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Sexual Attraction Fluidity and Well-Being in Men: A Therapeutic Outcome Study

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Recent legislative efforts initiated by politicians and activists have limited or threatened to limit the autonomy and self-determination of individuals desiring sexual attraction fluidity exploration in therapy (SAFE-T), claiming that SAFE-T is ineffective and harmful. The American Psychological Association has claimed that there is not enough rigorous research to draw conclusions about the efficacy or beneficence and nonmaleficence of SAFE-T. The present longitudinal study examined the sexual attraction fluidity (SAF) and wellbeing of psychotherapy clients while participating in SAFE-T. Participants were 75 adult male psychotherapy clients reporting both same-sex attraction experiences (SSAE) and the desire to participate in SAFE-T to achieve SAF. Well-being was measured with the OQ-45.2, SSAE, and opposite-sex attraction experiences (OSAE) with a Likert scale, and sexual attraction identity (SAI) with a Likert-type item. Results of *t*-tests of the means of baseline and final well-being measures revealed a clinically and statistically significant improvement in well-being. A linear mixed model was used to analyze the SSAE, OSAE, and SAI data obtained at baseline, 6 months, 12 months, 18 months, and 24 months, with results showing statistically significant fluidity of all three factors. SSAE decreased, OSAE increased, and SAI moved toward heterosexual identity.

Keywords: sexual attraction fluidity, well-being, OQ-45.2, SAFE-T, psychotherapy

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The American Psychological Association and other mental health organizations (American Psychiatric Association, 2013, 2018; National Association of Social Workers, 2015; Substance Abuse and Mental Health Services Administration, 2015) have provided guidance to psychologists to dissuade clients from exploring sexual orientation change (American Psychological Association, 2019, 2012, 2021) or what we call *sexual attraction fluidity* (SAF). The American Psychological Association (2012) defines "sexual orientation" as "the sex of those to whom one is sexually and romantically attracted." The organization acknowledges that while persons commonly may identify—or be identified—as lesbian, gay, bisexual, or heterosexual, "sexual orientation does not always appear in such definable categories and instead occurs on a continuum" (p. 11). Also, "research indicates that sexual orientation is fluid for some people. This may be especially true for women (e.g., Diamond, 2007; Golden, 1987; Peplau & Garnets, 2000)" (p. 11).

The 2012 American Psychological Association's *Practice Guidelines* state that "efforts to change sexual orientation have not been shown to be effective or safe" (p. 14). In defense of this position, they state that there is insufficient research evidence to demonstrate the impact of sexual orientation change efforts (SOCE) on the well-being and SAF potential of individuals. The organization critiques existing research as inadequate for providing clear, empirical support for *sexual attraction fluidity exploration in therapy* (SAFE-T), saying that the research includes "biased sampling techniques, inaccurate classification of subjects, assessments based solely upon self-reports, and poor or nonexistent outcome measures" (American Psychological Association, 2012, p. 14). Paradoxically, they use similar research to support their opposition to SAFE-T. The revised guidelines produced in 2021 contain no improvements in the quality of evidence supporting the APA's opposition to SAFE-T, despite amplification of the claims of harm (American Psychological Association, 2021; see *Guideline Four*). The references are largely replicated from the original guidelines. One exception is a newer retrospective, observational study (Blosnich et al., 2020) comparing lifetime suicidality of participants who had not explored their sexual attraction fluidity with participants who had received primarily religious interventions (81% of the participants experienced only religious interventions) at some point in their lives. They found that participants who had sought assistance also had higher suicidality. The 2021 guidelines imply that this descriptive, retrospective, non-experimental design study demonstrates that professional psychological SAFE-T instigates suicide. Again, this is despite the observational, descriptive, and retrospective design of this study of predominantly religious mediation and despite Blosnich et al.'s extensive discussion of the inadequacy of the study for making such inferences (p. 1029). The study instead seems to communicate that individuals who experience distress are more likely to seek assistance. Taking into consideration this confusing guidance, we agree with the APA's original assertion (2012) that the clinical outcome research for SAFE-T is inadequate and needs to be updated.

Prominent SAF researchers Bailey et al. (2016) agree, at least in principle, with the need to pursue SAFE-T outcome research, stating "the more politically controversial a topic, the more it is in the public interest to illuminate it in a revealing and unbiased manner" (p. 46). The level of efforts of activists and politicians to regulate this clinical practice establishes SAFE-T as a

controversial topic. Such efforts have included attempts to remove the rights of individuals to receive, and mental health professionals to give, therapeutic support for pursuing SAFE in no less than 20 states and several municipalities (Movement Advancement Project).

The literature review provides a theoretical foundation for continued SAFE-T outcome research followed by an overview of the psychotherapy harm research. The previous research provides a rationale for conducting this and future research on SAFE-T, despite the American Psychological Association's injunction against supporting clients' goals to explore SAF.

Literature Review

Theoretical Foundations

Sexual Attraction Fluidity

Arguments against allowing individuals to pursue SAFE-T rest on a long-held presupposition that homosexual attraction is immutable. However, this presupposition is contradicted by evidence of *sexual attraction fluidity* (SAF). The Laumann et al. (1994) study of human sexuality observed that people do change the objects of their sexual attraction over time. More recently, Diamond and Rosky (2016), in their comprehensive review of the SAF literature, unequivocally concluded that sexual attraction is mutable, apart from any professional therapeutic assistance. They support their claims, in part, with evidence from failed attempts to discover chromosomal and other biological evidence of programming for sexual attraction, and from the broad body of literature demonstrating that SAF is the norm, particularly for people who have had same-sex attraction experiences (SSAE). The antecedents and influences of SAF include relational, emotional, cultural, and biological elements (Diamond, 2008; Diamond & Rosky, 2016; Farr et al., 2014), with life experiences having a particularly significant influence (Diamond & Rosky, 2016; Silva, 2017). Typically, SAF moves toward opposite-sex attraction experiences (OSAE; Diamond & Rosky, 2016).

