considered their therapy successful because they adopted a lifestyle of chastity, "regard themselves as having reestablished their sexual identities to be defined in some way other than by their homosexual attractions. No data . . . suggest that this is a maladaptive or unsustainable outcome" (Jones and Yarhouse, 2011, pp. 422–423).

- **"Reinforces homophobia"**—Some critics claim SOCE is harmful simply because it reinforces negative attitudes toward homosexuality itself—attitudes sometimes referred to as "homophobia" or "homonegativity." Often the assertion is that it reinforces "internalized homophobia"—a belief within the client that there is something undesirable about same-sex attractions, which in turn may damage the client's self-esteem. Sometimes critics claim SOCE is harmful simply because it reinforces "societal homophobia"—the belief by anyone (not just the client) that homosexuality is undesirable. Davison (1978), for example, says that "to assume that people are not being hurt by the prevalent prejudices is . . . naïve. . . . [P]eople are being hurt by the availability of change-of-orientation programs, and these include people who are not themselves seeing therapists" (pp. 171–72). Similarly, Burack (2015) charges, "The ex-gay movement encourages the flourishing of a morality" that fails at "connecting the ideology and public policies they espouse . . . to the forms of harms that befall these same-sex attracted people." However, she is referring to individuals "damaged by the culture wars" before they even seek therapy—not people "damaged" by SOCE itself (225).

The question of whether any aspect of homosexuality (same-sex attractions, homosexual conduct, or an LGB identity) is desirable or undesirable, though, is in large part a question of morality, ideology, and personal opinion. Jones and Yarhouse (2007) point out that a different ideological construct results in a completely different evaluation of what is harmful, noting that

> anecdotes of harm from the attempt to change must be counterbalanced against counter anecdotes, specifically the type that circulate in ministry circles of individuals who experience despair in the gay community because they do not know that the possibility of an alternative to the gay lifestyle exists. (p. 361)

Jones and Yarhouse therefore assert that, as part of "informed consent,"

> clients should also be told of the potential benefits, risks and costs of *not* attempting the intervention; in the case of homosexuality, for example, we do not know what the potential risks would be for conservative religious clients of limiting treatment options to only those approaches that aim to integrate experiences of same-sex attractions into a gay identity. (p. 381)

The idea that SOCE "reinforces homophobia" is essentially an ideological conviction, not an objective harm.

What Does *Constitute Harm?*

There are, of course, several things that could legitimately be counted as "harms," if it could be proved that they are a result of participating in sexual orientation change efforts. Some are clear-cut harms, and some others at least raise legitimate concerns. These include:

- **Depression and anxiety**—Any noticeable deterioration in a person's mental health as a direct result of a particular intervention could legitimately be labeled harmful. Depression and anxiety are two of the most common manifestations of poor mental health.
- **Other "psychological distress"**—There may be other mental health consequences that do not fit strictly under the label of "depression" or "anxiety" that could still be counted as harms. "Psychological distress" is a broad term intended to capture these possibilities.
- **Suicidal thoughts or actions**—The most dramatic negative mental health result possible is when an individual commits suicide. Any intervention that can be shown to result in higher levels of suicidality—including suicidal thoughts, suicide planning, suicide attempts, and actual completed suicides—would certainly be considered harmful.
- **"Shame"**—Critics of SOCE frequently claim that SOCE not only results in "shame" in clients, but intentionally operates by instilling "shame." Many SOCE therapists would take issue with this, insisting that clients come *into* therapy with a sense of shame, and one of their first goals is to overcome it (see, e.g., Nicolosi, 2010). If "shame" is defined as the equivalent of "guilt," some people would suggest it is not really a harm—just as pain serves the important function of warning about physical harm, guilt serves the important function of warning about moral harm. There are some things of which we *should* be "ashamed."[16] However, to the extent that "shame" reflects a lack of personal self-esteem, it may be considered a legitimate mental health concern.
- **"Aversion" therapy**—A key tactic used by critics of SOCE is to recount horror stories of clients subjected to what is called "aversion" (or "aversive") therapy. This is a form of behavioral therapy in which a negative physical stimulus (such as a mild electric shock or nausea-inducing medicine) is applied in connection with homosexual arousal, in an effort to create an "aversion" to homosexual arousal or conduct via the negative association with physical pain or discomfort.[17] Similar methods have been used for other purposes, such as helping people to quit smoking. Throckmorton's (1998) review of the literature cited five articles on "[a]versive therapies . . . to change sexual orientation" between 1935 and 1974.[18] In their debunking of "myths" about aversion therapy, however, Byrd & Phelan (2011) declare, "Aversion techniques are no longer used to treat unwanted homosexual attractions."[19] The most recent documented use of *physical* aversion

[16] The article by Burack (2015) offers an explanation of "the conservative Christian interpretation of guilt" (pp. 223–224).

[17] A milder variant of the "aversive" concept is what is called "covert sensitization," defined by the American Psychological Association as "a behavior therapy technique for reducing an undesired behavior in which the client imagines performing the undesired behavior . . . and then imagines an unpleasant consequence. . . . (American Psychological Association, 2020). For a comparison of (physically) aversive therapy and covert sensitization, see McConaghy et al. (1981).

[18] Throckmorton (1998) cites an additional four articles on "the use of covert sensitization" published between 1970 and 1976.

[19] This appears to refer to physical aversion techniques, not to "covert sensitization," which may have persisted longer in some quarters. One of the most recent studies on the "Measures of Harm" list (Santero et al., 2018) includes "covert aversion" as a SOCE technique recalled by 82 of the study's 125 subjects. However, they also found it the least beneficial of 15 such techniques (Table 3, p. 6). The most recent documented use of *physical* aversion techniques that I have found is forty years ago, in McConaghy (1981).

techniques that I have found is forty years ago, in McConaghy et al. (1981). (Any reports of its more recent use should therefore be greeted with skepticism. See Sprigg, 2018a.) Theoretically, aversion therapies could and should be subjected to the same tests for long-term negative mental health consequences as any other therapy. However, the fact that they involve the application of physical pain or discomfort, and the fact that virtually all SOCE therapists have renounced such techniques, is sufficient reason to consider any use of physical aversion therapy as a "harmful" approach.

With that preliminary framework for how to think about this issue established, let's now take a look at what the 79 studies in the "Measures of Harm" document actually show.

