A Comprehensive Critical Review of the "2021 [American Psychological Association] APA Resolution on Sexual Orientation Change Efforts"

Walter R. Schumm[1], James E. Phelan[2, 3] & Christopher H. Rosik[4, 5]

[1]Kansas State University

[2]Veterans Health Administration, Columbus, Ohio

[3]Grand Canyon University

[4]Link Care Foundation, Fresno, California

[5]Fresno Pacific University

Walter R. Schumm, Ph.D., is Emeritus Professor of Applied Family Science, Department of Applied Human Sciences, College of Health and Human Sciences, Kansas State University, who retired recently after 42 years of teaching and research at Kansas State. His earned degrees include a bachelor's degree in Physics from the College of William and Mary (Virginia), 1972; a master's degree in family and child development from Kansas State University, 1976; and a Ph.D. in family studies from Purdue University in 1979. He was the editor of the journal *Marriage & Family Review* from 2010 to 2020 and continues to serve as an associate editor/reviewer for numerous social science journals. He is a Fellow with the National Council on Family Relations (NCFR) and a certified family life educator. His primary research interests have included military families and same-sex parent families, often with a focus on strengths or weaknesses of methodologies used in studying diverse types of families. He retired as a colonel, U.S. Army, in 2002 after nearly 30 years of service in the Army Reserve and Army National Guard, having commanded units from detachment, separate platoon, and company levels to battalion and brigade levels.

James E. Phelan, LCSW, MBA, Psy.D, is the acting Chief of Staff Education at the Veterans Health Administration, Columbus, Ohio. He is an adjunct professor at Liberty University and Grand Canyon University and a consulting editor for the Journal of Social Work Practice in the Addictions.

Christopher H. Rosik, Ph.D., is a psychologist and director of research at the Link Care Foundation in Fresno, California, as well as a clinical faculty member of Fresno Pacific University. Dr. Rosik is a Past-President of the Alliance for Therapeutic Choice and Scientific Integrity and currently serves as the editor for the Journal of Human Sexuality.

Correspondence concerning this article should be addressed to Dr. Walter R. Schumm, 5900 Lake Elbo Road, Manhattan, Kansas 66502-8996. Email: schumm@ksu.edu. An abridged version of this article is being published in Nobel International Journal of Social Sciences Research.

A Comprehensive Critical Review of the "2021 [American Psychological Assocation] APA Resolution on Sexual Orientation Change Efforts"

This is a comprehensive version of a shorter report by the same authors (Phelan et al., in press). We have examined the "*APA [American Psychological Association] Resolution on Sexual Orientation Change Efforts*" (APA, 2021) and while doing so have noted several problems. The APA (2021) Resolution report is largely flawed in terms of theory, logic, and science. The APA's position features several examples of non-sequiturs for which we respond. It relies almost exclusively on sexual minority theory when many other theories might be useful. It relies upon seriously flawed logic, treating SOCE as unchanged and unimproved over the past six decades. In addition, it relies upon very weak and limited science, overlooking recent reports on SOCE outcomes, not considering effect sizes for SOCE treatments, treating correlational results as causal, and often overlooking ways of testing more complex models of SOCE. The same limitations apply to much of the material reported in APA's book edited by Haldeman (2022a), therefore not deserving a separate review. As such, we concluded that readers of the APA (2021) resolution report or Haldeman (2022a) for that matter, would walk away with unequivocal, one-sided, and misguided information about the topic of SOCE, and therefore a fact-checked critical analysis is presented. We address the report's main sections, respond to non-sequiturs, and we present summary results from several more recent SOCE studies.

Keywords: sexual orientation change efforts (SOCE), sexual orientation, sexual minority stress, conversion therapy, therapeutic harm, LGBT

In this comprehensive version of our shorter report (Phelan et al., in press), we have thoroughly examined the "*APA Resolution on Sexual Orientation Change Efforts*" (APA, 2021) and Haldeman's (2022a) APA book; while doing so we have noted several problems. As such, we provide a comprehensive fact-checked critical analysis of these reports. This effort is important because readers of the original reports would walk away with unequivocal or one-sided information about the topic of Sexual Orientation Change Efforts (SOCE). The scope of our comment is limited, as it does not mainly apply to issues related to transgenderism or attempts to deal with gender identity change, even though the APA (2021, p. 1) considers them to be part of SOCE, which is of interest because Przeworski et al. (2021) stated that "as there are currently no data examining the impact of therapies seeking to alter the gender identity of transgender and gender-nonconforming individuals" (p. 82) and likewise "virtually no research regarding potential harmful effects of attempts to alter gender identity" (p. 95), a situation also acknowledged by Fish and Russell (2020). Since Przeworski et al. (2021) is likely the most recent review of SOCE, we include comments with respect to it.

This critical review is important because APA considers this "policy" to be based on sound evidence (p. 4) and to be more conclusive than their 2009 resolution on SOCE (APA, 2009). "Resolutions" generally are precursors to laws and ordinances. It should be recognized that we are not the first to present a critique of similar APA (2009) past resolutions as there have been older (Phelan, Whitehead, & Sutton, 2009) and more recent (Freedman, 2020; Sprigg, 2021) critiques of APA (2009). Among the more recent reports, Freedman noted numerous examples of ways in which the APA had misrepresented the results of previous SOCE evaluations, thereby engaging in many cases of unethical research misconduct. Furthermore, the 2009 APA report omitted inclusion of many other SOCE evaluations

and appeared to have relied only on older literature reviews (Adams & Sturgis, 1977) for 29 of the 37 studies. We address the report's main sections, respond to non-sequiturs, and we present summary results from several recent SOCE studies.

Sexual Orientation Change Efforts (SOCE)

The APA starts out their report discussing sexual orientation and SOCE. We agree with them that sexual orientation is multidimensional. As in their earlier report APA (2009), they identify sexual orientation in terms of patterns of attraction, behavior, and identity. They furthered this by saying it was associated with experiences such as fantasy. In their earlier 2009 report, they discussed that sexual orientation also encompassed how persons label themselves. Interestingly, they even include value as a dimension of sexuality.

Defining and measuring sexual orientation presents significant challenges, however such as a lack of consensus, narrow interpretations, and lack of construct validity. Researchers who've attempted to measure "sexual orientation" and its presumed components typically have relied on a few instruments which have been criticized as inconclusive, oversimplified, loose, and imprecise (Phelan, 2019). Because of this, it would be unfair for them to claim any or all dimensions of sexual orientation, are immutable. In fact, that leaves a monocultural option that forces people into one choice in the matter.

According to the APA, "Sexual Orientation Change Efforts (SOCE) includes a range of techniques used by a variety of mental health professionals and non-professionals with the goal of changing sexual orientation or any (APA, 2009) of its parts" (APA, 2021, p. 1). SOCE is said to include one *or* more of the following:

- non-scientific explanations of sexual orientation diversity
- claims that sexual attraction can be changed through therapy
- predetermined outcomes
- information that same-gender orientations are caused by childhood events or family dysfunction

The APA explains that SOCE takes on a variety of interventions including ". . . using religious practices such as prayer, [or] scripture study . . ." and ". . . exorcism . . . [or] implementing aversive conditioning . . ." They also point out that the National Association of Social Workers (NASW) refers to them as "reparative therapy, conversion therapy, or transformational ministries" and says they are "supported by Focus on the Family and affiliates" (NASW, 2015). For professional organizations (see also, Plante, 2022) to link illegitimate therapeutic practices with religion in general is most inappropriate and unfortunate.

In the opening section that explains SOCE, the APA only describes horrid-like interventions; even Haldeman (2022b) focuses on past unethical types of interventions, admitting that "*more recent"* forms of SOCE are *not* included in the critiques in his APA book (p. 8). Indeed, Haldeman's (2022a) book did not address more recent SOCE research, much of which will be discussed here, below. The APA report does not mention SOCE as using standard talk therapies, for example interpersonal psychotherapy (Byrd, 2009), even though Glassgold (2022) has recognized that today's SOCE are mainly verbal or "talk" therapies. While aversion therapies were used experimentally, predominantly in the 1970's for many types of behavior reductions including homosexuality, the practice is seldom used to try to change

sexual orientation (even though such practices are often recalled, Boulos and Gonzalez-Canton, 2022), and the facts are often ignored and many myths exist (Byrd & Phelan, 2010). Rosik and Popper (2014) have presented an unbiased and detailed comparison of gay-affirmative, sexual identity, and change-oriented approaches, with different goals, methods, advantages, and disadvantages for different clients.

The APA asserts, "Because of the social stigma they experience, individuals with same- and multiple-gender attractions and behaviors may be referred to collectively as sexual minorities" (p. 1). When one hears the term "sexual minority" one probably thinks that members of such groups are oppressed by the "sexual majority" and accordingly suffer lower levels of education, income, per capita family income, etc. However, research (Elwood, et al., 2017; Elwood et al., 2020) has found that sexual minorities in at least one state (California) have reported higher levels of education, higher levels of income, fewer children per household, and higher levels of per capita income, as well as lower rates of racial minority statuses, than sexual majorities (Schumm, in press, p. 3). While results from California may not generalize to other states or countries, citing former President Obama as an exception to blacks being poor is clearly not the same situation as an entire state of millions in which thousands of sexual minorities are of higher socioeconomic status than millions of other (heterosexual) residents.

The term "sexual minority" may bring to mind concepts such as poverty, poor housing, and welfare, but in reality, sexual "minorities" are in many cases more educated, with higher income, and wealthier than many other minorities, even some majorities. It is even possible that their greater socioeconomic status may be a driver in their success in terms of political objectives, outspending their opponents.