Further, in contradiction to the narrative that accepting and embracing a "sexual orientation" is the best option for psychological health (American Psychological Association, 2012, 2021), Diamond notes an association between psychological maturity in women and the rejection of self-labeling in accordance with sexual attraction experiences (Diamond, 2008). Finally, the American Psychological Association agrees that individuals can and do experience SAF, stating, "sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid" (2009, p. 14).

If, as Diamond and Rosky (2016) conclude, sexual attraction experiences can change with apparently no conscious effort, it is reasonable to assume that some individuals should be able to influence their attractions as a byproduct of processing trauma and other emotions or relational concerns while participating in SAFE-T. Further, a person may choose to intentionally change or influence the effects of the relational, emotional, cultural, and/or biological factors which have contributed to or otherwise co-occur with their experience of sexual attraction. This logic is corroborated by decades of research. Reports of self-determined SAF exploration include accounts of individuals successfully utilizing a variety of means in support of this process. Some individuals report assistance through religiously mediated interventions (Jones & Yarhouse, 2011; Shidlo & Schroeder, 2002; Spitzer, 2003) and others using psychotherapeutic interventions (Karten & Wade, 2010; Nicolosi et al., 2000; Phelan,

2014, 2017; Phelan et al., 2009; Santero, 2012; Shidlo & Schroeder, 2002).

Reported Beneficence and Harm for Persons who Participate in SAFE-T

As established earlier, the American Psychological Association has claimed that SAFE-T is "not safe," i.e., harmful, without the benefit of rigorous empirical evidence to support their assertion (American Psychological Association, 2012, 2021). It is problematic that they support their position with research that has "a host of methodological problems . . . including biased sampling techniques, inaccurate classification of subjects, assessments based solely upon self-reports, and poor or non-existent outcome measures" (2012, p. 14). Additionally, the context of the general harm literature is omitted from the American Psychological Association's evaluation of the potential harm of SAFE-T, which calls the validity and wisdom of the assertion into question. As Rosik states, "any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general" (2014, p. 112). Accordingly, we provide a general background concerning the helpfulness (beneficence) and harmfulness (maleficence) of psychotherapy practices in general before reviewing their relevance to therapy outcomes for sexual minorities.

General Population Beneficence and Harm. There are various definitions for the term *harm* in the psychotherapy outcome literature, including damage (Dimidjian & Hollon, 2010), negative side-effects, and clinical deterioration (Bergin, 1966; Lambert, 2013). It should be noted that embedded in the harm literature are accounts of non-effective therapy resulting in no change in the client's presenting problem. It appears that every established approach to psychotherapy, even when documented as generally effective or helpful, is frequently ineffective for client goals that are approved by the American Psychological Association (e.g., reducing depressive symptoms). For example, one study determined that 45% of clients presenting with depression experienced no reliable change (Kraus et al., 2016). This evidence of the frequent ineffectiveness of psychotherapy is particularly salient to provide a context for the American Psychological Association's concern that SAFE-T is not sufficiently effective.

In contrast to reports of ineffective psychotherapy, "clinical deterioration," i.e., unwanted side-effects or "harm," can and does occur for a relatively small number of clients. A conservative estimate of the range of individuals who get worse while receiving psychological treatment is 3–10% (Berk & Parker, 2009; Boisvert & Faust, 2003; Kraus et al., 2011). Lambert (2013) reports that reviews "of the large body of psychotherapy research, whether it concerns broad summaries of the field or outcomes of specific disorders and specific treatments" lead to the conclusion that, while "psychotherapy has proven to be highly effective" (p. 176) for many clients, all clients do not report or show benefits. In addition, the research literature on the "negative effects" of psychotherapy offers "substantial . . . evidence that psychotherapy can and does harm a portion of those it is intended to help." These include "the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment" (p. 192). Such findings have been reported in the therapeutic and scientific communities for over three decades (Lambert, 2013; Lambert & Bergin, 1994; Lambert et al., 1977; Lambert et al., 1986; Lambert & Ogles, 2004; Nelson et al., 2013; Warren et al., 2010).

Harm can occur through acts of commission or omission. Acts of commission may range from explicit violations of ethics,

such as sexual exploitation, to the practice of therapeutic interventions no longer recommended for the treatment population, such as catharsis induction with victims of trauma or aggressive confrontation with substance abusers (Berk & Parker, 2009; Dimidjian & Hollon, 2010). Examples of omission include the failure to make a referral to another professional for more appropriate or effective treatment (Berk & Parker, 2009), ignoring systemic concerns such as family of origin influences (Castonguay et al., 2010), and overlooking intercultural conflicts (Wendt et al., 2014). Many individuals who present with distress related to sexual attractions identify family and cultural conflicts (Beckstead & Morrow, 2004). Adapting treatment goals and interventions to every client's specific cultural background is essential for best outcomes (Smith et al., 2011).

In the current study and previous sexual minority research, participants frequently identify strongly with their religious and ethnic culture (Balsam et al., 2011; Parent et al., 2013). This is consistent with the conclusion of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (American Psychological Association, 2009, p. v) "that the population that undergoes SOCE tends to have strongly conservative religious views that lead them to seek to change their sexual orientation." Therefore, the potential harm of ignoring, dismissing, or denigrating cultural identities are particularly applicable for those who seek SAFE-T. The ability to understand and affirm a client's culture appears to influence therapist effects as it communicates to the client that the therapist understands him or her (Smith et al., 2011; American Psychological Association 2009, 2012).

Therapist effects continue to emerge as possibly the strongest correlate of both benefit and harm. Therapist characteristics, such as her or his own mental health, style, personality, approach, philosophy, and especially the therapist's ability to connect to the client and his or her agenda, are strongly associated with (positive or negative) outcomes (Berk & Parker, 2009; Castonguay et al., 2010; Kraus et al., 2011). Therapist effects have a particularly significant influence on dropout rate (Swift & Greenberg, 2014), and incompetent clinical work is correlated with deterioration, increased suicidality, and violence (Lutz et al., 2007).