Results

No Harm Mentioned

The first finding is perhaps the most surprising—18 of the 79 studies (23%) do not contain *any* assertion or even discussion of the possibility of "harm" to individual clients resulting from SOCE. This must cast doubt on the credibility of the "Measures of Harm" document right from the start.

The studies that do *not* assert that SOCE causes harm—and therefore should never have been placed on the list—are:

Borowich (2008)
Burack (2015)
Davison (1978)
Drescher (1998)
Drescher (2009)
Fetner (2005)
Fischer & Good (1997)
Freund (1960)
Freund (1977a)
Freund (1977b)
Hill & DiClementi (2003)
Hoffmann (2012)
O'Donohue & Plaud (1994)
Pfaus et al. (2012)
Ponticelli (1999)
Reamer (2014)
Savin-Williams (2016)
Schrimshaw et al. (2013)

This collection of sources is diverse. The fact that they do not assert that SOCE harms individual clients does not mean they are not critical of the practice.

Drescher, for example, is a prominent SOCE critic, the author of four of the sources on the "Measures of Harm" list. In his 1998 article, however, his strongest charge is that SOCE is unscientific, not that it is harmful; he claims that SOCE therapists "obscure their increasingly fundamentalist religious political agendas behind scientific and pseudo-scientific language" (p. 38). Ironically, Drescher's charge that some therapists are "preaching dogma and stifling dissent" (p. 19) could be applied to those seeking to ban SOCE, not just to those who practice it.

Several question the effectiveness of SOCE, but without asserting it is harmful. The earliest source on the entire "Measures of Harm" document, Freund (1960), reported, "Hitherto, there has been no proof of the efficacy of any form of treatment as applied to homosexuals" (p. 324). Hill and DiClementi (2003) argue "internalized homophobia" that causes some clients to *seek* SOCE (not that results from it) could cause them to distort their self-reporting for studies that appear to show the effectiveness of SOCE, such as a widely publicized 2003 study by Robert Spitzer (Spitzer, 2003). Reamer's (2014) book chapter offers 20 pages about ethical and moral challenges, calling SOCE "questionable" and "controversial," but its most direct critique says, "Social workers who use intervention

approaches for which there is no empirical support violate ethical standards" (p. 242). However, his only suggestion of "harm" relates to Christian social workers who might refuse to treat, refer out, or terminate treatment with LGBT clients—not ones who offer them SOCE (p. 241).

Three of the articles on this list deal with the role of "conditioning" in the development of sexual arousal or behavior. This is the concept behind "aversion therapy," but none of these articles assert harm to individual clients. O'Donohue & Plaud (1994) give a historical overview of research on "the relationship between conditioning and human sexual behavior" (p. 321), including experiments on homosexuals and pedophiles, but they do not report harms. Although the title of the Hoffmann (2012) paper is "Considering the Role of Conditioning in Sexual Orientation," the paper itself only includes a single paragraph directly related to SOCE, which concludes that "the effectiveness of these procedures is difficult to assess"—despite the paper's broader conclusion that "descriptive and some experimental research support a role for experience, and in particular conditioning, in the development of sexual arousal patterns in humans" (p. 67). Pfaus et al. (2012) is a study not of humans but of *rats*, which "describes how experience with sexual reward strengthens the development of sexual behavior and induces sexually-conditioned place and partner preferences in rats" (p. 31). In this startling experiment, some rats were not only conditioned to tolerate, but to actively prefer, sex with partners that smelled like dead bodies. Despite this demonstration in animals of "a high degree of plasticity" (p. 52) and "an extraordinary level of flexibility" in sexual arousal, the authors asserted, "This does not mean that sexual orientation and preferences can be altered once they are established" (p. 55).

Two of these sources focus on media, rather than on therapy or counseling per se. Drescher (2009) discusses "techniques of distorting science in the media." Only two pages of this twelve-page article are devoted to SOCE, including a paragraph on a widely reported series of ex-gay newspaper ads that led to a *Newsweek* cover story in 1998 (pp. 217–218). Drescher acknowledges, "Political distortions of science can occur on the right and left wings"—but all of his examples are on the right (p. 213). Ironically, however, many of his criticisms could apply directly to distortions of the facts about SOCE by its critics:

> [S]ound policy making requires objective scientific data . . . [but] special interest groups often try to distort scientific findings . . . Also troubling is the publicizing of "research" created solely to support political agendas. Such activities raise the troubling question of whether science as we know it can survive politicization . . . [including] contemporary attacks on science in what have come to be known as the "culture wars." (p. 213)

Drescher even acknowledges conservative criticisms "that mainstream mental health organizations like the two APAs, which for decades have had openly gay, lesbian and bisexual members, have been taken over by 'gay activists' within the organization" (p. 223).

Fetner (2005) analyzes the same 1998 "Truth in Love" ad campaign and the response to it from LGBT organizations. However, according to Fetner, the response of those organizations in 1998 to the claim that sexual orientation can change was *not* to claim that efforts to change are harmful, but to re-establish "a symbolic foundation that

understands LGBT people to be an oppressed minority group" p. (84).

At least a third of Burack's (2015) paper is devoted to "the application of psychoanalytic theory to interpret the deep structure and unconscious meanings of ex-gay ideology" itself (p. 224).

Sources That Assert Harm, but with No Subjects

More than a third of the sources on the "Measures of Harm" list—28 of 79, or 35%—do assert or suggest that SOCE may be harmful, but feature *no* study subjects. In other words, these are either literature reviews or opinion pieces, but ones that do not involve any direct examination of clients who have undergone SOCE. They have a sample size of *zero*.

Of course, there is a place for literature reviews—such as this one. However, some of these sources barely merit even the label of "literature review." In fact, four of the sources I have classified in this category *do not cite a single source* that demonstrates harm from SOCE. Those are:

> Forstein (2001)
> Haldeman (1994)
> Tozer & McClanahan (1999)
> Wakefield (2003)

Douglas C. Haldeman is one of the most prominent critics of SOCE and author of four of the sources on the "Measures of Harm" list. Even before these four sources, in 1991 Haldeman published a book chapter on "sexual orientation conversion therapy for gay men and lesbians" (Haldeman, 1991), which represents the earliest use of the term "conversion therapy" that I have yet discovered.[20] Although his 1994 article describes anecdotally several harms that may ensue from SOCE, such as "increased guilt, anxiety, and low self-esteem," it is significant that he admits a complete absence of data on the topic:

> Not one investigator has ever raised the possibility that conversion treatments may harm some participants. . . . The research question, "What is being accomplished by conversion treatments?" may well be replaced by, "What harm has been done in the name of sexual reorientation?" *At present, no data are extant.* (Haldeman, 1994, p. 225; emphasis added)

Tozer & McClanahan (1999) report on a 1997 American Psychological Association resolution that was critical of SOCE, but note, "The resolution addressed the sociopolitical context in which conversion therapies take place rather than targeting specific techniques of psychotherapists," adding that "it did not explicitly ban reorientation therapies." Part of the reason is that the chair of the panel that passed the resolution admitted, "Researchers have yet to show conclusively that conversion therapy is indeed harmful" (p. 732).[21]

Forstein (2001) says that an ethical response to "a patient who wants to change

[20] I have a theory that Haldeman's use—and perhaps coining—of the term "conversion therapy" may be the reason why it is the term favored by SOCE critics, even though practitioners virtually never use it. Perhaps the use of the word "conversion" is a subtle way of suggesting that SOCE is essentially a religious undertaking, not a therapeutic one. It could even represent a deliberate effort to conflate all SOCE methods with the similar-sounding "aversion" therapy. I have only come across two articles in which a practitioner or defender of SOCE uses the term "conversion therapy" in a neutral or favorable way (Throckmorton, 1998; Rosik, 2001).

[21] Tozer & McClanahan cite the October 1997 issue of the *APA Monitor*, p. 15, for the latter quote, but do not give full bibliographic information.

their homosexual orientation" would require "[i]nformed consent that includes . . . what the risks and/or benefits might be, including outcomes which could seriously hinder social, sexual, and psychological functioning," but also noting "that there are no studies as of yet published in peer-reviewed, scientific, respected journals to provide these data" (p. 177).

Another nine of these sources cite *only one or two sources* that support the charge of harm. Those are:

Bright (2004)
Diamond & Rosky (2017)
Drescher (2003)
Friedman (2003)
Gonsiorek (2004)
Herek (2003)
Lasser & Gottlieb (2004)
Miville & Ferguson (2004)
Steigerwald & Janson (2003)

Fifteen of the "zero-subject" sources cite three or more sources related to SOCE harm:

Arthur et al. (2014)
Beckstead (2012)
Cramer et al. (2008)
Drescher (2001)
Grace (2008)
Green (2003)
Halpert (2000)
Hein & Matthews (2010)
Jenkins & Johnston (2004)
McGeorge et al. (2015)
Morrow & Beckstead (2004)
Schreier (1998)
Serovich et al. (2008)
Silverstein (2003)
Walker (2013)

Sources That Assert or Discuss the Possibility of Harm That Include Reports on Actual SOCE Clients

Only a minority of the sources found on the "Measures of Harm" document—33 of 79, or 42%—include a discussion of harm in the context of studies or case reports on individuals who have undertaken SOCE. However, some of these have sample sizes so small that it would be impossible to draw general conclusions from them. Nine of these articles reported sample sizes of *seven or fewer* SOCE clients. Four of them reported on *only one client.* They were:

Ford (2002)
Johnson (2004)
Moor (2002)
Schneider et al. (2002)

Here are the remainder of these "small-sample" sources, with the number of SOCE clients on which they report:

Dickinson et al. (2012)	7 clients
Green (2017)	2
Haldeman (2001)	4
Haldeman (2004)	3
Haldeman (2012)	2

Sources with Eight or More Subjects

That leaves a total of 24 sources on the list—only 30%—that discussed harms and examined samples of eight or more subjects. Fewer than half of these (11) featured sample sizes of 50 or more. They are discussed in "The Six Key Studies" (below). Here are the 13 articles that discussed samples of at least eight but less than 50 subjects:

Fjelstrom (2013)
Flentje et al. (2013)
Flentje et al. (2014)
Jacobsen & Wright (2014)
Johnston & Jenkins (2006)
King et al. (2004)

Krajeski et al. (1981)
Krajeski (1984)
Maccio (2010)
Maccio (2011)
Moran (2007)
Smith et al. (2004)
Tozer & Hayes (2004)

Generally, the larger the sample size of a study, the more reasonable it is to conclude that its findings might be generalized to the larger population the sample is intended to represent (in this case, the population of clients who participate in sexual orientation change efforts).

The Six Key Studies (50 or More Subjects)

The 79 sources on the "Measures of Harm" list represented only *six* studies which discussed harm and included samples of *50 or more* SOCE clients. Because some of those who conducted this research wrote more than one article on the resulting database, there are *eleven* articles in the list of 79 which are based upon these six most significant studies. Here is a summary of the key studies included on the "Measures of Harm" list:

***Dehlin et al. (2015)* and *Bradshaw et al. (2015)*[22]**

Sample Size: 1,612 (76% male, 24% female).

Sample Type: Web-based survey entitled "Exploration of Experiences of and Resources for Same-Sex-Attracted Latter-day Saints"; respondents had undertaken activities to "understand, cope with, or change" their sexual orientation; data collected from July–September 2011.

Assertion of Harm: 37% "of those whose therapy focused on SOCE evaluated the experience" as "harmful"—21% "moderately harmful" and 16% "severely harmful" (Bradshaw et al. 2015, p. 398.) "The clear evidence . . . is that dutiful long-term psychotherapeutic efforts to change . . . carry significant potential for serious harm. . . ." (Bradshaw et al., 2015, pp. 409–410).

Discussion: This study has two major advantages over most in the field:

- It has the largest sample size of any study on the "Measures of Harm" list; and
- It distinguished between different types of sexual orientation change efforts.

However, the sample was not random—it consisted of self-selected internet users. The authors admitted, "Our reliance on convenience sampling limits our ability to generalize our finding to the entire population. . . ." It also targeted *only* people who are (or were once) Mormons.

The study listed nine "SOCE methods:"

- Personal righteousness
- Individual effort
- Church counseling
- Psychotherapy
- Support groups
- Group therapy
- Group retreats
- Psychiatry
- Family therapy

"Personal righteousness" (including "prayer, fasting, scripture study") and "individual effort" (such as "journaling," "self-punishment," and seeking to "date the opposite sex"—Dehlin et al., 2015, 99) hardly qualify as SOCE (and certainly not as "conversion therapy").[23] The biggest

[22] An additional detailed analysis (and critique, from a pro-SOCE perspective) of these studies can be found in Rosik (2014).