Heterosexism and Monosexism

This statement is found in the APA (2021) report: "Heterosexism and monosexism are social stigmas and societal inequalities that denigrate, discredit, and disadvantage those with same- and multiple-gender attractions, behaviors, and associated identities" (p. 1). The APA is being accusatory and demeaning to individuals and groups with deeply held religious beliefs who hold heterosexual patterns and unitary sexuality (within marriage between one man and one woman) as sacredly valued and as a requirement of their faith. Furthermore, the APA's underlying assumptions are weak, i.e., that if you experience same-sex attractions or attractions to multiple persons, the only possible legitimate authentic response would be to identify with those as part of a group and to act on those attractions and engage in sexual activity accordingly with that group's support and encouragement, as well as that of society at large. Ignored is the reality that feelings or attractions are derived from underlying mental thoughts and working hypotheses and are usually derived from observations of one's total sensory environment over time.

Furthermore, heterosexism and monosexism accusations are pejorative with respect to even non-religious persons who want to engage in mixed-gender marriages that involve sexual fidelity. Because cisgender, heterosexual women can ill afford to have husbands who engage in same-sex relationships or opposite-sex relationships outside of their marriage, considering heterosexism and monosexism as "stigmas and societal inequalities" is inherently demeaning and stigmatizing towards such women. We must note that while same-sex and opposite-sex infidelity would both involve emotional pain, only the woman whose male partner cheats with another woman might lead to an extra-relational

pregnancy that can be ill afforded (i.e., if a woman has a lesbian partner who is only same-sex attracted, that partner would be unlikely to cheat with a man and thereby risk becoming pregnant).

However, any person can make observations that happen to be incorrect. Even if observations are correct, the interpretations from them can be incorrect. Even if feelings are deemed acceptable no matter what, they can be inappropriate in the sense of a response to incorrect perceptions or interpretations. Given a feeling, one should not be "locked in" to one set response but be free to find and select from multiple alternatives of possible actions in response. The theory of reasoned action and social exchange theory should remind us that individuals make decisions based on a host of perceived rewards, costs, alternatives, and the perceived views of important significant others, including society at large.

In contrast to such complexity, it seems that the APA report (2021) and Hendricks (2022) assume that if a person experiences same-sex attractions (SSA) then there can be no other option than to adopt a gay, lesbian, or bisexual identity and behave accordingly sexually, as well as joining an LGBT community. However, many people who have had same-sex behavior do not identify as gay or lesbian, but rather heterosexual (Geary, et al., 2018). Likewise, sexual minority theory seems to argue that if a sexual minority person perceives a microaggression from someone else that it could not possibly have any other origin other than intentional stigma against them. In contrast, we think there are many other, alternative possibilities and other useful theories regarding human behavior (Schumm, 2020b; Vrangalova & Savin-Williams, 2014) and that humans should count themselves as free to discount and reject assumptions that limit their own freedoms (so far as they do not harm others directly or indirectly).

The APA document seems to forget that much of what makes humanity noble is the ability to reject the felt power of feelings for the good of others; so, just because I am really hungry, does not justify or should not justify my cutting in a lunch line in front of other hungry people. Being noble would in contrast be my allowing others to reach the food before myself even if my "feelings" object or if the food runs out before I get to it. In particular, sexual feelings can so easily lead to selfish and exploitive behaviors that can be harmful to others for decades afterwards that it has traditionally been useful for societies to regulate the behavioral expression of sexual feelings, regardless of sexual orientations.

The APA dismisses other minority groups that do not support their agendas. For example, Brothers on a Road Less Traveled, who identify as a *voluntary* non-profit, multi-faith, international fellowship primarily of men from bisexual or same-sex-attracted backgrounds who—for their own, deeply personal reasons—typically *do not accept or identify* with the label "gay" and prefer instead to explore and address underlying issues, and for some, seek out change efforts. According to their own website (www.BrothersRoad.org): "many of us in the Brothers Road community have found that the nature of our sexual attractions has shifted over time—sometimes profoundly—as a result of our personal-growth and inner-healing work."

Contexts with Multiple Stigmas and Vulnerabilities

The APA Resolution (2021) report tells readers that they are ". . . concerned about the significant risk of harm to minors from SOCE," (p. 2) and that "LGBTQ+ individuals are exposed to individual, social,

and institutional levels of stigma, which negatively affect multiple health domains (Hatzenbuehler & Pachankis, 2016; Robinson, 2017)" (p. 2). Hendricks (2022, p. 8) has presented similar conclusions. Reading this at surface might lead the reader to gasp and think about SOCE as a culprit causing LGBTQ+ health problems. But, if you fact check the two reports they cite, you will see the first citation, Hatzenbuehler & Pachankis (2016) is not research, but rather a review article of theoretical and clinical reports. That paper does nothing to prove that harm has been done on large-scale researched populations. In addition, Robinson (2017) is also not research; in fact, the author makes clear that research on black LGBTQ and gender nonconforming youth in juvenile detention in the United States has not been performed on a large-scale and knowledge about these youth ". . . under detention or incarceration is speculative . . ." (p. 12). However, the APA uses these two reports to suggest that some sexual minorities who seek SOCE due so because of stigma and because they "typically" come from "religiously orthodox backgrounds" (p. 2).

The premise of the APA report is that multiple stigmas are responsible for LGBTQ vulnerabilities. Using primarily one theory, sexual minority theory, to interpret and explain such situations, is very limiting. For example, since sexual minority status can be invisible, might it not be more likely that microaggressions, if they are indeed real, originate from a perception of others that the individual was rude, or was gender-nonconforming, or using drugs, for example? As far as we can tell, such alternative explanations have seldom been empirically evaluated. Without more complex theories, such more complex explanations may never come to a scientific test. Might not the assumption that an experience of same-sex attraction (SSA) *has* to lead to same-sex identity (SSI) and *has* to lead to same-sex behavior (SSB) be itself a form of stigma, a form of internalized homophobia? If a social organization such as the APA demands that individuals with SSA must adopt SSI and engage in SSB—and that all others must think and act likewise—is that not oppressive and freedom-limiting in its own way, as well as arrogant? We agree with the APA that therapists should not be determining the goals of clients regarding their sexuality. However, we also assert professional organizations such as the APA likewise should not be determining these goals for clients nor should others assume that some goals are inherently wrong, even if no harm can be shown (Boulos and Gonzalez-Canton, 2022).

Science and SOCE

In this brief section the APA says that ". . . sexual orientation can evolve and change for some" (p. 3), but they do not think it can be altered through intervention and they advise against it. Haldeman (2022b, p. 8) makes the same argument. They say SOCE studies have methodological and statistical issues that have rendered many of the reports "invalid." This statement is not based on a new appraisal, but rather on their own earlier review of SOCE reports (APA, 2009). The other reason they are against SOCE use is because they feel it distorts others' "valid research" which says homosexuality is innate and immutable.

But, what about heritability? Current large-scale research by Ganna et al. (2019), which provided so-called insights into the "genetic architecture of same-sex sexual behavior" is problematic. For example, Hamer et al. (2021) noted that the researchers used overly simplistic behavioral phenotypes which ". . . led to widespread public confusion about the meaning of their study. Most accounts of the research, both in the scientific and mass media, focused on the

research's implications for 'gay genes,' 'sources of same-sex attraction,' and 'causes of homosexuality,' even though the study did not in fact investigate attraction or sexual orientation" (p. 2). Hamer et al. also pointed out that their use of binary measures has not been tested for reliability or validity.

Furthermore, the APA denies that childhood experiences, even adverse childhood experiences (ACEs) have anything to do with the development of sexual orientation. Some treat sexual abuse as having nothing to do with the development of homosexuality in all cases (e.g., Fjelstrom, 2013, p. 812). A previous review of this literature found numerous studies that identified an association between early childhood sexual abuse and the later development of homosexuality in both men and women (Schumm, 2013). Nicolosi et al. (2000, p. 1077; Byrd et al., 2008) reported that 60% of their sample of those surveyed about SOCE had experienced homosexual contact as a child at a median age of 10 years, with older persons (median age of 14). Even the APA's own handbook of human sexuality found the same association; some studies have used longitudinal data so that the early abuse clearly precedes the sexual development, although there are multiple possible explanations yet to be tested (Mustanski, Kuper, & Greene, 2014, pp. 609–610). In addition, male gender non-conformity is often associated with parental and peer rejection in childhood (Landolt, et al., 2004). While the APA Resolution claims the idea that "negative childhood events" might cause "same-gender orientation" has been discredited, that is simply not the case.

And what about immutability? The APA has admitted that research has obscured "what actually can or cannot change in human sexuality" (APA, 2009, p. 3). What exists on both sides are self-reports of change and reports of others saying they tried to change their sexual orientation but failed; therefore, they concluded that it is impossible for all. It is likely the reason why many behavioral efforts alone have failed is they had been aimed at redirecting sexual urges rather than the multidimensions of sexual orientation. The APA's own multidimensional definition of sexual orientation would indicate that at least some dimensions are indeed mutable. For example, clearly individuals can choose not to identify as LGBTQ in the same way some biologically born men and women choose not to identify with their sex assigned at birth. Ironically, the APA has no problems helping individuals with those change efforts.

SOCE proponents did not suggest categorical change was the goal of therapy in the first place (NARTH Board of Directors, 2012). Finally, the APA's essentialist view that homosexuality is innate and immutable is more ideological than scientific.