A review of literature that considers the importance of self-determination theory as applied to psychotherapy demonstrates that supporting clients' self-determination has powerful benefits, including reduction of depressive symptoms (Moore et al., 2020; Michalak et al., 2004; Pelletier et al., 1997; Ryan & Deci, 2008; Sheldon & Houser-Marko, 2001; Zuroff et al., 2007, 2012). Promotion of self-determination includes tailoring psychotherapy to the individual, as opposed to projecting a therapist's agenda, values, and possibly his or her interpretations onto the client (Norcross & Wompold, 2011). Other research has revealed that clients are helped when the therapist displays qualities of presence and empathy, and when they successfully communicate understanding and support for the client's values and goals (Lilienfeld, 2007; Moyers et al., 2016; Moyers & Miller, 2012; Timulak, 2010).

Overall, the general literature on clinical harm provides evidence that regardless of the client's presenting problems and stated goals, psychotherapy can result in poor outcomes. However, it does appear that some psychotherapeutic intervention is better than no intervention for most people suffering from psychological distress (Lambert, 2013; Lilienfeld, 2007) and privileging the client's agenda is essential for reducing harm (Lilienfeld, 2007; Moyers et al., 2016; Moyers & Miller, 2012; Norcross &

Wompold, 2011; Timulak, 2010; Zuroff et al., 2007, 2012).

Sexual Minority Beneficence and Harm. Comprehensive reviews of the sexual minority psychotherapy outcome literature have found that in addition to the problems of conflating psychotherapy with non-psychotherapeutic interventions, there are problems with the quality of the research (King et al., 2008; O'Shaughnessy & Speir, 2017). For example, there are few pretest-posttest designs, few control group designs, and few that use psychometric tests. Most of the research is retrospective (O'Shaughnessy & Speir, 2017; Przeworski et al., 2021) and includes recollections of client experiences from 40 years prior to data gathering (Israel et al., 2008). The data strongly supports self-determination theory with the consensus that poor outcome is frequently attributed to little support for the client's agenda (Israel et al., 2008; King et al., 2008). The Israel et al. (2008) review concluded that 25% of poor results (harmful or not helpful) are associated with the lack of support for the self-determination of the client.

Gay-Affirmative Therapy Outcomes. The American Psychological Association asserts that "the affirmative approach to psychotherapy grew out of an awareness that sexual minorities benefit when the sexual stigma they experience is addressed in psychotherapy with interventions that reduce and counter internalized stigma and increase active coping" (2009, p. 1). Ironically, research is lacking in support of this assertion. In their systematic review attempting to isolate outcomes for gay-affirmative therapy, O'Shaughnessy and Speir (2017) report that there are only four experimental, or quasi-experimental studies that measured gay-affirmative interventions. These studies report that efforts to eliminate or reduce gay-specific symptoms were largely ineffective. As an example, Pachankis et al. (2015) approached their carefully designed study with the assumption that anxiety, depression, alcohol abuse, and risky sexual behavior by men are the result of minority stress, internalized homophobia, and concealment of the participants' sexual experiences. One group received standard CBT and the other CBT modified with interventions targeting the researchers' gay-specific concerns. The results revealed no significant difference between the standard CBT group and the gay-specific CBT group for either depression or gay-specific symptoms. However, there was a decrease in depression in both groups. Because the depression was modified, but the gay-specific concerns remained the same, one might conclude that the depression was not directly tied to the gay-specific experiences.

A similar, more recent study "tested the efficacy of a minority-stress-focused cognitive–behavioral treatment" for sexual minority women dealing with "depression, anxiety, and alcohol use problems" (Pachankis et al., 2020, p. 613) and yielded similar results. The intervention used in this study was adapted from the one used in the Pachankis et al. (2015) study of sexual minority men mentioned above. Participants were tested at onset and at three- and six-month follow-ups and were randomly assigned to receive the ten-week intervention either immediately or after the three-month follow-up assessment. Overall, the women who received the intervention experienced significantly reduced depression and anxiety and a marginally significant reduction of their alcohol use problems. In their discussion, Pachankis et al. (2020) commented that "because the treatment was associated with only small reductions in minority stress processes and did not affect suicidality, future research is needed to elucidate the potentially unique mechanisms underlying sexual minority women's mental and behavioral health" (p. 626).

Several studies of gay affirmative or "gay specific" therapy (Reback & Shoptaw, 2014) were conducted to help gay men decrease drug use and risky sexual behavior with the goal of decreasing HIV transmission. Over a ten-year period, using replicated, randomized, control trials, Shoptaw, Reback, Larkins et al. (2008), Shoptaw, Reback, Peck et al. (2005), and Repack & Shoptaw (2014) showed that mainstream therapies, culturally adapted mainstream therapy, and a peer counseling model all effectively helped gay men significantly decrease casual same-sex behavior over the course of therapy. These gains were maintained at the six-month and the one-year follow-up. This research provides evidence that same-sex behavior can be effectively decreased through therapy to lower the medical health risks of the participants.

Both the King et al. (2008) and the O'Shaughnessy & Speir (2017) reports conclude that clients prefer affirming experiences in psychotherapy. However, both reviews deliberately excluded studies of sexual minorities seeking SAFE-T and therefore likely eliminated any participants who would have preferred to explore their SAF. It might be more accurate to say that clients who present with an agenda to affirm a sexual minority identity (since these are the only clients included in the report) are not benefited when a therapist ignores their agenda and promotes her or his own agenda.

Like the general population outcome research, sexual minority client outcome research supports self-determination theory. The participants who perceived their therapist as accepting and warm and supportive of their agenda had the best results (Israel et al., 2008; King et al., 2008; O'Shaughnessy & Speir, 2017). Particularly salient to the current study, clients preferred the counselor to see them and their problems outside of their sexual minority status and to not attribute their presenting problems to gay stress. At the same time, they wanted the therapist to be comfortable talking about sexuality issues (King et al.).

