientation change efforts do not increase suicide: Correcting a false research narrative. *Archives of Sexual Behavior*, 51(7), 3377–3393. <https://doi.org/10.1007/s10508-022-02408-2>

956. Blosnich, J. R., Henderson, E. R., Coulter, R. W. S., Goldbach, J. T., & Meyer, I. H. (2020). Sexual orientation change efforts, adverse childhood experiences, and suicide ideation and attempt among sexual minority adults, United States, 2016–2018. *American Journal of Public Health*, 110(7), 1024–1030. <https://doi.org/10.2105/AJPH.2020.305637>
957. Mammadli, T., Call, J., Whitfield, D. L., Holloway, B. T., & Walls, N. E. (2024). Understanding harms associated with gender identity conversion efforts among transgender and nonbinary individuals: The role of preexisting mental well-being. *International Journal of Transgender Health*, 25(1–2), 157–179. <https://doi.org/10.1080/26895269.2024.2333531>
958. Sullins, D. P. (2023). Critiques strengthen and improve the original findings: Rejoinder to commentaries on Sullins (2022b). *Archives of Sexual Behavior*, 52(3), 889–899. <https://doi.org/10.1007/s10508-023-02566-x>
959. Beckstead, A. L. (2012). Can we change sexual orientation? *Archives of Sexual Behavior*, 41(1), 121–134. <https://doi.org/10.1007/s10508-012-9922-x>
960. On page 43 in Glassgold, J., Beckstead, A. L., Drescher, J., Greene, B., Miller, R. I., & Worthington, R. L. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. American Psychological Association.
961. Lefevor, G. T., Beckstead, A. L., Rosick, C. H., Yarhouse, M. A., & Mansfield, T. (submitted for publication). A pre-registered, prospective, longitudinal examination of the impact of self-initiated sexual orientation change efforts on health and changes in sexuality.
962. Rosick, C. H., Lefevor, G. T., & Beckstead, A. L. (submitted for publication). Looking good? Accounting for social desirability responding in the relationship between mental health, well-being, and sexual orientation change efforts.

963. Bäckström, M., Björklund, F., & Larsson, M. R. (2009). Five-factor inventories have a major general factor related to social desirability which can be reduced by framing items neutrally. *Journal of Research in Personality*, 43(3), 335–344. <https://doi.org/10.1016/j.jrp.2008.12.013>
964. Zettler, I., Hilbig, B. E., & Moshagen, M. (2013). Dishonest responding and the HEXACO model: Delving deeper into the role of Honesty–Humility. *Personality and Individual Differences*, 54(1), 41–45. <https://doi.org/10.1016/j.paid.2012.12.020>
965. del Río-González, A. M., Zea, M. C., Flórez-Donado, J., Torres-Salazar, P., Abello-Luque, D., García-Montaño, E. A., García-Roncallo, P. A., & Meyer, I. H. (2021). Sexual orientation and gender identity change efforts and suicide morbidity among sexual and gender minority adults in Colombia. *LGBT Health*, 8(7), 463–472. <https://doi.org/10.1089/lgbt.2020.0490>
966. On pages 29-30 in Rosik, C. H., Beckstead, A. L., & Lefevor, G. T. (2025). Associations between health, identity labeling, sexuality changes, and engagement status of sexual orientation change efforts. *Researchers.One*. <https://researchers.one/articles/25.01.00002>
967. Wright, T., Candy, B., & King, M. (2018). Conversion therapies and access to transition-related healthcare in transgender people: A narrative systematic review. *BMJ Open*, 8(12), e022425. <https://doi.org/10.1136/bmjopen-2018-022425>
968. On page 113 in Choi, A. Y., Nylund-Gibson, K., Israel, T., & Mendez, S. E. A. (2018). A latent profile analysis of bisexual identity: Evidence of within-group diversity. *Journal of Bisexuality*, 18(1), 103–126. <https://doi.org/10.1080/15299716.2018.1529496>
969. Yarhouse, M. A. (2013). A Christian perspective on sexual identity. The Henry Center for Christian Leadership. <https://henrycenter.tiu.edu/wp-content/uploads/2013/11/Yarhouse-Homosexuality.pdf>
970. Ferguson, M. (2022, January 20). Conversion therapy: A survivor’s story [Webinar]. Presentation at the LGBTQ-Affirmative Psychotherapist Guild of Utah, Salt Lake City, UT.

971. Fromberger, P., Jordan, K., & Müller, J. L. (2013). Pädophilie: Ätiologie, Diagnostik und Therapie [Pedophilia: Etiology, diagnostics and therapy]. *Der Nervenarzt*, 84(9), 1123–1135. <https://doi.org/10.1007/s00115-013-3805-9>
972. *Ferguson v. JONAH*, No. L-5473-12 (N.J. Super. Ct. Dec. 18, 2015).
973. Rosik, C. H., Lefevor, G. T., & Beckstead, A. L. (2023). Sexual minorities responding to sexual orientation distress: Examining 33 methods and the effects of sexual identity labeling and theological viewpoint. *Spirituality in Clinical Practice*, 10(2), 73–92. <https://doi.org/10.1037/scp0000295>
974. On page 639 in Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. W. B. Saunders.
975. This list was adapted from an earlier writing project with Matheson, Guy Albert, and coauthors Beckstead, Rosik, Doyle, and Phelan. Please see our website (<https://findingcongruence.com/about-us/>) to know which books these other coauthors are involved in.
976. For another list of harms, read Anderson, J. R., Jones, T. W., Power, J., Jones, T. M., Despott, N., Pallotta-Chiarolli, M., & Gurtler, P. (2025). Mental health practitioners' knowledge of LGBTQA+ conversion practices and their perceptions of impacts on survivors. *Journal of Homosexuality*. Advance online publication. <https://doi.org/10.1080/00918369.2024.2319615>
977. Goodkind, R. (2018, March 10). Gay conversion therapist found guilty of having sex with male patients to “cure” them. *Newsweek*. <https://www.newsweek.com/gay-conversion-sexual-misconduct-therapy-canada-839728>
978. Fjellstrom, J. (2013). Sexual orientation change efforts and the search for authenticity. *Journal of Homosexuality*, 60(6), 801–827. <https://doi.org/10.1080/00918369.2013.774830>
979. Jacobsen, J., & Wright, R. (2014). Mental health implications in Mormon women's experiences with same-sex attraction: A qualitative study. *The Counseling Psychologist*, 42(5), 664–696. <https://doi.org/10.1177/0011000014533204>