Ethical and Professional Concerns

The APA is concerned that SOCE is associated with stigma and might be used coercively. The occurrence of stigma and the use of coercive methods are indeed concerning. What the APA fails to discuss is that many individuals who have suggested they have been coerced and to a lesser degree tortured, have provided stories which have not been verified, and in some cases were fabricated, but nevertheless remain influential to lawmakers (Constantine, 2021). We agree with the APA's opposition to things like prejudice and the need for respecting the dignity and worth of all people. However, this resolution is troubling:

> WHEREAS minors who have been subjected to SOCE have reported more suicide attempts than those who have not (Green et al., 2020; Ryan et. al., 2018), and these SOCE have been deemed "degrading, inhuman and

> cruel" creating "a significant risk of torture" by the UN HRC. (2020, p. 21)

In doing our fact-checking we found that the UN report relies on several failed notions. For example, in their summary they say, SOCE results in "long-lasting psychological and physical damage" (UN HRC, 2020, Summary). However, there is no research that specifically studies long-term damage. In fact, longitudinal studies have not revealed significant long-term damage (Jones & Yarhouse, 2007, 2011; Pela & Sutton, 2021). The risk of harm behaviors for those who have experienced SOCE is no different than it is for those who have not experienced SOCE. SOCE experience was found to have no statistically discernible effect on the risk of any present harm measured in terms of suicide ideation, suicide planning, suicide intention, and attempting suicide (Sullins, 2022). Other research is based on self-reports which is the same type of method they accuse as invalid for supporting SOCE.

As we will explore in more detail later, researchers can easily find reported "harms" from SOCE by advertising for those who might have been harmed and looking for study participants at sites likely to be populated with persons who are not very religious and who are currently and probably were, before SOCE, strong in an LGB identity, that is, persons much less likely to experience sexual orientation change from SOCE (e.g. Shidlo & Schroeder, 2002; McGraw et al., 2021). As Sullins et al. (2021) observed regarding the disparate findings in the SOCE literature, "*we propose a plausible explanation to harmonize this literature: Researchers are studying very different subpopulations of sexual minorities, distinguished in large part by their different experiences of contemporary, speech-based forms of SOCE, which should not be generalized to all sexual minorities*" [authors' emphasis] ("Harmonizing the SOCE Literature" section, para. 1). In other words, results can largely be determined by sampling bias in this area (e.g., Shidlo & Schroeder, 2002; McGraw et al., 2021), as well as other areas of social science (Schumm et al., 2021).

Current Contexts

In this section the APA makes several following points. After each, we have added a fact-checked response:

- Several professional associations have signed on to the United States Joint Statement Against Conversion Efforts (n.d.), which aims to end SOCE and gender identity change efforts.

  Our response: The fact that SOCE is opposed by several trade organizations and guilds appears more political than purely scientific. As only one of many examples that could be offered, consider that since 2014 the leadership of the NASW (who strongly appose SOCE) has endorsed 642 candidates for federal office (e.g., NASW, 2018). Political party affiliations of these endorsed candidates have been 642 Democrat, 0 Republican.

- The research on SOCE published since APA's (2009) task force report and resolution has continued to support the conclusions that former participants in SOCE look back on those experiences as harmful to them and that there is no evidence of sexual orientation change.

Our response: While some participants have reported regret, others have reported satisfaction (Stanus, 2013). Both rely on self-reports, but the APA only chooses to take sides with those who provided negative reports and ignore those who discover positive accounts (Sullins et al., 2021; Rosik et al., 2021, 2022).

- The consensus panel at the Substance Abuse and Mental Health Services Administration (SAMHSA) found no credible evidence to support SOCE with children and adolescents and called for an end to SOCE (SAMHSA, 2015).

  Our response: While that report was published by SAMHSA, many of the "experts" they used were partisan and had preset agendas against SOCE. In addition, the disclaimer section in that report clearly pointed out that: *"The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS"* (p. i).

- Decisions in cases that have challenged ordinances prohibiting licensed mental health professionals from providing SOCE to minors (Otto v. Boca Raton, 2019; Pickup v. Brown, 2013; Welch v. Brown, 2013) have upheld the authority of professional oversight bodies to regulate professional mental health care interactions and to prohibit SOCE by mental health professionals.

  Our response: Those cases have been abrogated by the Supreme Court decision in National Institute of Family and Life Advocates (NIFLA). Moreover, the case from the Eleventh Circuit Court of Appeals out of Florida was struck down, and a request for an en banc (by all the appellate judges) review of this decision was denied on July 20, 2022.

- Persecution of LGBTQ+ people worldwide is an international humanitarian issue, including systematic abuse, imprisonment, and torture. The U.S. field of psychology is influential around the world, and an updated APA policy has the potential to support the rights and safety of LGBTQ+ persons worldwide.

  Our response: We agree that persecution, including systematic abuse, imprisonment, and torture is unacceptable; however, there is no empirical evidence that SOCE supports these atrocities. It is the rhetoric of the APA that fuels certain entities to conduct bans and to eliminate rights and choices. For example, they take away rights to sell books (Ennis, 2019) and manipulate Google searches (GPAHE, n.d.). We have not heard similar reports from SOCE proponents advocating to ban gay-affirmative services and literature.

- APA supports policy on the federal level (e.g., Therapeutic Fraud Prevention Act, 2017) to:

- "dispel the distortions and inaccuracies favored by SOCE proponents"
- "prohibit SOCE with minors"
- "warn consumers that SOCE can be fraudulent"
- "advise professionals that SOCE are not ethical"

Our response: The APA's position seems to feature several examples of non-sequiturs, identified in italics below. Among these are: *If some SOCE has been unprofessional, unethical, punitive, involuntary, etc. that automatically means that all forms of SOCE are such*.

The APA (2021) Resolution argues that SOCE have included "nonscientific explanations," "claims that sexual attraction can be changed," had "pre-determined outcomes," or "dissemination of inaccurate information," which might be true of *some* SOCE, but isn't necessarily true of *all* SOCE, even though that is implied. The last claim is ironic in that the resolution itself is disseminating inaccurate information, as we are demonstrating here. We believe that the APA's (2021) Resolution epitomizes confirmation bias and belief persistence (Schumm, 2015, p. 2), an example of insistence on obsolete science despite considerable scientific evidence to the contrary of the APA's positions.

SOCE advocates are seen as being unscientific.

But consider this—do not psychologists think they can help people manage or change their drug abuse, alcoholism, marital problems, anxiety, depression, suicidality, social functioning, self-esteem, among many other things—but, suddenly when it comes to sexual orientation, the APA (2021) Resolution seems to say that we know nothing about its etiology and must assume that even if it unfolds over time by itself, we cannot possibly help people consider how to respond to their own same-sex sexual attractions and manage change in that area if that is what they want to try. Those opposed to talk-based, voluntary SOCE acknowledge that naturalistic change of sexual desires occurs regularly (e.g., Diamond & Rosky, 2016), but they are trapped by their ideological commitments into the untenable assertion that the only environments where change can never occur are those facilitated within a therapy context.

The APA (2021) Resolution argues against psychologists harming their clients, with which we agree. However, if SOCE can reduce adolescent suicidality (see Sullins, 2022), then denying SOCE to clients *is* by itself harming them.

If research with some groups has found dissatisfaction with SOCE, that means research with any group will inevitably find similar levels of dissatisfaction with SOCE.

The APA (2021) Resolution cites research of persons who report dissatisfaction and harms from SOCE (see also, Drescher, 2022, p. xii) but did not consider contrary evidence from groups that have reported satisfaction and benefits, rather than harms, from SOCE. For example, Nicolosi et al. (2000) found that only 7.1% of their clients reported reductions in three or more of their 17 measures of mental health after SOCE, while significant ($p < .001$) gains in mean scores were recorded on all 17 measures with t-tests. They also found that approximately 3–4% of their clients reported having had bad experiences with affirmative therapies (p. 1082). Sullins (2022) found that sexual minority persons who had undergone failed SOCE therapy did not suffer higher psychological or social harm. SOCE exposure reduced the effect of minority stress and childhood adversity for suicide attempts.

While the APA report and Haldeman (2022a) frequently associate SOCE with higher suicidality, they seem to forget that correlation does not equal causation, as Sullins (2021, 2022) has demonstrated.

If research on types of SOCE that were punitive and involuntary or ill-informed by social science research or theory has found problems, then this automatically means all types of SOCE that were non-punitive, voluntary, and well-informed by social science research and theory would automatically have the same adverse consequences and harms.

The APA (2021) Resolution overlooks the possibility that where SOCE has had problems it was not intrinsic to SOCE but may have reflected SOCE that was punitive, aversive, involuntary, and ill-informed by social science research and theory. Similarly, Prezeworski et al. (2021) describe SOCE practices as involving hypnosis, masturbatory reconditioning, aversion therapy, electric shock therapy, surgical removal of genitals, and threats of damnation (p. 82), even though they admit that such practices "are currently seldom used" (p. 82). However, readers of their paper might miss the "seldom used" phrase and assume the paragraphs dedicated to highly unethical practices tied to SOCE are still prevalent practices.

If SOCE in the past was conducted with ill-advised protocols, that automatically means that more recent SOCE will continue to be conducted with the same ill-advised protocols. Specifically, if SOCE was done improperly sixty years ago, it must logically continue to today with identical and improper protocols; it is not possible that SOCE might have changed over the past sixty years. A corollary would be that if one reviews the literature on SOCE, it is acceptable to overlook more recent examples of SOCE (to be reviewed here subsequently) as if they have never existed, which is exactly what the APA (2021) Resolution has done.