SAFE-T Outcome Research. Sutton (2014) has reviewed the SAFE-T outcome research literature and offered clarity on what conclusions may or may not be drawn about its documented harmfulness and benefits. This and the present review confirm the American Psychological Association's (2009) previous assertion that further research is necessary for documenting the beneficence and non-maleficence SAFE-T. As a background for the current empirical study, we highlight limitations of the SAFE-T research. Many are similar to the weaknesses found in the broad body of sexual minority literature (King et al., 2008; Israel et al., 2008) and the gay-affirmative outcome research (O'Shaughnessy & Speir, 2017) discussed earlier.

Clinical outcome studies designed to find evidence-based best practices for the treatment of all intra- and interpersonal difficulties typically use quantitative, prospective methodologies such as control trials, single group pretest-posttest, and other quasi-experimental designs (Des Jarlais et al., 2004; Kendall & Lippman, 1991; Liebherz et al., 2016; O'Shaughnessy & Speir, 2017). Studies investigating SAFE-T that use conventional methodological standards of evidence-based, clinical outcome research are lacking. Instead, the research purporting to investigate SAFE-T is primarily retrospective (Beckstead & Morrow, 2004; Blosnich et al., 2020; Bradshaw et al., 2015; Dehlin et al., 2015; Flentje et al., 2014; Meanley et al., 2020; Nicolosi et al., 2000; Phelan, 2014; Phelan et al., 2009; Salway et al., 2020; Santero, 2012; Shidlo & Schroeder, 2002; Smith et al., 2004; Sullins et al., 2021; Weiss et al., 2010) and qualitative (Beckstead & Morrow, 2004; Bradshaw et al., 2015; Flentje et al., 2014; Phelan 2014; Phelan et al., 2009; Shidlo & Schroeder, 2002; Smith et

al., 2004; Stanus & McDonald, 2013; Weiss et al., 2010). While retrospective and qualitative research is important for helping clinical outcome researchers form questions for evidence-based studies, these methods are not the standard for drawing conclusions and subsequently directing the development of clinical guidelines (Des Jarlais et al., 2004; Kendall & Lippman, 1991; Liebherz et al., 2016). An important exception to the use of a qualitative approach is a recent retrospective study (Sullins et al., 2021) reporting that 42.7% of 125 men pursuing sexual orientation change experienced reduction in same-sex sexuality. With its quantitative design, the Sullins et al. study provides an example of the type of research needed for offering evidence-based clinical guidance.

In addition to the basic design problems, there are some notable problems with participant selection. For example, the Shidlo & Schroeder (2002) study, which is highlighted as providing guidance for the development of the 2012 American Psychological Association LGB practice guidelines introduced bias at the outset when asking potential participants to "help document the harm" of SAFE-T. Both the Shidlo & Schroeder study and the more recent Flentje et al. (2014) study sought only dissatisfied gay-identified participants, consequently biasing the results. The practice of intentionally omitting participants who might have benefitted from SAFE-T from research on sexual minorities in psychotherapy is all too common. For example, O'Shaughnessy & Speir (2017) systematically excluded SAFE-T studies when reviewing the literature to assess the state of psychotherapy with sexual minorities. It seems the narratives of those who might have benefited from SAFE-T have too often been methodically excluded from the literature, *a priori*.

Most of the research reporting outcomes for individuals exploring SAF are investigations of the effects of non-psychotherapeutic experiences such as support groups, and religious or educational interventions (Dehlin et al., 2015; Jones & Yarhouse, 2007, 2011; O'Shaughnessy & Speir, 2017; Przeworski et al., 2021). Also, many studies intermingle these non-psychotherapeutic experiences with psychotherapy (e.g., Beckstead & Morrow, 2004; Blosnich et al., 2020; Bright, 2004; Przeworski et al.; Shidlo & Schroeder, 2002; Spitzer, 2003) resulting in unclear reports of the results and unanswered questions about the factors that lead to beneficent or harmful psychotherapy outcomes. These studies are often quite clear that the reports do not exclusively address outcomes of clinical interventions. For example, Blosnich et al., (2020) state that 81% of the participants in their study took part exclusively in religiously mediated interventions, not psychotherapy. However, these studies continue to be presented in counseling and psychology journals, representing the results as if they are related to psychotherapy outcomes.

An additional problem with this body of literature is obfuscation of terminology related to the practice of SAFE-T, resulting in misleading conclusions or no conclusions at all. For example, SAFE-T is not clearly defined by its opponents and is often labeled erroneously—and pejoratively—as *conversion therapy*, *reorientation therapy*, or using the generic term, *reparative therapy*, which was based on the specific SAFE-T model of psychotherapy labeled "Reparative Therapy" that was developed and promoted by Nicolosi (1993, 2020). Although often mistakenly presented as a specific approach to therapy, SAFE-T is an umbrella term for all therapeutic modalities or interventions which support client self-determination in relation to SAF exploration (Rosik, 2016, 2017).

Finally, much of the literature induces additional confusion by attributing reports of

harm to the exploration itself, as opposed to any specific interventions or therapist effects. For example, decades-old accounts of SAFE-T client experiences include descriptions of long-discredited psychotherapy practices that were once used for a variety of presenting problems and later discontinued (Lilienfeld, 2007). These include recovered memory techniques, rebirthing, aversion therapy, and misuse of electroconvulsive therapy (Israel et al., 2008). These same interventions were historically performed for the presentation of depressive symptoms (and other presenting problems) and were discovered to be similarly harmful to these clients. However, there is no current campaign against assisting clients wishing to influence their depression symptoms in therapy. Many authors who are critical of SAFE-T confuse or combine the treatment goals (sexual attraction fluidity exploration) with the treatment interventions and subsequently contend that the goals are harmful, as opposed to isolating the interventions as producing the harm.

Conclusions have been drawn about SAFE-T in the professional and public arenas without sufficient evidence. The concerns of professional organizations, mental health practitioners, politicians, and activists, regarding the beneficence and effectiveness of SAFE-T, can only be addressed with additional research employing prospective, empirical designs.