[23] Even "church counseling" may carry a different connotation in the LDS context from what it might imply to Protestants or Catholics. Mormons do not employ a professional clergy but are instead led

methodological weakness in this study, however, was that experiences with SOCE were rated on a single scale with "harm" and "effectiveness" at opposite ends. This is conceptually misguided, since harm and effectiveness are two different questions. A particular approach could be *both* "effective" (that is, result in some significant change in sexual orientation) *and* harmful (for example, result in an increase in depression and anxiety). On the other hand, a SOCE could be *neither* "effective" (because it results in no change in sexual orientation) *nor* harmful (because it results in no change to, or even an improvement in, other areas of mental health).

Nevertheless, the authors used a scale of 1–5, asking respondents to identify their experience as:

- 1 = severely harmful
- 2 = moderately harmful
- 3 = not effective
- 4 = moderately effective
- 5 = highly effective

(Dehlin et al., 2015, Table 1, p. 99[24])

An average rating above 3.0 for any particular method would indicate that for the average participant it was *more effective than harmful*. Despite the authors' generally negative tone toward SOCE, nearly half of these scores (8 of 17)[25] were above 3.0 (and a ninth was exactly 3.00). A *minority* of the scores showed the method more harmful than effective. Of the formal methods more commonly referred to as "therapy" or SOCE—psychotherapy, support groups, group therapy, group retreats, psychiatry, and family therapy—8 of 11 ratings were above 3.0, or more effective than harmful (Dehlin et al., 2015, Table 1, p. 99).

When exact percentages for each rating were reported, for a majority of methods (5 of 9), positive answers indicating SOCE was "effective" exceeded negative answers indicating it was "harmful."[26] No method of SOCE was rated "harmful" by a majority of respondents, and none was rated "severely harmful" by more than 27% (Dehlin et al., 2015, Figure 1, p. 100). In addition to the subjective self-rating, the authors employed some "pre-existing measures assessing psychosocial health" (Dehlin et al., 2015, p. 97). The authors reported that "SOCE participants in this sample showed no differences in quality of life from those who had not engaged in SOCE" (p. 102), and they also found no significant differences in self-esteem between these groups (Table 2, p. 101). This undermines any theory that SOCE would cause lasting damage that leaves people worse off than those who did not undertake SOCE.

A follow-up article (Bradshaw et al., 2015) focused on respondents who said they had undergone psychotherapy.[27] Respondents had been invited to write an open-ended narrative about their experiences. Strikingly, reports of "benefit" from

by "laypersons . . . without professional training in theology"—let alone in psychology (Keller, 1992, p. 288).

[24] Confusingly, the ratings were reversed when reported in the second journal article based on this survey, with 1 being "very effective" and 5 being "severely harmful." See Bradshaw et al. (2015), p. 398.

[25] With nine different methods, and results reported for both sexes, a total of 17 average scores were reported. One method, family therapy, had no women who pursued sexual orientation change as a goal.

[26] For two of the methods, positive answers were *more than double* the negative ones (Group Retreats, 48% effective to 20% harmful; Support Groups, 41% effective and 20% harmful).

[27] Only a little over half of their respondents (898 out of 1,612, or 56%) reported that they had undergone psychotherapy (Bradshaw et al., 2015, p. 394); but of those, only 367 (330 men and 37 women) reported that "they actually worked on sexual orientation change in therapy" (p. 399).

psychotherapeutic SOCE clearly outnumbered reports of "detriment." The authors even acknowledge this, stating that "experiences of harm or . . . distress were much less frequent than reports of benefit" (Bradshaw et al., 2015, p. 406). For example:

- 109 indicate that therapy overall was "positive" or "helpful," with 12 even describing it as "life-saving." In contrast, only 29 reported that they "felt worse after" therapy.
- 98 respondents said the therapy resulted in "improved self-esteem," while only 33 said they were "damaged" or found it "harmful."
- 80 reported that "depression and anxiety" were "decreased" by the therapy, while only seven said they "increased."
- While four respondents said they had attempted suicide after therapy, *fifteen* respondents said the therapy helped them *avoid* suicide (Bradshaw et al., 2015, Table 5, p. 407).

The data presented in these two articles simply do *not* support the authors' sweeping conclusion that there is "clear evidence" of a "significant potential for serious harm" from SOCE (Bradshaw et al., 2015, pp. 409–410), especially when psychotherapy is the method utilized.

Weiss et al. (2010)

Sample Size: 338 (267 "ex-gay," 79% male; 71 "ex-ex-gay," 82% male—Table 1, p. 297).

Sample Type: "Participants in this study were individuals who posted to Internet message boards related to changing one's sexual orientation from gay to straight. . . . This search resulted in three message boards for ex-gays and two for ex-ex-gays" (p. 294). "Five coders were involved. . . . [W]e read approximately 1,000 posts and created codes for any idea or expression that seemed relevant . . . [then] we identified core themes and grouped codes according to these larger thematic units . . ." (p. 296).

Assertion of Harm: "In both samples, statements of negative feelings during the ['conversion therapy'] process were far more common than those of positive feelings" (p. 305). "Participants in both studies reported depression, suicidal ideation, and deficits in self-esteem. Socially, both participant groups reported loneliness, social isolation, and lack of social supports while beginning or ending conversion therapy" (p. 312).

Discussion: By the authors' own admission, "This study used *qualitative* methodology," (p. 291, emphasis added), not *quantitative* methodology, suggesting it does not really belong on a list of studies with "*measures* of harm." With any study using "convenience samples" (that is, self-selected volunteers), there is no way of knowing whether the participants are representative of the larger population (in this case, of people who have undertaken SOCE). The authors argue that their methodology (of "online 'surveillance,'" p. 295) avoids the risk of participants volunteering for the study in order to promote a particular viewpoint ("response bias," p. 293). However, there is also no way of knowing whether people who voluntarily choose to post on a publicly available message board are representative of the larger population, and this methodology injects the possibility of bias not only on the part of the participants themselves, but of those "coding" their comments.

In addition, it is worth noting that most of those posting on the "ex-gay" message boards were people still in the process of seeking change, while those on the "ex-ex-gay" message boards were, by definition, people for whom SOCE was a *past* event. This creates an apples-to-oranges comparison between *current* SOCE clients pursuing change and *past* SOCE clients who

had since abandoned any effort to change any aspects of their homosexual orientation. The study omits the entire category of SOCE "successes" who may have *completed* the change process and now do *not* embrace a "gay" identity.