For example, Przeworski et al. (2021) reviewed 35 articles that they believed represented evaluations of SOCE. However, 17 (48.6%) of those articles were at least 20 years old and another eight (22.9%) featured small samples ($N < 75$), such that only ten were both recent and involved larger samples. Thus, they were drawing conclusions about SOCE today largely (71.4%) based on methodologically weak or very old (or both) studies. They cited data (Shidlo & Schroeder, 2002) in which 25% of SOCE participants had been coerced into attending; in the past that may have been the case, but that does not mean that twenty years later, coercion is desired by today's SOCE therapists, since coercion is generally associated with poor results from therapy. For example, suppose that neuroses were treated in unethical ways fifty years ago (e.g., Skinner boxes). Would that mean that today's better treatments of neuroses remain unethical? Other comments from Przeworski et al. (2021) about clients not pretending, not pleasing the therapist, and creating goals collaboratively probably apply not only to affirmative therapies but also to professional SOCE therapists today. While it is nice to consider archival data for historical purposes, one would expect that more recent studies would be methodologically stronger and therefore more important for drawing conclusions.

Research should be judged by different standards rather than by commonly held scientific standards, especially when political or religious values are at stake; that is, if it is acceptable for my favored studies to have a certain set of limitations that might but are not allowed to generate caution when drawing specific policy implications, but it is not acceptable for someone else whose

studies have the same limitations to draw any specific policy implications, especially if the policy results might contradict mine.

The APA (2021) Resolution cites several cross-sectional survey studies that have found associations between suicidality and SOCE experience but does not cite contrary studies or more recent research that indicates that suicidality may occur prior to SOCE and may be reduced by SOCE rather than enhanced by it. How hard would it be to propose alternative theories to the simplistic idea that SOCE directly causes suicide and nothing else much contributes; just get rid of SOCE and LGBT persons will never again express suicidality? Scientific theory needs to be much more complex! The suicide/SOCE connection is drawn in several places in the APA (2021) Resolution and by recent articles using only cross-sectional surveys (Dehlin et al., 2015; Goodyear et al., 2021; Green et al., 2020; Salway et al., 2020, 2021; also see Rosik, 2020), so the APA must be expecting even lay persons to assume that the primary answer to LGBT suicidality lies in eliminating SOCE (i.e., simple theory, simple plan). In fact, sexual minority persons who had undergone failed SOCE therapy do not suffer higher psychological or social harm (Sullins, 2022). We will say more about the confounds here later.

If people or organizations with power do not like something, then it must be wrong, regardless of the facts. For all the apparent goodness of speaking truth to power, the APA (2021) Resolution appears to seek to impose its will on others by the sheer force of how many organizations do not like SOCE and does not see value in contrary viewpoints, presumably especially religious viewpoints.

One might expect the APA to recall what one of its former presidents, who was a lifelong champion of gay and lesbian rights, said: "Of the patients [at his clinic in San Francisco] who had sought to change their sexual orientation, hundreds were successful" despite it being very difficult and that "Contending that all same-sex attraction is an unchangeable or immutable characteristic like race is a distortion of reality." He further stated that "Attempting to characterize all sexual reorientation therapy as 'unethical' violates patient choice and makes a third party the de facto determiner of therapeutic goals. Rather, it is unethical for a professional, or a professional organization like the APA, to prevent a patient from seeking help to change his or her sexual orientation if that is the psychotherapeutic treatment the patient desires after being informed of the difficulty of the work, the chances of success, and the possibility of recidivism. Accusing professionals who provide treatment for fully informed persons seeking to change their sexual orientation of perpetrating a fraud is not accurate. Such a tactic serves only to stigmatize the professional and shame the patient. A political agenda should not be permitted to prevent gays and lesbians who desire to undertake sexual orientation change efforts from exercising their right to self-determination" (Cummings, 2013, pp. 6–7).

It is acceptable for me to disparage the research of others without much scientific basis, but it is not acceptable for others to disagree with my research even if there is scientific basis for that disagreement.

The APA (2021) Resolution argues that people would not be concerned about changing their sexual orientation if SOCE did not exist. The idea is to blame the therapist for the client having needs, so if the therapist would just disappear, personal or marital problems would disappear. If there was no SOCE, then no one would ever feel unwanted same-sex sexual attraction. If the message is unwelcome, is it the fault of the messenger?

Another problem is that asymmetrical (biased) standards are implicitly used when

evaluating SOCE research. Using some raw data drawn up by Schumm in a few minutes, let's suppose that a therapist was running a marriage therapy program, using the scores from one spouse to assess change. The data here used five 1's, four 2's, four 3's, four 4's, three 5's, and four 6's at pre-test, with the following sets of scores for pretest 1's (7, 2, 3, 4, 5); 2's (1, 1, 5, 5); 3's (6, 6, 5, 4); 4's (5, 3, 5, 6); 5's (6, 5, 6); and 6's (7, 6, 6, 7), so anyone is welcome to replicate our analyses. This data is presented graphically in Table 1.

Table 1

Hypothetical distribution of post-test scores based on pre-test scores (ranging from 1 to 7)

Pre-test scores below; Post-test scores to the right	**1**	**2**	**3**	**4**	**5**	**6**	**7**	Remarks: Cells contain the number of cases
Extremely Dissatisfied (1) N = 5	0	1	1	1	1	0	1	Only one person changed from a pre-test score of 1 to a post-test score of 7
Very Dissatisfied (2) N = 4	2	0	0	0	2	0	0	Two scored lower at post-test
Somewhat Dissatisfied (3) N = 4	0	0	0	1	1	2	0	One did not change
Mixed/Not Sure (4) N = 4	0	0	1	0	2	1	0	One scored lower at post-test
Somewhat Satisfied (5) N = 3	0	0	0	0	1	2	0	One did not change
Very Satisfied (6) N = 4	0	0	0	0	0	2	2	Two did not change
Extremely Satisfied (7) N = 0	0	0	0	0	0	0	0	No cases in this pre-test group

There were 24 spouses assessed at pre-test and post-test on an item whose score ranged between 1 and 7, with higher scores indicating greater marital satisfaction. With the data used, the pre-test mean was 3.33 (*SD* = 1.79) and the post-test mean was 4.83 (*SD* = 1.74). The mean difference was 1.50 and the standard deviation of the difference was 1.69. Depending on which website calculator is used, Cohen's *d* was between 0.84 and 0.89, a large effect size. The results were very significant, $t(23) = 4.23$ ($p < .001$). Using a Wilcoxin signed-ranks test, $z = 3.45$, $p = .001$, so the results would be similar using either parametric or nonparametric statistics. It is likely that most therapists would consider the results impressive, both substantial in effect size and very significant statistically.

However, SOCE critics would probably argue that in the raw data only one spouse changed from a 1 to a 7 and only three ended up at a 7 while three scored lower at post-test

and three more were unchanged at post-test with many (n = 11) changing by only one or two points in a positive direction (so that the majority of the clients (n = 14) either did not change at all or only changed a "little". One might claim that of the 24 clients, seven were divorced during or after the program, which might be taken as failure, harm, or success (Moxley et al., 1987). Both explanations of the results are technically correct.

While most scientists would present the first set of results and claim "success," SOCE critics are more likely to take issue with the results by focusing on the second set of results, assuming the outcome measured was sexual orientation (i.e., few (n = 3) clients became completely heterosexual (and most—two of three—of them started as "mostly" heterosexual so their change was small), only one changed from completely gay to completely heterosexual, and most remained more or less bisexual (i.e., started out as bisexual and ended up as bisexual), while three became "more" gay. SOCE critics would probably conclude from the data that SOCE was not effective, despite the "impressive" first set of results. Furthermore, SOCE critics could argue that the program was "harmful" because some clients got "worse," some did not change at all, and for all the time and expense lost to the participants, a majority got worse or got little benefit from the program. Perhaps marital therapy should be banned, given such poor results! It is also interesting that recent research has found a number of interventions (other than SOCE) to be ineffective (Williams et al., 2020), even more harmful than effective, and yet we are unaware of calls for their termination by major professional organizations, or at least not with the same fervor as for SOCE.

We believe that the same standards should be used for SOCE as for other types of therapeutic interventions rather than carving out a special set of standards for SOCE not used elsewhere for evaluating therapeutic interventions. In other words, we do not think it is logically coherent to apply different standards statistically just because the outcome measure is different. In other words, SOCE critics are apt to use a double standard or special pleading when evaluating SOCE results.

APA Claims: "Sexual Orientation Diversity Is Normal and Healthy"

In this section the APA resolves that "diversity in orientation represents normal human variation." From the perspective of many religions, the original sexual diversity was mixed-gender; in some sense, same-gender sexuality is a retreat from diversity, even a regressive situation. Same-sex sexuality is not uncommon in human history (and "normal" in that sense) but seldom has it been deemed adequate as a total replacement for heterosexuality. The research that has linked adult homosexuality to childhood sexual abuse would seem to suggest that at least certain types of homosexuality are a result of developmental stresses or trauma and may not be healthy (Schumm, 2013; Tolman & Diamond, 2014).