Method

The purpose of the current study was to determine the effects of sexual attraction fluidity exploration in therapy (SAFE-T) on well-being and sexual attraction fluidity (SAF). The participants were adult males presenting for psychotherapy with the desire to explore their SAF potential. Using a quasi-experimental, single-group, longitudinal, repeated measures design, the study evaluates the fluidity of opposite-sex attraction experiences (OSAE), same-sex attraction experiences (SSAE), sexual attraction identity (SAI), and well-being in male adult psychotherapy clients.

Participant Recruiting and Selection

The researchers received permission to recruit participants from new clients at two private practice psychotherapy clinics known for providing SAFE-T and sharing licensed clinicians. The researchers were not affiliated with these clinics and were not employees or contractors. The intent of the design was to allow observation of real-life client experiences in a clinical setting, providing more generalizable results than a controlled setting, such as a university psychotherapy training clinic (Weisz, Donenberg et al., 1995; Weisz, Jensen et al., 2005). Male adults reporting SSAE and a desire to explore SAF were provided a letter of invitation to participate in the study. Potential participants were assured that their participating in the study, or declining to participate, would have no impact on their clinical services. Further, consent for treatment and consent for research participation were clarified as distinct processes. Clients who agreed to participate, reviewed, and signed consent-for-participation forms that included research evidence related to the harm and beneficence of psychotherapy. The research assistant reviewed the consent form with each participant to address any questions.

One hundred and five participants ages 18 to 76 were recruited and began participation by the completion of pretests, and 75 participants completed the study. The 30 participants who did not complete the study included one participant who was withdrawn from the study when it was discovered that his clinician violated the research protocol when asking the participant to elaborate on a posttest SAE item. Six of the non-completers withdrew from the study. One stated that he no longer experienced same-sex attractions,

another that he did not want to be associated with the study, and four stated that they did not need further psychotherapeutic services. Twenty-three participants discontinued clinical services prior to the 6-month SAE posttest measure.

Instruments

OQ-45.2

Well-being was measured using the Outcome Questionnaire 45.2 (OQ-45.2). The OQ-45.2 is a 45-question instrument administered through an online testing center (http://www.oqmeasures.com). It is designed to provide real-time feedback of psychotherapy clients' progress. The OQ-45.2 is norm-referenced and has demonstrated the ability to detect change even in short-term therapy (Doerfler et al., 2002) with good reliability and validity (Lambert, 2004; Lambert et al., 1996). The measure was designed to assess for improvement and deterioration within three domains of client function: psychological, interpersonal, and social functioning (Lambert, 2012). Each item is rated using a 5-point scale (0=never, 1=rarely, 2=sometimes, 3=frequently, 4=almost always) with a range of possible scores of 0-180. A lower score indicates higher functioning and well-being (Lambert et al., 2001). Following recommendations for the use of the instrument to conduct research, the first (baseline) and last measures were compared.

SAQ

The Sexual Attraction Questionnaire (SAQ) Pretest and Posttest (adapted from Santero, 2012) uses separate Likert scales for two measures: opposite-sex attraction experiences (OSAE) and same-sex attraction experiences (SSAE). OSAE and SSAE items measure frequency of thoughts, feelings, and behaviors (kissing & sex) using a 5-point scale (1=never, 2=almost never, 3=monthly, 4=weekly, and 5=almost daily). Sex is defined as touching genitals, and oral, anal, or vaginal intercourse. The SAQ also measures sexual attraction identity (SAI) using a 6-point Likert-type item (1 = almost entirely heterosexual identity, 2 = more heterosexual than homosexual, 3 = bi-sexual, 4 = more homosexual than heterosexual, 5 = almost entirely homosexual, and 6 = homosexual). Both the pretest and posttest version of the SAQ include demographic questions and the pretest version includes questions about desires and motivations for SAFE-T.

Procedures

Instrument Administration

To obtain a baseline measure of SSAE, OSAE, and SAI, participants completed the pretest version of the SAQ prior to beginning SAFE-T. Subsequent measures were obtained throughout the course of treatment using the posttest version of the SAQ at 6 months, 12 months, 18 months, and 24 months. All SAQs were completed through Survey Monkey (http://www.surveymonkey.com). Additionally, prior to beginning SAFE-T, participants completed a baseline measure of well-being using the OQ-45.2 and repeated measures prior to each subsequent SAFE-T session throughout the course of treatment. The OQ-45.2 measures were administered through the OQ-45.2 online testing center (http://www.oqmeasures.com). If a participant had not completed the testing before the session, he completed the assessment in his therapist's office prior to the session using either his own or the therapist's device.

Intervention

The clinicians who provided psychotherapeutic services used Reintegrative Therapy™ (RT; Reintegrative Therapy Association, 2017, 2019; Nicolosi, 2017). RT is described as a specific combination of evidence-based, mainstream treatment interventions for trauma and

addiction. RT includes the use of EMDR and mindful self-compassion, emphasizing client autonomy and self-determination and is supportive of SAFE-T. While the standard RT treatment protocol was designed for treating trauma and addictions, therapists at the clinics report observations of a co-occurring reduction in SSAE in some men (Nicolosi, 2017).

In routine clinical settings clients autonomously end treatment for a variety of reasons. Often treatment ends because either the client, the therapist, or both believe that the therapeutic goals were met, or have determined that the treatment has plateaued in its effects. Other reasons for ending treatment include geographic relocation, changes in insurance coverage, or the desire to pursue other treatment options. Since this study took place in such a real-life clinical setting, treatment length was individualized according to the needs of the participants and therefore varied for each participant.

Statistical Analysis

Initial data analysis included the performance of *t*-tests comparing the means of the baseline measures of the participants completing services within 6 months and the 75 participants who completed the study with at least one posttest SAQ measure. Additionally, descriptive data, including means and standard deviations at each measure, and SAQ categorical data describing the participants who completed the study was compiled.