Even the title of this study indicates that it is about "ex-gay and ex-ex-gay *experiences*" (emphasis added) in general, not about specific facilitated "change efforts" or "therapy" in particular. Although critics routinely refer to all SOCE as "conversion therapy," it is striking how few of the subjects in this study reported having undertaken actual "therapy." On the ex-gay message boards, out of 57 messages regarding "strategies tried," less than a third involved "therapy" (16 religious, 2 secular). That is smaller than the number who participated in a religious "support group" (19), and about the same as those who used what we might call informal religious methods ("prayer," "accountability partner," "reading ex-gay books," or "confession"—16 total; Table 2, p. 298). On the ex-ex-gay message boards, only four out of fifteen reported "strategies tried" involved "therapy"—fewer than the number (5) who saw "marriage" as a "strategy" (Table 3, p. 300).[28]

Although it is true that comments which were generally negative in tone exceeded those generally positive in tone on both message boards (according to the coders), it is still striking how few reported some of the "harms" usually raised in critiques of SOCE. For example, on the ex-gay message boards, out of 540 coded comments, only 18 indicated experiences of "depression" (13 "explicit" and 5 "implicit"), and 15 indicated some form of suicidality (13 "active" and 2 "passive"—Table 2, p. 299). On the ex-ex-gay message boards, out of 105 coded comments, only 4 indicated "depression" and only 2 indicated "suicidal ideation or attempt" (Table 3, p. 300). Notably, the authors indicated:

> The majority of respondents that reported being suicidal stated that it was the prospect of being gay . . . that led them to thoughts of suicide, rather than the struggle of trying not to be gay. (p. 306)

Since "ex-ex-gay message boards" might be expected to attract a disproportionate number of people asserting harm or expressing bitterness about the change process, it was actually surprising how positive some of their comments were. They certainly undermine, rather than support, the claim that SOCE generally causes lasting damage. As the authors report:

> Most of the posters to the ex-ex-gay boards report currently being in overall good psychological health. The most common statements . . . were that they valued their journey through the process. . . . By and large, ex-ex-gay posters view their experience in the ex-gay movement as having yielded positive results in the long run. . . . (pp. 308–309)

Beckstead (2001); Beckstead (2003); Beckstead & Morrow (2004)

Sample Size: 50 (45 men, 5 women).

Sample Type: Convenience sample of people "who had undergone therapy to change their sexual orientation" from various sources in Utah and in Mormon circles, as well as "snowball sampling" (referrals from other participants) between 1997 and 2001.

[28] While some participants may enter SOCE with marriage to an opposite-sex partner as an ultimate *goal*, I am not aware of any therapist or counselor who would recommend it as a *strategy* to accomplish change, and most would strongly caution *against* any rush toward marriage by an individual who has struggled with same-sex attractions.

All "had experienced a Mormon religious upbringing or conversion." Forty-two chose to be interviewed; "Of these, 20 (2 women, 18 men) reported only positive outcomes and were classified as 'proponents,' and 22 (2 women, 20 men) reported primarily negative outcomes and were classified as 'opponents.' . . . In addition, 8 other individuals (1 woman, 7 men) who had also undergone conversion therapy" participated in "a focus group discussion" (Beckstead & Morrow, 2004, pp. 656–657).

Assertion of Harm: "Most opponent participants believed . . . that 'conversion therapy damages each aspect of an individual.' . . . Overall, 4 proponent and 4 opponent participants attempted suicide after counseling . . ." (Beckstead and Morrow, 2004, p. 671).

Discussion: As with Weiss et al. (2010), Beckstead and Morrow (2004) acknowledge, "Qualitative methods were selected for this investigation," methods "that sought to understand the subjective meanings participants attributed to their experiences" (p. 654). Methods that are "qualitative" (rather than "quantitative") can produce anecdotes; but they cannot, by definition, produce "measures" of harm. Furthermore, the authors state explicitly, "The results of this or any qualitative study are not intended to generalize to the larger population of individuals who have undergone conversion therapies" (p. 683.).

In Beckstead (2001), the potential for harm is not even listed as one of the two key issues "surrounding the ethics of sexual reorientation therapy"; instead, client "self-determination" and the therapy's "efficacy" are cited. In Beckstead's writings in general there are extensive discussions of the potential for harm, but most of the "harms" asserted fall in the categories that I have mentioned as *not* being the type that might (if sufficiently prevalent and severe) justify legal restrictions on pursuing the goal of sexual orientation change in therapy. For example, Beckstead & Morrow (2004) cite "lost loves and friendships, wasted time and resources, a slowing down of the 'coming-out' process," and "decreased capacity for same-sex intimacy" (p. 671); and Beckstead (2003) claimed that SOCE reinforces "negative stereotypes of the lives of lesbian, bisexual, and gay individuals" (p. 423).

However, Beckstead & Morrow (2004) admit, "Both proponent and opponent participants described positive experiences with conversion therapy, which was an unexpected finding . . ." (p. 668). Yet another "unexpected finding was that several opponent participants expressed a need for the option of conversion therapy because as they explained, it gave them the space to explore being an 'ex-gay' as they met others like themselves" (p. 673).

Beckstead and Morrow (2004) acknowledge that "proponent participants . . . reported only conversion therapy benefits, no therapeutic harms, and heterosexual functioning" (pp. 684–685). A separate article (Beckstead, 2001) focuses entirely on the views of SOCE "proponents." It notes that SOCE therapy "seemed to develop for participants a new sense of belonging, self-efficacy, and acceptance" (p. 101), and says, "Participants referred to this increased self-understanding and self-acceptance as finding 'wholeness' and congruence" (pp. 102–103).

Beckstead and Morrow (2004) say that "it is important to value the successes made by proponent participants" (p. 686) and that "we must accept that participants' self-identifications and constructed perspectives are valid for them . . ." (p. 685). Although they ultimately "denounce" SOCE—asserting that its benefits can be obtained by other means (p. 686)—they are more respectful than most SOCE critics of the fact that for many clients, "their sexual identities [are] peripheral to their religious identities" (p. 663), and "not all same-sex-attracted

individuals are able to enter into or benefit from . . . therapy that focuses solely on identifying as LGB" (p. 686).

***Santero et al. (2018)*[29]**

Sample Size: 125 (all male).

Sample Type: Participants recruited from "[e]x-gay ministry groups and affiliated private therapists throughout the United States," surveyed between January and February 2011 (p. 3). A large majority (97%) had undergone professional therapy, but most (86%) had also participated in "less formal" methods (p. 4). The sample was highly religious, with 98.6% having an "[a]ctive belief system" and 89% identifying themselves as some type of Christian (p. 3). Religious reasons were the most common reason cited (by 64%) for entering SOCE (p. 4).