The APA fails to consider the complexity of the many meanings of normal. Normal can be defined statistically (here heterosexual orientation and behavior could be considered normal by its sheer prevalence), psychologically, and morally. When combined with evaluative terms, such as "a normal and positive variant of human sexuality," the APA is making moral judgments about sexual behavior that are outside its scope of expertise and where they have no greater authority than religious organizations (if not less authority). Whatever meaning of normality one chooses as applied to sexual orientation, we do know that homosexuality as an identity is anomalous in the animal kingdom. As

Bancroft observed, "We should also keep in mind that whereas homosexual interactions are common across many species, exclusive homosexual involvement, with the rejection of opportunities for heterosexual activity, is exceedingly rare in nonhumans" (Jannini et al., 2010, p. 3252).

The APA (2021) argues that there is no scientific basis for regarding any sexual orientation as resulting from trauma or parenting. However, several studies have analyzed previous research and found a higher rate of nonheterosexuality among offspring of same-sex parents, including a recent meta-analysis (Schumm & Crawford, 2021a). Another meta-analysis found that same-sex parental approval of sexual diversity might be one among other variables linking higher rates of nonheterosexuality among the children of same-sex parents (Schumm & Crawford, 2021b). Same-sex parents appear to be more vulnerable to break-ups, which generally are not helpful to the children involved (Schumm, 2020a, 2020b).

The APA (2021) claims that a large percentage of sexual minorities are actually bisexual and not exclusively same-gender attracted individuals and that SOCE "protocols" oversimplify, misrepresent, or dismiss bisexuality. The APA is correct that, especially for women, a large percentage of LGBT persons are bisexuals. However, SOCE research as reported in several articles does recognize this situation (Bondy, 2021; Jones & Yarhouse, 2007, 2011; Spitzer, 2003), including the fact that men can also be bisexual (Sullins et al., 2021).

The APA (2021) claims that stigma against sexual minorities (heterosexism, monosexism) contributes to depression, suicidality, anxiety, and substance abuse. Sexual minority stress theory does argue in favor of the idea that stress imposed on sexual minorities contributes to depression, anxiety, substance abuse, and suicidality. However, sexual minority theory is not without its critics (Bailey, 2020; Rosik, 2019, Schumm, 2020b, etc,). Research that tries to untangle relations among those variables is relatively scarce and is usually limited by the problem that current associations among those variables may be confounded by previous conditions prior to the time that the surveys were conducted (Sullins, 2022). Some research that has tried to control for stigma and discrimination has not been able to eliminate adverse outcomes (Schumm, 2013), suggesting that sexual minority stress cannot explain all of the adverse outcomes found among homosexuals. In fact, Schmitt et al.'s (2014) updated meta-analysis (which summarizes results of multiple studies) found LGB-related discrimination (i.e., heterosexism) explained less than 9% of the relationship between discrimination and well-being and discrimination and psychological distress. It appears minority stress is accounting for only a part, possibly a small part, of the causative influence on sexual orientation health disparities.

In fact, the best study of minority stress theory found that despite over 50 years of dramatically and progressively increasing societal affirmation of and civil rights for LGB-identified individuals, as well as the censoring of change-exploring therapy, the psychological stress of LGB-identified individuals has continually worsened. The originator of this minority stress theory, Meyer, and colleagues used the same Generations data set as Blosnich and colleagues (2020) and Sullins (in press) used. Meyer and colleagues noted their study of the minority stress theory was the first to use a nationally representative sample, a large-scale study, and questions and measures specific to this population. They concluded the findings did not support the minority stress theory (Meyer, Russell et al., 2021). In addition, Bailey's (2020) proposed genetic model to explain sexual minority disparities

in mental health outcomes is overly simplistic in its causal attributions and that the research evidence for such a model is weak (Meyer, Pachankis et al., 2021).

The APA (2021) claims that psychologists "do not misrepresent research" but don't they do this in some sense? Schumm has provided extensive evidence that psychologists and sociologists have misrepresented research by citing more often their own and the research of others that looks more favorably upon homosexuality than equally credible research that found otherwise (Schumm, 2015, p. 6; Schumm & Crawford, 2020; Schumm et al., 2020).

A paragraph in Przeworski et al. (2021) is worthy of consideration, entitled "LGBQ sexual orientation is not a form of psychopathology." Most SOCE consumers are highly religious and view their same-sex behavior not as a problem of pathology but one of morality, a domain psychology has no unique authority to arbitrate. Furthermore, it is not clear that SOCE advocates see sexual orientation as necessarily pathological (Sutton, 2019), as Przeworski et al. claim. They cite one study that said the clients were told they could not live fulfilling lives as gay individuals, but on the other hand, some reports (Spitzer, 2003; Whitehead & Whitehead, 1999, pp. 219–223) have found that gay persons themselves have volunteered for SOCE because they felt that the gay life was "emotionally unsatisfying," which raises the question of who was telling whom what. Przeworski et al. then claim that the view that homosexuality is problematic is "antiquated and has been refuted in recent literature" (p. 92).

Przweworski et al., as well as Hancock and Haldeman (2022, p. 131), cite Hooker's (1957) research, claiming she did not find any differences in the psychological functioning of gay men, even though that claim was not Hooker's (Schumm, 2015), as she *did* find significant differences between her gay men and her heterosexual sample (Cameron & Cameron, 2012; Schumm, 2012). Przeworski et al. proceed to cite only six studies that are all 25 to 30 or more years old to support the idea that "Empirical research has since amassed demonstrating that same-sex attraction is not associated with poorer psychological functioning," or that there were no differences in "psychological symptoms and self-esteem" (p. 92). Then they proceed to cite more recent research (although still more than ten years old) in at least seven studies that found increased rates of anxiety, mood disorders, substance use, and suicidality for LGB persons, which is explained away as a result of discrimination and minority stress. Thus, there are differences in psychological functioning—and were as far back as Hooker's research—but the causes remain in debate. Researchers should test not merely to see if discrimination might cause *some* of those differences (it probably does) but whether it causes *all* of any differences observed.

SOCE Reinforces Societal Stigma for Sexual Minorities

The APA argues that SOCE reinforces the idea homosexuality is disordered and that the idea treatment can change sexual orientation is contrary to scientific evidence and leads to stigma against sexual minorities. In other words, APA argues that stigma leads to bad things for LQBTQ people.

Again, we can agree that stigma is not good. But is it the intent of SOCE to stigmatize gays? First, one must consider whether anti-SOCE research itself stigmatizes LGBT persons. For example, Skerven et al. (2019) cite as evidence of harm to LGBT persons the idea that sexual minority stress shortens the lifespans of LGBT persons by 12 years; however, that idea was based entirely on an article (Hatzenbuehler et al., 2014) that was

retracted for statistical errors (Hatzenbuehler et al., 2018), which when corrected found no change in lifespans (Regnerus, 2017). Second, there is evidence that when persons are surveyed about previous SOCE that did not lead to changes in sexual orientation, they may feel that it was related in some ways to felt stigma (Skerven et al., 2019). However, one confounding factor that has not been studied so far is whether SOCE (as with other therapies) is voluntary or involuntary. Even premarital counseling or education that was not voluntary has been found to be less effective (Schumm & Denton, 1979). Parallel logic would suggest that when parents or others impose SOCE on children or adolescents or religions impose SOCE on adults, that it would be less effective, although some have claimed that SOCE is inherently involuntary because of societal discrimination (Maccio, 2011, p. 243).

In Schumm's (2022) recent re-analysis of Sullins et al. (2021), even when the SOCE participants increased in their same-sex sexual orientation, a majority rated the experience as favorable, which would seem to be unlikely if they had felt that the experience had been stigmatizing.

SOCE and Risks of Harm

Sprigg (2021) reviewed 79 studies listed in Doyle (2019), investigating whether SOCE programs were more harmful than other forms of counseling. Some of those 79 studies did not mention homosexuality, some did not report any new data, while others did not involve SOCE at all. Only six studies involved 50 or more human subjects. Spriggs reports that methodological weaknesses would support an idea that there is no definitive *proof* of the effectiveness of SOCE (p. 7), but yet there is considerable *evidence* of its effectiveness (p. 8). Furthermore, Sprigg argued that although it was true there has been anecdotal evidence of harm from SOCE, research has not shown that "SOCE is more harmful than other forms of therapy, more harmful than other courses of action for those with unwanted SSA, or more likely to be harmful than helpful for the average client" (p. 30), while the methodologically stronger studies were among those most often providing positive evidence for the effectiveness of SOCE. The results of some of those studies, as well as more recent ones, will be discussed later in this report. Since recent advancements in psychology dictate less reliance on null hypothesis significance testing and more reliance on effect sizes, as well as concern for harms as well as benefits, we will consider treatment effect sizes as well as significance levels and will discuss harms found related to SOCE (McKay & Jensen-Doss, 2020; Williams et al., 2020).

The APA states that SOCE reinforces sexual minority stress and that "sexual minority youth and adults who have undergone SOCE are significantly more likely to experience suicidality and depression than those who have not undergone SOCE" (p. 5). There are indeed a number of studies that feature an apparent association between having experienced SOCE and mental health concerns (Haldeman, 2022a). However, in a reanalysis of Blosnich et al. (2020), one of those studies reporting such an association (utilizing a nationally representative sample), Sullins (in press) took into account the pre-"SOCE" distress levels of the study subjects. While the effect of controlling for pre-SOCE suicidality was larger for adults than for minors, Sullins reported that after controlling for pre-existing conditions, there no longer remained any positive associations of SOCE with suicidality. Far from increasing suicidality, recourse to SOCE generally reduced it. For the most part the observed reduction in suicidality is not small, especially for those who received SOCE treatment as adults. Following SOCE, the

odds of suicide ideation were reduced by two-thirds (AOR of .30) for adults and by one-third (AOR of .67) for minors. Furthermore, in Schumm's (2022) re-analysis of Sullins et al. (2021), he found that even among those currently in or who had already been in SOCE with a current age of 18–25 years, the reported positives experienced in self-esteem, social functioning, suicidality, and depression in general outweighed any negatives. A case-wise analysis of the relative positives and negatives found that for about 70% of the youth, the positives exceeded the negatives and the reverse was only the case for less than 6% of the SOCE-experienced youth.