The effect of SAFE-T on well-being was evaluated using a *t*-test of the baseline and final OQ-45.2 mean scores with the addition of *Cohen's d* calculation of effect size. The use of baseline and final measure of the OQ-45.2 method has been recommended by others if the goal of the research is to determine the overall effect of the treatment, as opposed to tracking the slope of well-being change (Baldwin et al., 2009).

The linear mixed model was used to analyze the SAQ data (SSAE, OSAE, & SAI). The use of this model has several advantages over the more commonly used repeated-measures ANOVA for the analysis of within-group repeated measures, particularly a study that is conducted in a real-life clinical setting that lacks the controls of a laboratory setting. The conventional approach to the analysis of longitudinal, repeated measures data, the repeated-measures ANOVA, requires that the entire data set be dropped when a single measure is missing, introducing bias, and lowering power. The repeated-measures ANOVA only functions well when missing data is not a problem (which is rare in a two-year study), when comparing independent groups across multiple measures, and when sphericity can be assumed.

Longitudinal research requires analysis of incomplete datasets that does not introduce the bias inherent by dropping entire cases, as is required when using the repeated measures ANOVA. The repeated measures ANOVA requires the same number of repetitions of the measure for each participant in contrast to the linear mixed model. This accommodated participants' datasets if they delayed completing the measure at one of the designated time points or discontinued treatment before the final measure (Seltman, 2018).The linear mixed model performs well with smaller sample sizes, which is particularly important when conducting research in real-life clinical settings with specific and somewhat less common presenting problems, as in the case of individuals seeking SAFE-T. This model also allows for non-independence of observations inherent in a within-subjects design (Seltman, 2018). The analysis of the SAQ data was

conducted using Proc Mixed in SAS 9.4 software.[3]

Results

Preliminary Analysis

A preliminary analysis was conducted to assess for baseline score differences between participants that completed the study with at least one posttest SAQ measure (n=75) and the participants that terminated services prior to the 6-month SAQ measure (n=24). *T*-tests were performed using the means of the baseline measures of well-being (OQ-45.2), sexual attraction experiences (SSAE & OSAE), and sexual attraction identity (SAI). The results demonstrated no statistically significant differences in initial presentation for any of the factors (Table 1). The 24 individuals who completed services prior to the first posttest measure had comparable levels of well-being, SSAE, OSAE, and SAI at the initiation of SAFE-T as the 75 participants who remained in therapy for at least six months.

Table 1

T-test of means of Baseline Scores: 24 month and less than 24 month

Variables	24 Month Mean (Standard Deviation)	Less than 24 Month (Standard Deviation)	df	*t*	*p(2-tailed)*
OQ-45.2	71.27 (n=75) (20.48)	75.63 (n=24) (24.97)	97	-.860	.39
SSAE					
SS Sex	1.63 (n=75) (1.18)	1.93 (n=28) (1.18)	102	-1.140	.25
SS Kissing	1.42 (n=75) (.85)	1.82 (n=28) (1.10)	102	-1.965	.052
SS Thoughts	3.88 (n=75) (1.29)	3.82 (n=28) (1.30)	102	.211	.83
SS Feelings	3.61 (n=75) (1.43)	3.43 (n=28) (1.23)	101	.604	.18
OSAE					
OS Sex	1.38 (n=75) (.879)	1.63 (n=27) (1.00)	101	-1.212	.22
OS Kissing	1.52 (n=75) (1.00)	1.64 (n=28) (1.00)	101	-.560	.57
OS Thoughts	2.38 (n=75) (1.30)	2.29 (n=28) (1.00)	102	.344	.73
OS Feelings	2.74 (n=75) (1.30)	2.54 (n=28) (1.40)	102	.678	.49
SAI	4.2 (n=75) (1.40)	3.86 (n=28) (1.40)	102	1.159	.24

Notes: The n varied for dropouts due to occasional missing data.
Scales for sexual attraction experiences were 1–5; scale for sexual attraction identity was 1–6.
$p < .01$.

[3] Effect sizes for the SAQ data were not calculated. While there are standard methods for calculating effect sizes of paired samples t-tests (we used Cohen's d for the OQ-45.2 t-test), there are no agreed-upon methods for calculating effect sizes for mixed models (Lorah, 2018; Tymms, 2004). Additionally, the design of the study, with repeated measures and no control or comparison group further diminishes the ability to calculate effect sizes for the SAQ data (Tymms, 2004).

A detailed description of the characteristics of the participants who completed the study (n=75) is presented in Table 2. The typical participant was 18–35 years old (52%), Roman Catholic (57%), religious (75% attended church once or more per week), and White (83%). Ninety-two percent of the participants answered "yes" to the question about whether they desired to explore SAF and reported that they were predominately motivated by either religious reasons (30%) or a desire to pursue a traditional marriage (37%).

Table 2

Characteristics of Participants

Category	Total	Percentage (rounded to nearest whole number)
Age		
18–25	27	36
26–35	25	33
36–45	9	12
46–55	9	12
56–65	3	4
66+	2	3
Religion		
Agnostic	5	7
Baptist	3	4
Buddhist	1	1
Episcopal	1	1
Jewish	2	3
LDS	1	1
Muslim	7	9
Non-denominational Christian	7	9
Other Christian	6	8
Roman Catholic	42	57
Religiosity—attends church:		
Daily	8	11
A few times a week	18	24
A few times a month	5	7
1 x per week	25	33
Major holidays	4	5
Rarely or never	15	20
Ethnicity		
African American	2	3
Arabic	5	7
Asian/Pacific Islander	2	3
Hispanic	3	4
White	63	83
Desire for SA fluidity		
Yes	69	92
No	1	1
Not sure	5	7
Motivation for SAFE-T		
Desire for traditional marriage	28	37
Religious reasons	23	30
Social	5	7
Parent's Suggestion	2	3
Other*	17	23

**Note: Most participants citing "other" described it as a combination of two or more of the following: desire for traditional marriage, religious reasons, desire to improve psychological well-being, and a quest for value congruency.*

Well-Being

A *t*-test comparing the means (see Table 3) of the first and last measures of the OQ-45.2 completed by each participant was conducted to detect overall change in well-being. The results indicated a statistically significant difference, with a large effect size in the baseline and final well-being measures (*t*=6.970, *p*=.0001; *Cohen's d with Hedges correction*=.80). Additionally, the difference in the means of the pretest and posttest scores of 16.71 points exceeded the OQ-45.2 reliable change index of 14 points (Lambert et al., 1996; Lambert & Ogles, 2004). A change that is equal to or greater than the reliable change index indicates that the change is a true change in the client's clinical condition (Lambert & Ogles, 2004). Additionally, the posttest mean of 54.56 was well below the OQ-45.2 clinical cutoff level of 63 points (Lambert & Ogles, 2004). Therefore, the results indicate both a statistically significant and a clinically significant change in the well-being scores of the participants.