Assertion of Harm: "The techniques that participants rated as the most harmful to SOCE overall (all responses combined) were 'going to the gym' (16 percent), 'imagining getting AIDS' (used as 'covert aversion' 13.6 percent), 'stopping homosexual thoughts' (12.8 percent), and 'abstaining from masturbation' (10.4 percent)" (p. 9). "Only one participant reported extreme negative effects, which were on suicidality and self-harm" (p. 11).

Discussion: Among the hypotheses tested by Santero et al. were that SOCE "produces more harm than help" and that it is "more harmful than therapies on completely different unwanted problems" (p. 3). However, the authors found that SOCE was overwhelmingly more helpful than harmful to those they surveyed. Participants experienced "moderate-to-marked decreases in suicidality, depression, substance abuse, and increases in social functioning and self-esteem. Almost all harmful effects were none to slight" (p. 1).

The authors asked respondents to rate seventeen therapy "techniques" by endorsing "one response only from [the] entire [9-point] harm/help range" (p. 6). The weakness of using such a single scale has already been noted with respect to the Dehlin et al. (2015) and Bradshaw et al. (2015) studies. "Overall, the hypothesis that any technique was predominantly harmful was strongly rejected,

[29] The Santero et al. study passed peer review and was published in a peer-reviewed journal, *The Linacre Quarterly* (the official journal of the Catholic Medical Association), in 2018. However, less than a year later, the journal formally retracted the study due to what they called "unresolved statistical differences," asserting that "a statistical review of the paper, which was recommended during peer review, had not been conducted." When the editor commissioned such a review "after receiving questions about the article," the review identified "concerns regarding the methodology," such as this: "No common intervention was given to participants that would allow for a valid conclusion to be drawn." Specifically, the editor (or the "statistical reviewer") asserted that "the paper did not clearly address whether all respondents were treated according to the same (or similar) protocols and for the same periods of time, and/or by therapists of like or similar training and expertise." This standard, however, is one that virtually none of the "Peer-Reviewed Journal Articles" on the "Measures of Harm" list would be able to meet. (Compare, for example, the nine widely varying techniques studied by Dehlin et al., 2015, as noted above.) The authors responded, "The only uniformity needed and employed, was SOCE and therapeutic involvement." The editor did not indicate that the authors had in any way mis-stated or misrepresented their data or statistical analyses in the published paper, noting explicitly "that the retraction is not based on any action taken by the authors but only the statistical concerns outlined above." Nevertheless, she stood by the retraction. See: Retraction notice: Effects of therapy on religious men who have unwanted same-sex attraction (2020). Co-author Neil Whitehead has given a further detailed defense of the study and its statistical methods (Whitehead, 2019). In 2021, a completely new and original peer-reviewed analysis of the same data set was published, and the authors "found pursuit of SOCE to be associated with enhanced psychological well-being for a large majority of participants, with negative effects being reported by less than 1 in 20 consumers" (Sullins et al., 2021, p. 15).

and effect sizes . . . were all large" (Santero et al., 2018, p. 9).

With respect to six different "mental health issues," however, "respondents were asked to give both positive and negative experiences" (p. 14). In this analysis, "Positive effects on self-esteem were all marked or extreme, and the three respondents with initial suicidality all experienced an extreme beneficial effect" (p. 9). "Participants reported improvements (with large effect sizes) in self-esteem and social functioning, and similarly decreases in suicidality, substance abuse, depression, and self-harm. Before therapy, they had experienced an average of three of these problems" (p. 12). Therefore, "The hypotheses that harm predominates is rejected strongly because calculated probabilities are extremely low" (p. 10). "Most importantly, the overwhelming majority—70 percent of the participants—claimed only beneficial effects from the therapy" (p. 14).

Santero et al. were among only a few authors on the "Measures of Harm" list (together with Jones and Yarhouse, 2007 and 2011) who compared the potential benefits and harms of SOCE with those of other types of therapy. "The study . . . had a similar harmfulness rate compared to general psychotherapy. The percentage of patients leaving treatment worse off than when entering is 5–10 percent. . . . The current study had a similar rate (12 percent) for depression. . . . In the present study, increased suicidality was 8.9 percent, but intensity was slight, and other unwanted problems were less than 5 percent" (pp. 13–14). Therefore, note the authors, "This therapy is not really exceptional but should be considered in the ranks of the conventional . . ." (p. 15).

Shidlo and Schroeder (2002); Schroeder and Shidlo (2002)

Sample Size: 202 (90% male, 10% female).

Sample Type: Convenience sample recruited by various means including "gay and lesbian Web sites and E-mail lists," "newspaper advertisements in the gay and lesbian and the nongay press," and "direct mailings to gay and ex-gay organizations and to a national professional association of conversion therapists" (Shidlo and Schroeder, 2002, p. 251).

Assertion of Harm: "One group (155 individuals)" who now identify as gay "experienced significant long-term damage from the conversion therapy. . . . Many consumers of conversion therapies reported to us that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination" (Shidlo and Schroeder, 2002, p. 254). "These negative effects include depression, poor self-esteem, and difficulties with intimate relationships" (Schroeder and Shidlo, 2002, p. 161).

Discussion: Even though it is now nearly two decades old, Shidlo & Schroeder (2002) is still probably the most widely cited article in support of the proposition that SOCE is harmful. (A companion article, Schroeder & Shidlo, 2002, focuses primarily on ethical issues involved in the actions of SOCE therapists, rather than on outcomes for clients.) That is probably because at the time it was published, "No large-scale study ha[d] been made with the specific goal of looking at the harmfulness of conversion therapies" (Shidlo & Schroeder, 2002, p. 249).

Initial recruiting for the study was heavily biased. Advertisements bore the headline, "Homophobic Therapies: Documenting the Damage," and openly declared the conclusion before even undertaking the study, saying that the authors "intend to use the results to inform the public about the

often harmful effects of such therapies" (Shidlo & Schroeder, 2002, Appendix A, p. 259). Nevertheless, "After the first 20 interviews, we discovered that some participants reported having been helped as well as harmed" (p. 251). Therefore, they changed the project's name to "Changing Sexual Orientation: Does Counseling Work?" and declared more neutrally, "We want to know how it affected you" (Appendix B, p. 259).