980. Shidlo, A., & Gonsiorek, J. C. (2017). Psychotherapy with clients who have been through sexual orientation change interventions or request to change their sexual orientation. In K. A. DeBord, A. Fischer, K. J. Bieschke, & R. M. Perez (Eds.), *Handbook of sexual orientation and gender diversity in counseling and psychotherapy* (pp. 291–312). American Psychological Association.
981. Ben-Shahar, A. S., & Shalit, R. (Eds.). (2018). *When hurt remains: Relational perspectives on therapeutic failure*. Routledge.
982. On page 1253 in Flentje, A., Heck, N. C., & Cochran, B. N. (2014). Experiences of ex-ex-gay individuals in sexual reorientation therapy: Reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality*, 61(9), 1242–1268. <https://doi.org/10.1080/00918369.2014.926763>
983. Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.
984. On page 306 in Weiss, E. M., Morehouse, J., Yeager, T., & Berry, T. (2010). A qualitative study of ex-gay and ex-ex-gay experiences. *Journal of Gay & Lesbian Mental Health*, 14(4), 291–319. <https://doi.org/10.1080/19359705.2010.506412>
985. Flentje, A., Heck, N. C., & Cochran, B. N. (2014). Experiences of ex-ex-gay individuals in sexual reorientation therapy: Reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality*, 61(9), 1242–1268. <https://doi.org/10.1080/00918369.2014.926763>
986. Stanisławski, K. (2019). The Coping Circumplex Model: An integrative model of the structure of coping with stress. *Frontiers in Psychology*, 10, 694. <https://doi.org/10.3389/fpsyg.2019.00694>
987. For more information, go to <https://self-compassion.org> and read Neff, K. D. (2021). *Fierce self-compassion: How women can harness kindness to speak up, claim their power, and thrive*. Harper Wave; Neff, K., & Germer, C. K. (2018). *The mindful self-compassion workbook: A proven way to accept yourself, build inner strength, and thrive*. The Guilford Press; Neff, K. D., & Germer, C. K. (2024).

Mindful self-compassion for burnout: Tools to help you heal and recharge when you're wrung out by stress. Guilford Press.

988. On page 645 in Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist*, 32(5), 641–650. <https://doi.org/10.1177/0011000004268877>
989. On pages 4 and 5 in American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. American Psychological Association.
990. Linden, P., Beckstead, A., DiClementi, J., Mackaronis, J., Struve, J., Clinton, L., Kluck, A. S., Morales, E., & van Wanrooij, T. (in press). Living assertively: Resilience skills for LGBTQIA+ people and people with a different or no label. LGBTQIA+ Peacebuilding Project. <https://findingcongruence.com/living-assertively>
991. Burger, J., & Pachankis, J. E. (2024). State of the science: LGBTQ-affirmative psychotherapy. *Behavior Therapy*, 55(6), 1318–1334. <https://doi.org/10.1016/j.beth.2024.02.011>
992. Skidmore, S. J., Lefevor, G. T., & Hale, W. J. (2022). Suicidal ideation among active and nonactive/former Latter-day Saint sexual minorities. *Journal of Community Psychology*, 50(8), 3517–3534. <https://doi.org/10.1002/jcop.22591>
993. Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. M. (2021). Minority stress, distress, and suicide attempts in three cohorts of sexual minority adults: A U.S. probability sample. *PLOS ONE*, 16(3), e0246827. <https://doi.org/10.1371/journal.pone.0246827>
994. Utah Department of Health and Human Services. (2025). Systematic medical evidence review of hormonal transgender treatment for adolescents with gender dysphoria. Utah Department of Health and Human Services.

995. Ceci, S. J., Clark, C. J., Jussim, L., & Williams, W. M. (2024). Adversarial collaboration: An undervalued approach in behavioral science. *American Psychologist*. Advance online publication. <https://doi.org/10.1037/amp0001391>
996. Kahneman, D. (2003). Experiences of collaborative research. *American Psychologist*, 58(9), 723–730. <https://doi.org/10.1037/0003-066X.58.9.723>
997. Rosik, C. H., Beckstead, A. L., & Lefevor, G. T. (2025). Associations between health, identity labeling, sexuality changes, and engagement status of sexual orientation change efforts. *Researchers.One*. <https://researchers.one/articles/25.01.00002>
998. Hoffmann, H. (2012). Considering the role of conditioning in sexual orientation. *Archives of Sexual Behavior*, 41(1), 63–71. <https://doi.org/10.1007/s10508-012-9915-9>
999. This Conclusion is somewhat similar to the Conclusion in our companion chapter in *Feel Secure in Yourself*, published by Bloomsbury Publishing, <https://www.bloomsbury.com/us/feel-secure-in-yourself-9781538190418>. We have permission to include it here to help connect this book with the chapter's ideas and recommendations.