Table 3

Table of Descriptive Statistics

Mean (Standard Deviation)

Variable	Baseline N=75	6 mo. N=75	12 mo. N=53	18 mo. N=28	24mo. N=22
SSAE	2.63 (0.86)	2.32 (0.87)	2.39 (0.87)	2.39 (0.87)	2.39 (0.87)
OSAE	2 (0.86)	2.23 (0.9)	2.09 (0.93)	2.09 (0.93)	2.09 (0.93)
SAI	4.2 (1.38)	3.32 (1.56)	3.19 (1.54)	3.25 (1.53)	3.5 (1.26)
PREOQ N=75	71.27 (20.48)				
POSTOQ N=72					54.56 (23.32)

Notes: Scales for sexual attraction experiences were 1–5; scale for sexual attraction identity was 1–6; scale for OQ-45.2 was 1–100 with a clinical cutoff of 63.

Pearson's-*r* correlational analyses of the well-being measures and length of treatment were conducted to discover any relationship between length of treatment and the pretreatment and posttreatment measures of well-being (OQ-45.2). There were no significant relationships between length of treatment and measures of well-being, pretreatment (*r*(74)=-.094, *p*=.425) or posttreatment (*r*(71)=-.224, *p*=.059). Additionally, there was no significant relationship between improvement in well-being, measured by the difference in baseline and final OQ-45.2, and length of treatment, (*r*(71)=.137, *p*=.250).

Sexual-Attraction Fluidity

A linear mixed model (Proc Mixed in SAS 9.4) was used to analyze the SAQ data measuring SSAE, OSAE, and SAI fluidity. The linear mixed model is ideal for repeated measures data because it accounts for the fact that multiple responses from the same person are more similar than responses from other people. An additional advantage of mixed models, in comparison with the more conventional ANOVA, is that all available data is used (i.e., it allows for missing data). A random factor for subject and a random slope for time were included in the model. The addition of the random slope for time

allows the trajectory of fluidity in SSAE, OSAE, and SAI over time to vary across subjects while the fixed effect for time allows for participant change over time.

Modeling OSAE as the outcome (Table 4), the best fitting model included time as a fixed effect, a random factor for subject, and a random slope for time. The results indicate that OSAE increased statistically significantly during SAFE-T.

Table 4

Final Model of OSAE as Outcome

Effect	*6(SE)*	*df*	*t*	*p*
Intercept	2.0630 (0.0985)	74	20.95	<.0001
Time	.1012 (0.0298)	74	3.4	0.0011

p=<.01

Modeling SSAE as the outcome (Table 5), the best fitting model for SSAE fluidity also included time as a fixed effect, a random factor for subject, and a random slope for time. The result of the analysis shows that SSAE decreased statistically significantly during SAFE-T.

Table 5

Final Model of SSAE as Outcome

Effect	*6(SE)*	*df*	*t*	*p*
Intercept	2.5410	74	27.32	<.0001
Time	-0.1167	74	-3.70	0.0004

p=<.01

The best-fitting model for SAI included SSAE, OSAE, and time as fixed effects, a random factor for subject and a random slope for time (Table 6). Allowing for an unstructured covariance matrix did not improve the model. The results demonstrate statistically significant fluidity of SAI toward heterosexual identity.

Table 6

Summary of Final Model with SAI as Outcome

Effect	*6(SE)*	*df*	*t*	*p*
Intercept	4.0070 (0.3493)	74	11.46	<.0001
OSAE	-0.7232 (0.084)	101	-7.64	<.0001
SSAE	0.57 (0.0947)	101	6.3	<.0001
Time	-0.2127 (0.0523)	74	-3.85	0.0001

p=<.01

Discussion and Recommendations

In terms of the ethical principles of *beneficence* and *non-maleficence* (American Psychological Association, 2017, 2021), the results show that participants in this study experienced significant improvement in their well-being, as measured by the OQ-45.2. The OQ-45.2 measures interpersonal problems and their psychological and social functioning.

In addition, as measured by the *SAQ*, results show that participants experienced a significant *decrease* in the frequency of their same-sex attraction experiences, i.e., thoughts, feelings, and behaviors, including explicitly sexual ones. Participants also reported a significant *increase* in their opposite-sex attraction experiences. Finally, the participants in this study reported significant fluidity or change toward a heterosexual identity.

Overall, the results of this study document that exploring sexual attraction fluidity in therapy can be effective, beneficial, and not harmful. The Reintegrative Therapy™ (RT; Reintegrative Therapy Association, 2017, 2019; Nicolosi, 2017) used by the therapists in this study resulted in participants achieving desired decreases in same-sex attraction experiences (SSAE) and increases in opposite-sex attraction experiences (OSAE). In addition, the participants experienced improvement in their overall intra- and inter-personal well-being. These findings are consistent with almost a century of clinical reports and qualitative and retrospective studies which document that SAFE-T has been successful in helping patients or clients to intentionally diminish SSAE and develop or increase OSAE in a beneficent and non-maleficent manner (Nicolosi et al., 2000; Phelan, 2014; Phelan et al., 2009; Santero, 2012).