As with several other key studies, the authors acknowledge that the "structured interviews" they used (Shidlo & Schroeder, 2002, p. 250) were a form of "qualitative analysis" (p. 251). They also admit that their "open-ended question" about harm ("Do you feel that this counseling harmed you or had a negative effect on you?") "was not a quantitative measure. . . ." They then followed up with "a checklist of symptom areas . . . developed in our pilot interviews" (listing 13, from "self-blame for not trying hard enough to change" to "alcohol and substance abuse").

Yet somewhat surprisingly, Shidlo and Schroeder declared, "We do not report here on the frequency of responses to these items . . . ," admitting that their methodological choices "came at the expense of sensitivity, reliability, and content and construct validity" and even that participant reports may not be an "accurate recollection. . . . Our results, therefore, focus on the meanings of harm attributed by clients, and the accuracy of these attributions remains to be determined . . ." (p. 254).

The one finding on which Shidlo and Schroeder did report specific data was suicide attempts: "Twenty-five participants had a history of suicide attempts before conversion therapy, 23 during conversion therapy, and 11 after conversion therapy" (Shidlo & Schroeder, 2002, p. 254). Since this suggests a rate of suicidality less than half as high after therapy as it was before, it is hard to see how this provides support for the theory that such therapy is harmful. The opposite would appear to be the case.[30]

Some of the specific "harms" reported by gay-identified participants are things which would be considered "successes" by individuals still pursuing SOCE. For example, under the category of "Intrusive imagery and sexual dysfunction," one male reported, "In a sex act, I can imagine . . . my wife . . . and I find that disturbing. . . . The first time I attempted to have anal intercourse with my lover, I couldn't. . . ." The authors also cite "loss of same-sex partners or missed opportunities to commit to long-term relationships with same-sex persons" as "harms" (Shidlo & Schroeder, 2002, p. 255).

Given the bias with which Ariel Shidlo and Michael Schroeder undertook their study, it is remarkable that 23% of their participants were people who did *not* report being significantly harmed by SOCE, including 26 (13%) who considered their therapy to have been "successful" and 21 (10%) who were now gay-identified but "reported few or no long-term damaging effects and actually felt strengthened by their experience of having tried to change" (Shidlo & Schroeder, 2002, pp. 253–254). From my own analysis of Shidlo and Schroeder's reported ratings for specific interventions, it appears that although 85% of interventions were reported to have been harmful at least to *some* degree, a remarkable 61% of

[30] Warren Throckmorton—a Christian psychologist who was once a defender of SOCE but has become increasingly critical of it (Ward, 2017)—has argued that the high rates of suicide attempts reported *during* SOCE therapy could be taken to suggest that the therapy is harmful, and the lower rates after SOCE could suggest it is *quitting* therapy that is beneficial. However, Throckmorton acknowledges that "one cannot make any conclusive statements about reorientation and suicide risk from Shidlo and Schroeder's data" (Throckmorton, 2011).

interventions were also reported to have been *helpful* to some degree (p. 257).

In the end, though, Shidlo & Schroeder's often-cited study cannot bear the weight that has been placed upon it by critics of SOCE—as their own words demonstrate:

> *The data presented in this article do not provide information on the incidence and the prevalence of failure, success, harm, help, or ethical violations in conversion therapy.* (Shidlo & Schroeder, 2002, p. 250; emphasis in the original)

Jones and Yarhouse (2007, 2011)

Sample Size: 98 (72 men, 26 women) at the beginning of the study (Time 1, or T1); 73 at T3; 63 at T6, "a 6-7-year retention rate of 64%" (Jones and Yarhouse, 2011, p. 410).

Sample Type: Participants within the first three years of pursuing "religiously mediated sexual orientation change" were recruited from sixteen different ministries affiliated with the umbrella organization Exodus International.[31]

Assertion of Harm: Data for one small subset of their sample, those who abandoned the change effort early, "would appear to indicate that the Time 1 dropouts were considerably distressed. . . . Those opposed to attempts to change sexual orientation might well argue that this is the evidence of harm that they anticipated; it would appear that the change process produced significant distress and was fruitless for these individuals" (Jones and Yarhouse, 2011, p. 358).

Discussion: Jones and Yarhouse first reported their findings in a detailed, 414-page book in 2007, then more succinctly but with added longitudinal data in a peer-reviewed journal article in 2011. They sought to meet several standards for a strong research study, which they said should:

- "be *longitudinal*, following participants over time";
- "be *prospective*, starting with participants who are initiating the change process";
- "examine the experience of a *representative sample*";
- "gather data . . . with the best existing *standard measures* . . . of sexual orientation and other variables;" and
- "examine a *large* sample" (Jones and Yarhouse, 2007, pp. 106–107).

They also note that many of these criteria overlapped with those recommended by the American Psychological Association (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 6) for further research in this field (Jones & Yarhouse, 2011, p. 406).

The authors therefore seem fully justified in declaring, "This study is the best designed and implemented study to date on religiously mediated change of sexual orientation," and in adding, "The study, although not above criticism, is significantly stronger than any other existing study" (Jones & Yarhouse, 2007, p. 143). Rather than a "qualitative" exploration of the SOCE experience, as in so many other studies, Jones and Yarhouse used a standardized tool:

> Psychological distress was measured by the 90-item SCL-90-R [Symptom

[31] At one time, Exodus International was the leading umbrella organization of Christian ex-gay ministries. However, during the period from 2007 to 2013, the president of Exodus, Alan Chambers, began publicly moving away from the belief that "change is possible" with respect to sexual orientation. This led many member ministries to resign from Exodus and form a new umbrella organization, Restored Hope Network (https://www.restoredhopenetwork.org/), and Exodus International was disbanded in 2013. For an account of these events, see Feldmann (2013).

> Check List-90-Revised[32]] . . . a measure designed for use in research and clinical settings. . . . We focused on the SCL-90-R's three global indices of the degree of respondent distress: . . .
> - the number of symptoms and intensity of distress; . . .
> - the intensity of distress symptoms experienced; and . . .
> - the number of discrete psychological symptoms regardless of intensity (Jones & Yarhouse, 2011, p. 412, bullet points added).