Studies such as Turban et al. (2020), Green et al. (2020), Goodyear et al. (2021) are delivered in the mass media, and in gay prominent publications and social media outlets as decrying SOCE as harmful to LGBT people and that makes them suicidal. The fact that these studies used many study participants and were published in prestigious journals also makes them more attractive to SOCE opponents. Even still, such studies are purely politically driven and speculative. For example, Turban et al. (2020) touted that LGBT people have an "association" between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts; however, they admit that it is possible that conversion efforts themselves were *not* causative of these poor mental health outcomes. Furthermore, as Larzelere et al. (2004) noted, those who engage in psychotherapy concerning suicidal tendencies are far more likely to commit suicide after therapy than control groups, making it appear that psychotherapy causes suicides; however, the result is an artifact of intervention selection bias, the same bias that is often overlooked when reporting correlations between SOCE and suicidality. As Larzelere et al. (2004) stated, "The logical error of affirming the consequent occurs when one observes the implied correlational pattern and concludes that the presumed causal pattern is therefore confirmed. This is a logical error because many other causal patterns could also generate the same correlational pattern" (p. 297). Furthermore, observed correlations can be due to other factors that obscure the true, underlying correlation (Rosenberg, 1968).

Furthermore, Sullins (2022) found that if pre-SOCE conditions were taken into account, SOCE reduced suicidality, showing that correlations between SOCE and suicidality were an artifact of higher suicidality before SOCE being a factor for entering into SOCE. In other words, observed correlations between SOCE experiences and mental health distress do not prove causation, least of all for SOCE conducted by well-trained professionals (Rosik, 2020). That fact is ignored often. As a recent example, Goodyear et al. (2021) stated that "Sexual Orientation and Gender Identity and Expression Change Efforts (SOGIECE) are known to contribute to significant psychosocial harms, including mental health morbidity" (p. 1). As evidence of that alleged causal effect, the next sentence says, "For example, recent national surveys of 2SLGBTQ+ people in Canada and the United States have indicated that exposure to SOGIECE is association with loneliness, regular illicit drug use, suicidal ideation, and attempted suicide (citations omitted). Despite these well documented harms . . ." (p. 1). In other words, some correlations were observed, and that by itself is assumed to be sufficient to "prove" causation. That sort of logic is simply not scientific. Rosik (2020) has discussed many other flaws of recent research intended to prove harm from SOCE.

APA suggests SOCE is harmful to youth, and that it does not work even though there is little outcome research on how SOCE actually affects youth, or the long-term

effects of SOCE on consumers. They reference Ryan et al. (2018) but fail to mention the use of this study in buttressing SOCE has been challenged on methodological grounds in the same journal (Rosik, 2021). Even affirmative therapies have garnered some reports of harm (Nicolosi et al., 2000). Psychotherapies in general have risks of deterioration, from 5–24% (Rosik & Popper, 2014). Again, Sullins et al. (2021) did not find much in the way of harm to youth in their assessment of SOCE. One factor overlooked is that adolescents may not have the authority to seek treatment for any condition or concern, so most often, it may be their parent(s) who send them—possibly against their wishes—for any kind of treatment, whether related to SOCE or not. This involuntary situation often bodes poorly for successful treatment outcomes, regardless of the type of intervention (Schumm & Denton, 1979).

The APA is correct that there have been no randomized control/treatment group longitudinal SOCE studies with pre-tests and post-tests. However, there have been studies that assessed SOCE outcomes for varying times since SOCE had occurred. As noted before, if SOCE was involuntary or assessed by persons who remained LGBT after SOCE or involved methods of torture, one would not anticipate positive evaluations, just as if one were to assess the effects of family therapy, one might obtain different results from samples of those who divorced after the therapy versus those whose marriages improved versus those who reported no change (Moxley et al., 1987). At the same time, when SOCE has been voluntary, non-punitive, and involved highly religious participants or participants who were anticipating heterosexual marriage, results have been positive (Bondy, 2021; Jones & Yarhouse, 2007, 2011; Karten & Wade, 2010; Spitzer, 2003; Stanus, 2013; Sullins et al., 2021). While results have been more positive for those who reported changes in sexual orientation in a heterosexual direction, those who changed in a more homosexual direction have also reported positive evaluations of their SOCE experience.

For programs designed to foster change, evidence is often reported in terms of significant differences between pre- and post-test scores that also reflect small ($d = .20$) to medium ($d = .50$) to large ($d = 0.80$) effect sizes (Cohen, 1992). Ideally, randomized treatment and control groups would be used. The best we have to date for larger sample studies ($n > 70$) involves retrospective pre-SOCE scores and current post-SOCE or during-SOCE scores. The disadvantage of such studies is that observed changes might have occurred in the absence of treatment or been caused by factors outside the treatment protocols. However, if SOCE were ineffective, one might expect to find small, non-significant effect sizes across most measured outcomes. On the other hand, if SOCE were effective, one might find medium to large and statistically significant measured outcomes. With that in mind, we will present the summary results from several recent studies.

First, we will remind readers that Larzelere et al. (2004) found very small effect sizes for numerous psychotherapy programs, including delinquency interventions ($d = 0.12$) and sex offender therapies ($d = 0.24$), as well as what we have already noted, that therapies with suicidal youth appeared to increase their rates of attempting suicide. In contrast, one meta-analysis of SOCE found positive effect sizes between .72 and .89 (Byrd & Nicolosi, 2002). Nicolosi et al. (2000), in a study of 689 men and 193 women, found an effect size of 1.37 for homosexual orientation [means of 5.84 ($SD = 1.24$) before SOCE and 3.77 ($SD = 1.37$) after SOCE] and an effect size of 1.84 for frequency of homosexual behavior with a partner [means of 4.70 ($SD = 2.14$) before

SOCE and 1.54 (*SD* = 1.15) after SOCE]. Schaeffer et al. (1999, 2000) studied follow-up results from 102 men and 38 women, who were trying to change their sexual orientation due to their religious beliefs, recruited from Exodus International conferences in 1993, 1994, and 1995. The average ages of the participants ranged from 35–47 years while the average level of education was some college. More of the sample reported behavioral change (no homosexual behavior for a year, 63.6%) than reported having changed their sexual orientation (29.3%), a significant difference by our estimate, McNemar test (df = 1) of 46.02, $p < .001$. The more religious subsample reported more behavioral success ($p = .045$) (Schaeffer et al., 1999, p. 333). Overall, involvement in SOCE was not related to behavioral success, but those who had been in SOCE for at least 38 sessions (n = 34) compared to a shorter-term therapy group (n = 52) had more success, 70.6% versus 44.2% ($p = .02$) (Schaeffer et al., 1999, p. 336). Effect sizes for sexual orientation between the initial contact and follow-up were small (0.00 to 0.17 towards less homosexual) although much stronger for those not successful (0.24 to 0.51 towards more homosexual). Notably, all four groups of men and women were substantially less homosexually oriented at follow-up than at age 18 (successful men, -1.19; successful women, -1.11; other men, -0.33; other women, -0.21). The differences between men across the two groups (-0.50) and between the women (-1.65) at follow-up were both significant ($p < .05$). In general, the self-reported mental health of those in the successful group was better or had improved while, in comparison, it was worse or had declined in the other group: loneliness, -0.77; paranoia, -0.55; self-acceptance compared to a year ago, 0.50; guilt, -0.47; self-acceptance, 0.46; depression, -0.35, all significant, $p < .05$. Similar results, in many ways, were found in later studies.

Karten and Wade (2010) reported SOCE results for 117 men. They noted that there are men with SSA who "experience their homosexual orientation and behavior at odds with who they really are" (p. 86). Motivations for SOCE included conflict between religion and homosexuality (88%), belief that a gay lifestyle was not emotionally satisfying (85.5%), or family disapproval (34.2%). Effect sizes and significance levels for their outcomes included heterosexual self-identity ($d = 1.45, p < .001$), homosexual feelings and behavior ($d = -1.53$, $p < .001$), and heterosexual feelings and behavior ($d = 1.12$, $p < .001$). Marriage was associated with lower SSA/SSB after SOCE ($p < .05$). They noted that "highly religious homosexual men may feel alienated from the gay community" (p. 98). Without reporting significance levels or effect sizes, they reported that SOCE seemed associated with improvements in psychological functioning, including with respect to self-esteem, social functioning, depression, self-harmful behavior, suicidality, and alcohol and drug abuse (from most to least magnitude, respectively).