A finding that was of particular interest to us was the absence of a relationship between time in treatment and initial measures, final measures, or differences between initial and final measures of well-being. We speculated that the participants ending treatment earlier began with greater well-being, but in fact, there was no relationship between baseline well-being and time in treatment. Further, we wondered if those staying in treatment for twenty-four months had continued treatment because their well-being decreased during treatment, but again, the correlational analysis demonstrated no relationship.

Study Limitations

The most basic limitations of this study are common aspects of contemporary longitudinal clinical outcome research conducted in real world (i.e., outside of lab) settings. This includes the use of a single group, which in this case was warranted by the real-life clinical setting of the study, in which the researchers were observers, as opposed to a lab setting in which participants would be randomly assigned to a separate control, or treatment group. The use of a single group design prevents our knowing if persons who wanted to use SAFE-T to achieve SAF but were not treated would have experienced fluidity anyway. Also, the instrument that measures sexual attraction experiences (the *SAQ*) is self-report. Further, as is typical for longitudinal research performed in a real-life clinical setting, some clients completed treatment before others, resulting in various numbers of posttest measures.

Another possible limitation of the study is the high degree of religiosity of the participants. Eighty-four percent of the participants reported an identification with some variety of Christian denomination, over half (57%) of which were Roman Catholic. The potential influences of this finding on the generalizability of this study's results are unclear. As discussed above, it has been observed that the general population of

clients who participate in SAFE-T "tends to have strongly conservative religious views" (American Psychological Association, 2009, p. v). If clients seeking SAFE-T tend to be "conservatively religious," as were those in the present study, then the results may indeed be generalizable to the larger, general population of clients who undergo SAFE-T, but maybe not to the smaller population of non-religious clients.

Finally, this study focused exclusively on the experience of men seeking SAFE-T. Clinical literature describes that some women for whom same-sex attractions experiences are unwanted participate in SAFE-T and reportedly experience SAF as a result (Hallman, 2008, 2009; Patton, 2009).

Recommendations for Further Research

The real-life clinical setting and the longitudinal and quasi-experimental design of this study in which the environment was not manipulated has strengths that would be diminished with the introduction of control groups, comparison of treatment modalities, and random assignment. However, using control groups and random assignment might provide a clearer picture of the factors that influence SAF and well-being, including treatment modality, time, and external factors. Further, including post-therapy follow-up measures would document what happens to individuals after they leave therapy.

To address the cost of conducting a multi-year study and the problems of missing data inherent in longitudinal studies, future researchers might consider a cross-sectional design. In contrast to the single-group design of this study, a cross-sectional design would allow the researchers to assess several separate cohorts of clients (e.g., pretreatment cohort, 6 months in treatment cohort, 12 months in treatment cohort, etc.) while maintaining the advantages of the real-life clinical setting.

In consideration of the high religiosity of clients seeking SAFE-T, further research is needed to help clarify the factors which influence religiously motivated clients to participate in and to benefit from SAFE-T. In addition to religiosity, research that seeks to identify other cultural and demographic characteristics, including gender, that correlate with desire for SAFE-T would provide a more nuanced, less monolithic characterization by clinical organizations of individuals who seek SAFE-T. Studies including male and female participants and clinicians from various ethnic national, religious, and socioeconomic backgrounds across diverse clinical and geographical settings would facilitate developing a less biased view of these individuals.

Finally, consideration must be given to the recognition that unintended SAF may co-occur when clients are in therapy to help them address trauma and manage and resolve other bio-psycho-social issues. It should be noted that just as gay-affirmative therapists (Repack & Shoptaw, 2014; Shoptaw, Repack, Larkins et al., 2008; Shoptaw, Repack, Peck, et al, 2005) have intentionally worked to help clients diminish same-sex behavior to enhance their medical and mental health, so do the therapists who practice SAFE-T. For over a century now, SAFE-T approaches have been documented as helping clients to experience SAF by helping them to manage and resolve a range of bio-psycho-social issues. These include depression, anxiety, post-traumatic stress, including sexual abuse, substance and behavioral (including sexual) addiction, and codependent relationships. The possible consequence of "unintended" SAF occurring when GLB-identified persons use therapy to

deal with such bio-psycho-social issues also needs to be studied.[4]

Recommendations Concerning American Psychological Association Warnings and Anti-SAFE-T Legislation Advocacy

It is no longer true that there is no scientific evidence concerning whether SAFE-T is helpful or harmful. While this present study is a modest beginning, the studies by Shoptaw, Reback, Larkins et al. (2008), Shoptaw, Reback, Peck et al. (2005), and Repack & Shoptaw (2014) in which "gay specific" (gay affirmative) therapy was conducted to help gay men decrease their risky sexual behavior offer additional examples. In effect, these studies show that SAFE-T can help "gay men" intentionally modify their behavior with no significant negative consequences reported. This past research and the present study document that continued warnings by the American Psychological Association and other mental health associations against clients using SAFE-T are misinformed, unprofessional, and even unethical in terms of meeting the legitimate self-determination needs of clients. Similarly, the past failure of American Psychological Association to instruct those engaged in anti-SAFE-T legislation advocacy that research does not document that SAFE-T is harmful, and that all mainstream psychotherapy has a risk of harm, is no longer acceptable. The organization's future omission to report at least the results of the present study as "emerging" evidence that at least some clients who want to manage and try to resolve unwanted same-sex attraction and behavior have done so, using SAFE-T, likewise will be unacceptable.

The present study shows, through a more rigorous research design, that persons with unwanted same-sex attraction may reasonably expect to benefit from—and not to be harmed by—their participation in SAFE-T. On a professional and humane level, such persons clearly have the right to seek and receive professional assistance to try do so. Further, on a professional, ethical, and political/legislative level, properly trained mental health professionals have the right to offer such assistance.

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[4] It has been reported that when the Reintegrative Protocol used in this study has been used to treat emotional trauma, spontaneous change in sexual attraction sometimes occurs as a byproduct of trauma resolution. Similarly, when this Protocol has been used to treat binge eating disorder, "unintended" SAF sometimes happens (Joseph Nicolosi, personal communication, August 25, 2020).

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