The authors report,

> Our analysis yielded no support for the hypothesis that our participant's scores . . . would show significant movement toward worsened psychological functioning as a result of [SOCE]. . . .
>
> [T]he one consistently statistically significant shift was the shift in the Positive Symptom Distress Index in a direction of *less distress.* In other words, . . . participants reported that their intensity of distress symptoms changed for *the better* to a statistically significant degree. . . . (Jones and Yarhouse, 2007, pp. 370–371)

Jones and Yarhouse (2007) also sought to analyze the spiritual well-being of their participants using the 20-question Spiritual Well-Being Scale (SWBS), as well a 38-item Faith Maturity Scale (FMS). With respect to the SWBS, "*every* reported mean difference . . . indicat[ed] an improvement (however modest) in spiritual, religious, and existential well-being. A number of these changes were statistically significant" (p. 348). With respect to the FMS, there were few changes over time, but "there is no evidence . . . that involvement in the change process caused a decline in faith maturity" (p. 352). In summary, "If involvement in [SOCE] is supposed to be detrimental to the spiritual well-being of the participants . . . , we find no evidence of it in this population" (p. 349).

The bottom line is that the authors found

> little evidence that involvement in the . . . change process was harmful to participants in this study. Taken together, these findings would appear to contradict the commonly expressed view of the mental health establishment . . . that the attempt to change is highly likely to produce harm for those who make such an attempt. (Jones & Yarhouse, 2007, p. 387)

Conclusion

As noted above, several of the earlier journal articles and sources cited in the "Measures of Harm" list not only did not provide "measures of harm" from SOCE, but they included specific acknowledgment that no scientific evidence of such harm had been discovered (Haldeman, 1994, p. 225; Tozer & McClanahan, 1999, p. 732; Forstein, 2001, p. 177). A turning point appeared to come with the publication of Shidlo & Schroeder's 2002 study, documenting harms reported by some of their sample of 202 former SOCE participants. As noted above, however, these authors conceded that they used "qualitative data" and "qualitative methods" (250), and thus could not provide "a quantitative measure" of harm (254). Their own caveat could not have been more clear:

[32] "The SCL-90-R is a ninety-item self-report inventory . . ." (Jones and Yarhouse, 2007, p. 333).

> *The data presented in this article do not provide information on the incidence and the prevalence of failure, success, harm, help, or ethical violations in conversion therapy.* (Shidlo & Schroeder, 2002, p. 250; emphasis in the original)

Despite this rather sweeping acknowledgment of their study's severe limitations, Shidlo & Schroeder (2002) are often cited as the definitive source proving the harmfulness of SOCE.[33]

The other most frequently cited source in support of the belief that SOCE is harmful is a 2009 Task Force Report that was published by the American Psychological Association. After conducting their own "systematic review of the peer-reviewed journal literature" on SOCE, they concluded that such efforts "involve some risk of harm" (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. v). However, they found the *level* of risk impossible to quantify:

> We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 42)

Nevertheless, as with Shidlo and Schroeder's study, the Task Force's rather modest assertion that change efforts "involve some risk of harm" has been inflated in the subsequent re-telling. The California Legislature's findings in SB 1172, the nation's first therapy ban, said, "The task force concluded that sexual orientation change efforts can pose *critical health risks* to lesbian, gay, and bisexual people" [emphasis added] (*Sexual Orientation Change Efforts*, 2012)—although the term "critical health risks" appears nowhere in the Task Force Report, which never applied the term "critical" at all to the potential "risk of harm" it identified. (In fact, in their effort to be comprehensive and to communicate accurately about what they did and did not find, the APA Task Force Report made a number of concessions about SOCE that seriously undermine the case for placing legal restrictions upon it (see Sprigg, 2018b).

Exaggerations of what the scientific evidence shows even reached the White House, under former President Barack Obama. In response to a petition, Obama Senior Advisor Valerie Jarrett in 2015 endorsed efforts to prohibit SOCE, claiming, "The *overwhelming scientific evidence* demonstrates that conversion therapy . . . can cause *substantial* harm" [emphasis added] (Jarrett, 2015). It is odd that a White House advisor could reach such a sweeping conclusion, when the APA's own Task Force had stated that "recent studies do not provide valid causal evidence of . . . [SOCE] harm" (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Most of the 79 studies on the "Measures of Harm" list suffer from significant methodological weaknesses. Several are explicitly "qualitative" rather than

[33] For example, one 2019 article flatly declared, "The evidence actually shows that conversion therapy is harmful to those who undergo treatment"—citing only Shidlo and Schroeder (2002). See Romero (2019), 213.

quantitative, which means by definition that they cannot provide "measures" of harm. The two strongest studies methodologically (Jones & Yarhouse, 2007 and 2011; Santero et al., 2018) show the most positive outcomes and the fewest reports of harm. While these 79 studies do provide anecdotal evidence that *some* SOCE clients *report* the experience was harmful, they do not provide scientific proof that SOCE is more harmful than other forms of therapy, more harmful than other courses of action for those with SSA, or more likely to be harmful than helpful for the average client.

If the alleged "overwhelming scientific evidence" of "critical health risks" caused by SOCE cannot be found in the 79 studies on the "Measures of Harm" list—and it cannot—then it is questionable whether it can be found anywhere.

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Note: References marked with an asterisk were included in the list of 79 sources labeled, "Peer-Reviewed Journal Articles and Academic Books on 'Conversion Therapy' Outcomes That Include Measures of Harm." *Those marked with a single asterisk (*) were read in full by the author; those marked with a double asterisk (**) were analyzed with a keyword search (see Appendix).*

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Appendix

Keywords Searched in 24 of the "Measures of Harm" Studies

In the studies which the author of this paper did not read in full, keywords related to possible harms of SOCE were searched. These terms included negative ones (e.g., danger, harm, risk); neutral ones (consequence, outcome, result); and positive ones which might be contrasted with the negative (benefit, help, safe). All forms of a word were included (noun, adjective, singular, plural, etc.). Each time a relevant word was identified in the text of the study or article, the context was examined to determine if it was actually a reference to harmful outcomes attributable to SOCE. Not all of these words were searched in every article; instead, this list was continually expanded as new possible keywords were identified. Nevertheless, I feel confident that this search was thorough enough to identify any references to harms of SOCE in the articles not read in full.

abuse
adverse
anxiety
aversion
benefit
breakdown
complication
consequence
concern
damage
danger
death
decrement
depression
destructive
deteriorate
detriment
difficult
discomfort
distress
effect
exacerbate
exploitation
guilt
harm
help
hindrance
homophobia
hurt
impact
maladaptive
negative
outcome
problem
psychotic
reaction
recondition
result
risk
safe
self-destructive
sensitization
sequelae
severe
shame
suicide
symptom
torture
troubled
violate
well-being
worse
wound