Jones and Yarhouse (2011) conducted a quasi-experimental longitudinal study examining changes in outcome measures over 6–7 years, involving 72 men and 26 women who had been involved in faith-based ministries for SSA. Nearly 92% reported having been "born again." The retention rate over time was 64%. They found significant changes over time for SSA ($d = 3.21, p < .05$), and same-sex fantasy ($d = 3.47$, $p < .05$), but not same-sex infatuation ($d = 1.87$). Breaking down the changes in SSA from the first to last, of those who scored Kinsey 6, only one became completely heterosexual while four became mostly heterosexual; in contrast, two remained Kinsey 6 and 3 were Kinsey 5. Eight remained the same before and after SOCE. Twenty-two shifted in a more homosexual direction while 31 shifted toward heterosexuality. To assess

psychological harms, three parts of the SCL-90 scale were used, with effect sizes of -1.30 (n.s.), -2.14 ($p < .05$), and -3.68 ($p < .01$), indicating that overall, psychological health improved, despite or associated with SOCE. From year one to year six, 23% became more heterosexual, 30% engaged in chastity, 16% were continuing with SOCE, but 25% remained confused or kept a gay identity.

Bondy (2021) assessed SOCE among 128 men, 13 women, and 15 others. While SSA appeared to decrease with SOCE, Bondy claimed that "attraction change was not a key variable in this study" (p. 104); regardless, the effect size was small ($d = .14$) and not significant ($p > .05$). Bondy reported that many of the clients retained the same levels of SSA (41%) or became more homosexual after SOCE (19.8%) while 37.2% became more heterosexual. Over 28% of the clients reported childhood sexual abuse. There were more reports of positive SOCE experiences ($k = 470$) than negative ones ($k = 263$). It appeared that SOCE was seen more positively by those who entered it voluntarily rather than due to external pressures and those with lower initial SSA. SOCE was seen more negatively by those whose initial SSI was congruent with their initial SSA and by those who believed that changing SSA was immoral. Bondy concluded that "SOCE may be perceived to be more beneficial if the person does not believe their SSA defines their identity" (p. 104). He also found that congruence between SSA and SSI was related to having more external pressures to enter SOCE and stronger beliefs that SOCE was immoral. Several implications for clinicians were discussed, most notably the importance of respecting the client's feelings (especially regarding sexuality shame brought on before SSA by family or religion) and helping clients explore their SSA/SSI development process more than trying to alter it directly.

Pela and Sutton (2021) cite Diamond and Rosky (2016) as having claimed "unequivocally" that sexual attraction is "mutable" apart from SOCE (p. 63). They also cite research in which 5% to 24% of clients experience deterioration and up to 45% no change during general psychological therapy. They also noted that many studies that have found adverse effects of SOCE recruited those expected to have been unhappy with their SOCE experience or who had not changed from it. Some studies have relied so heavily on religious counseling that they should not have been described as psychotherapy. They reframed their counseling process as sexual attraction fluidity exploration (SAFE) therapy (SAFE-T) to minimize a direct focus on changing SSA/SSI/SSB. Their study was completed by 75 adult men. Most (75%) of the men attended church once or more a week. Some (36%) were between 18 and 25 years of age with another 33% under the age of 36. The study experienced considerable attrition as only 22 men did the 24-month follow-up measures. In terms of overall mental health, among those who were tested, well-being improved over two years with an effect size of 0.80 ($p < .001$), a substantial improvement larger than the scale's reliable change index. They claimed that 57% of their clients reported improvements in emotional well-being compared to an average of 37% for general psychotherapy. SSA decreased over time ($d = 0.28$, $p < .01$) as did SSI ($d = 0.52$, $p < .01$).

The authors claimed significant increases for OSA, although the effect sizes seemed small and changed considerably depending on the time of the measurement. Pela and Sutton (2021) concluded that "It is no longer true that there is no scientific evidence concerning whether SAFE-T is helpful or harmful" and that professional associations who warn against the use of SOCE are "misinformed, unprofessional, and even

unethical in terms of meeting the legitimate self-determination needs of clients" (p. 78).

Rosik et al. (2021) examined a sample of 192 sexual minorities to identify what characteristics might be related to perceiving five psychotherapy goals, four of which are associated with sexual orientation change efforts (SOCE), as being helpful or harmful. They also sought to determine whether these perceptions are associated with the health measures of depression, anxiety, life satisfaction, and physical health. They found that the goals of reducing same-sex attractions (SSA), feeling heterosexual attractions, and eliminating SSA were, on average, considered mildly to moderately harmful by the overall sample. The goal of not acting on SSA was rated between no effect and mildly helpful. However, a typically overlooked subgroup of participants who did not identify as LGBT and who were more traditionally religious tended to have greater perceptions of the helpfulness of goals associated with SOCE. Traditional religious belief, identity, and activity were associated with rating some goals of SOCE goals as at least mildly helpful. In fact, differences between participants who rejected an LGBT sexual identity and those who were LGBT-identified evidenced large effect sizes and median statistics for the non-LGBT participants were in the mildly to moderately helpful range for all change-oriented goals, with the exception of eliminating SSA, which obtained a no effect median. There was a heightened level of depression and anxiety among sample participants overall, but past pursuit of change-oriented goals did not appear to be a major explanation for current levels of distress.

Rosik et al. (2022) later utilized the same data set to examine 33 methods sexual minorities employed to address their sexual orientation distress, including some typically associated with SOCE (e.g., resisting or trying to overcome sexual desires). Utilizing a sample of 281 participants, the authors examined participants' ratings of perceived helpfulness for each method. They examined these methods for the full sample, between those who did or did not identify as LGB+, and between those with conservative, nonconservative, and non-theological viewpoints. Findings from the full sample indicated 13 methods that promoted acceptance of or were neutral toward same-sex sexuality were consistently perceived to be helpful while two aversive cognitive and behavioral techniques were generally rated as somewhat to moderately harmful. Other methods displayed much greater variability in their ratings. These methods mostly reflected religiously motivated intentions to live in congruence with religious values by restricting and otherwise discouraging SSAs and behavior. However, an examination of group differences by theological orientation and between participants who were LGB+-identified and those who were not revealed these methods tended to be perceived as mildly to somewhat harmful for the LGB+-identified and non-theological groups but mildly to somewhat helpful for those not identified as LGB+ and who endorse conservative theological beliefs.

Sullins, Rosik, and Santero (2021) evaluated the effectiveness and harms of SOCE among 125 men. Sprigg (2021) cited this study as one of the two strongest studies methodologically" (p. 30) done regarding SOCE. Nearly all the men (96%) attended church at least a few times a month. Significant declines were found for SSA, SSB, and SSI. Full remission of unwanted SSA was achieved by 14% and by 26% for SSB, while nearly 43% achieved partial remission of some aspect of same-sex sexuality. Ten percent or less of the men experienced gains in same-sex sexuality with SOCE. Married men responded more positively to SOCE than unmarried men.

Positive changes in self-esteem, social functioning, depression, self-harm, suicidality, and alcohol/substance abuse outweighed parallel negative changes by substantial levels. No more than 5% of the men reported marked or extreme negative changes for any of the six items assessed for change. Between 12% and 61% of the men reported marked or extreme positive changes across the same six items. Sullins et al. (2021) argued that studies with highly religious groups have found better results for SOCE than studies that involved non-religious, highly LGB-identified groups, with research with either group alone yielding an incomplete picture of SOCE effectiveness and relative harms.

Schumm (2022) further analyzed the data from Sullins et al. (2021). Effect size changes for SSA, SSI, SSB, and OSB at pre-test were 0.94 (p < .001), 0.60 (p < .001), 0.56 (p < .001), and 0.24 (p = .010), respectively, using parametric statistics. Higher retrospective pre-SOCE SSI predicted less change, while higher retrospective pre-SOCE SSB predicted more change. When participants reported exact congruence between SSA and SSI both before and during/after SOCE, their evaluation of SOCE was strongly related to their sexual orientation with r = -.70 (p < .001), such that the more gay the men, the less satisfied they were with SOCE and vice versa. Przeworski et al. (2021) argued that persons who lacked "LGBQ identity development" were more likely to seek SOCE and to be "highly vulnerable" (p. 92). In contrast, the data here found that a number of men scoring at maximum levels of LGBQ identity development had sought SOCE, and while a few changed, many did not, but nevertheless even those who did not change rated SOCE highly. On the other hand, those lower in identity development seemed to be somewhat more likely to respond to SOCE and report a more heterosexual orientation after SOCE. Other combinations of congruence yielded non-significant results. Those who became engaged or got married during SOCE had the largest gains in OSB compared to other marital situations. When results were evaluated for those currently between 18 and 25 years of age, positive reports regarding self-esteem, depression, suicidality, and social functioning (all p < .01) greatly exceeded negative reports about their SOCE experience. Reports of slight to moderate harms were rare, never exceeding 5.6%.

Ratings of SOCE did not vary as a function of time since beginning SOCE, suggesting that recall bias, if present, was not related to time, as Przeworski et al. (2021, pp. 90, 94) argued responses might be. Maccio (2011) surveyed former SOCE participants with an average time since SOCE of over 13 years, finding ineffective outcomes as recalled by 37 persons. Since that suggested an effect of time since SOCE on change, we conducted repeated measures analyses for each key outcome (SSA, SSI, SSB) using time since SOCE as a between subjects variable; however, none of the three interaction terms were significant, leading us to reject the hypothesis that time since SOCE was related to perceptions of change with SOCE. When perceived helpfulness with SOCE was recoded into three between subjects levels (none to slight, moderate/markedly, and extremely) and interactions were tested between helpfulness and change over time, there were three significant (p < .001) group by time interactions for SSI, SSA, and SSB (not for OSB) with effect sizes for change over time increasing linearly as a function of satisfaction: SSA (-0.53/0.74/1.41), SSI (-0.45/0.37/0.97), and SSB (-0.30/0.55/0.71). In other words, the more the clients changed, the more effective they rated the helpfulness of SOCE, so that from a client perspective, change did matter as something they seemed to have wanted from SOCE, rating SOCE as

more helpful when more change occurred and as less helpful when it did not. However, even when clients remained mostly or entirely gay, most rated SOCE as helpful, indicating that SOCE had benefits for many even when no change did occur.

What do these studies tell us? With groups of persons who are highly motivated and engaging in SOCE voluntarily, who are likely highly religious and who do not want their identity to be automatically determined by SSA, are probably experiencing sexual fluidity, especially those already married or anticipating a heterosexual marriage, results seem relatively good, with far more positive than negative results for their mental health. However, drastic shifts in SSA, SSI, or SSB are fairly rare, even though changes, on average, usually have involved medium to large effect sizes and are often statistically significant. Some SOCE clients may report stronger levels of SSA, SSI, and SSB after SOCE, of whom some will also report that SOCE was helpful for them. At the same time, if one were to study SOCE experience among non-religious persons who currently identify strongly as lesbian or gay and probably did so before or during SOCE, or who engaged in SOCE due to external pressures rather than on their own volition, one can expect to find far more negative results and more frequent reports of harm. The findings of these studies challenge assertions such as the "failure rate of SOCE has been estimated at ≥ 97%" (Salway et al., 2020, p. 503) or that SOCE have been associated with numerous adverse health outcomes. They also question the claims of "no meaningful evidence of reported SOCE effectiveness" or "considerable evidence of SOCE-related harm" (Dehlin et al., 2015, p. 104). These studies would question the assertion that all SOCE are necessarily "pseudoscientific practices" (Salway et al., 2020, p. 503) or inherently "harmful and unwarranted" (Salway, et al., 2021, p. 13). Some research has found no differences in mental health between SOCE participants and non-SOCE participants (Sullins, 2022).

Alternatives to SOCE

There is certainly merit in some of the APA's suggestions; non-punitive and voluntary therapies probably work better regardless of the therapeutic goals for the client. When the client brings their goals to the therapy rather than the therapist determining the goals, that is probably best for the client, regardless of the type of therapy. But it is arbitrary for the APA to assume that in all cases of SOCE, the provider determined the goals for the clients or used punitive methods.

Research on more recent SOCE programs suggests that SOCE has been more voluntary, non-punitive, and open to clients, based on their own self-determination, reaching different goals other than changing one or more aspects of sexual orientation. Since different clients appear to have different results with SOCE, it is probably best to conceptualize therapy as exploration regarding change rather than having a solitary or "one and only" goal of change of all aspects of sexual orientation (SSA, SSI, SSB). This is part of the reason some professionals have coined the term sexual attraction fluidity exploration in therapy (SAFE-T; Rosik, 2016). SOCE therapists might be well advised to explain the many apparent, even if short-term, advantages of SSI and SSB (e.g. autonomous lived experiences), while also discussing possible long-term disadvantages (e.g. heightened levels of riskier health conditions). There may be new approaches for therapy with LGBT clients that might benefit SOCE therapists, such as dialectical behavior therapy (Skerven et al., 2019). Furthermore, given the long duration of SOCE interventions, and the fear of harm, SOCE providers should monitor for harm across a

variety of dimensions throughout the programs and revise treatments accordingly when/if harms are observed; harms may include deterioration of mental health, be reflected in drop-outs, effects on other family members, increased suicidality, or feelings of inauthenticity (Fjelstrom, 2013; Williams et al., 2020; McKay & Jensen-Doss, 2020). Social desirability, adapted to the SOCE environment (Schumm, 2015, p. 40, recommended that social desirability questions should be adapted to the nature of the research), should be assessed and monitored throughout treatment and controlled statistically or by design in assessment of SOCE outcomes lest artificially positive outcomes merely reflect various forms of social desirability, self-deception, or desire to please the therapist or other significant others.

Conclusion

We have examined the report, "*APA Resolution on Sexual Orientation Change Efforts*" (APA, 2021), and similar recent reviews of SOCE literature (Haldeman, 2022a; Przeworski et al., 2021), and addressed the reports' main themes, responded to non-sequiturs, and we presented summary results from several recent SOCE studies. The APA Resolution features several illogical non-sequiturs as well as asymmetrical logic (it is good for me but not you) which are not recognized as limitations in that report. Readers of the "*APA Resolution on Sexual Orientation Change Efforts*" (APA, 2021), and similar recent reviews of SOCE literature, would walk away with unequivocal, one-sided information about the topic of SOCE.

The overarching proverbial messages made in the *APA Resolution on Sexual Orientation Change Efforts* report and others (Haldeman, 2022a, 2022b, 2022c; Przeworski et al., 2021) are that SOCE is rooted in heterosexism and monosexism, supports a number of horrid-like interventions, does not work, and is inherently harmful. When corrected for methodological oversights, however, the research shows that change-oriented goals did not appear to be a major explanation for current levels of overall distress and following SOCE, and the odds of suicide ideation were reduced. While only portraying SOCE as supporting horrid-like interventions, they most often fail to mention SOCE as using standard talk therapies (excepting Glassgold, 2022), for example interpersonal psychotherapy, and omitted any discussion about consumers with positive narratives and have admitted that their critiques were not up-to-date enough to include recent SOCE research (Haldeman, 2022b). While Boulos and Gonzalez-Canton (2022) acknowledge that most SOCE today involves only "talk" therapy (p. 188), they continue to argue that even "talk" therapy inflicts "myriad and serious emotional harms" on its "victims" (p. 199), an argument that we believe is not based on most scientific evidence about recent SOCE programs involving voluntary, consensual participation by clients.

The APA (2021) Resolution, as well as other recent reviews (Haldeman, 2022a; Przeworski et al., 2021) is flawed in terms of theory, logic, and science. They rely almost exclusively on sexual minority theory, when many other theories might be useful, including social exchange theory, planned behavior/reasoned action theory, mediational theories, stress sensitization theory, and justification theory, among others. They rely upon seriously flawed logic, treating SOCE as unchanged and unimproved over the past six decades. They rely upon very weak and limited science, overlooking recent reports on SOCE outcomes, not considering effect sizes for SOCE treatments, treating correlational results as causal, and often

overlooking ways of testing more complex models of SOCE. Ultimately, they attempt to develop and promote public policy on SOCE based on all of those severe limitations and impose that policy on entire states and nations no matter the limitations, while seeking to discredit any scholars or groups who might disagree with the APA's false "science" or related attempts to impose its will on others.

Brief Summary Bullets

Introduction

The proverbial monocultural content of the APA Resolution report and similar reports misinforms readers and policymakers.

Minority Stress

The APA claims minority stress leads to health disparities among LGBTQ persons. However, minority stress accounts for only a small minority of the causative influence on sexual orientation health disparities. Research shows that changes in the social environment had limited impact on stress processes and mental health for sexual minority people. The APA report relies almost exclusively on sexual minority theory when many other theories might be useful.

Heterosexism and Monosexism

The APA says heterosexism and monosexism are social stigmas, yet in turn they marginalize individuals who want to engage in male-female marriage that involves sexual fidelity.

Stigma

The APA's claim that stigma is responsible for LGBTQ vulnerabilities relies solely on sexual minority theory whereas explanations of other theories are not considered. Taking a deeper dive into the facts, it appears minority stress accounts for only a small minority of the causative influence on sexual orientation health disparities. The idea that sexual minority stress leads to reduced lifespans is an idea based entirely on an article that was retracted for statistical errors which, when corrected, found no change in lifespans.

Science and SOCE

The APA claims SOCE dismisses "valid research" that says homosexuality is innate and immutable, yet their claim is ideological rather than scientific. While the APA Resolution claims the idea that "negative childhood events" might cause "same-gender orientation" has been discredited, this is simply not the case.

Ethical and Professional Concerns

The APA's claim that SOCE is often used coercively and is potentially torturous is not supported by research, but often by deceptive reporting.

APA Claims, "Sexual Orientation Is Normal and Healthy"

The APA claims "diversity in sexual orientation represents normal human variation"; however, this is a moral judgment outside their scope of expertise whereas they have no greater authority than religious organizations (if not less authority). The research that has linked adult homosexuality to childhood sexual abuse would seem to suggest that at least certain types of homosexuality are causatively shaped by developmental stresses or trauma and may not be healthy.

APA Claims That "SOCE Reinforces Societal Stigma for Sexual Minorities"

Research has shown that voluntary participation in SOCE need not be a result of stigma. Research has also shown that even when SOCE participants increased their same-sex sexual orientation, a majority rated

the experience as favorable, which would seem to be unlikely if they had felt that the experience had been stigmatizing.

SOCE and Risk of Harm

The APA says sexual minority youth who undergo SOCE are more likely to experience suicide and depression; however, research finds that there is no positive association of SOCE with suicide and, in fact, recourse to SOCE generally reduces it. Further, observed correlations between SOCE experiences and mental health distress do not prove causation. When SOCE was voluntary, non-punitive, and involved highly religious participants or participants who were anticipating heterosexual marriage, results have been positive.

Alternatives to SOCE

We agree that any therapeutic effort should be voluntary and not coerced; however, the goals do not have to be "one and only" essentialism as the APA prescribes. Using sexual minority theory to explain everything squashes any other explanations to be tested.

Conclusion

The APA report attempts to develop and promote public policy on SOCE based on studies with severe limitations and impose that policy on entire states and nations, while seeking to impose its will on others and discredit any scholars or groups who might disagree with it.

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