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Sexual Orientation Change Efforts Among Current or Former LDS Church Members

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This study examined sexual orientation change efforts (SOCE) by 1,612 individuals who are current or former members of the Church of Jesus Christ of Latter-day Saints (LDS). Data were obtained through a comprehensive online survey from both quantitative items and open-ended written responses. A minimum of 73% of men and 43% of women in this sample attempted sexual orientation change, usually through multiple methods and across many years (on average). Developmental factors associated with attempts at sexual orientation change included higher levels of early religious orthodoxy (for all) and less supportive families and communities (for men only). Among women, those who identified as lesbian and who reported higher Kinsey attraction scores were more likely to have sought change. Of the 9 different methods surveyed, private and religious change methods (compared with therapist-led or group-based efforts) were the most common, started earlier, exercised for longer periods, and reported to be the most damaging and least effective. When sexual orientation change was identified as a goal, reported effectiveness was lower for almost all of the methods. While some beneficial SOCE outcomes (such as acceptance of same-sex attractions and reduction in depression and anxiety) were reported, the overall results support the conclusion that sexual orientation is highly resistant to explicit attempts at change and that SOCE are overwhelmingly reported to be either ineffective or damaging by participants.

Keywords: LGBTQ, SOCE, psychotherapy, religion, Mormon

Many twenty-first-century, traditional world religions continue to denounce both same-sex attractions (SSA) and same-sex sexual activity as immoral, despite a growing social and professional consensus that views both as positive variants of human sexuality (Fontenot, 2013). As a result of this conflict, many traditional religious individuals who experience SSA engage in sexual orientation change efforts (SOCE) in an attempt to conform to religious teachings and social pressure (Beckstead, 2012; Jones & Yarhouse, 2011; Maccio, 2010). Despite a recent increase in public discourse regarding SSA, SOCE studies have been limited in quantity, scope, and methodology, and ultimately have failed to demonstrate either the effectiveness or benefit/harm of SOCE (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation [APA], 2009). Even with the APA's (2009) extensive report and recommendations regarding SOCE, considerable questions remain regarding SOCE demographics, prevalence, and intervention types. Consequently, the purpose of this study was to document and evaluate the prevalence, variety, duration, demographics, effectiveness, benefits, and harm of SOCE within one particular faith tradition—the Church of Jesus Christ of Latter-day Saints (LDS, Mormon). We built upon the APA (2009) recommendations for improving SOCE research by using (a) more representative sampling methods, (b) more precise measures of sexual orientation and identity, (c) references to life histories and mental health concerns, and (d) increased inquiry regarding efficacy and safety.

Brief History of SOCE Research

Some early studies purported to demonstrate SOCE effectiveness (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, Armstrong, & Blaszczynski, 1981; Tanner, 1975). While not claiming the elimination of a same-sex orientation, some of these authors reported limited success in decreasing same-sex attraction and behavior, usually without a reciprocal increase in opposite-sex attraction or sexual behavior (cf. APA, 2009). However, this work suffered from major methodological flaws, including the absence of control groups, biased samples, very small treatment groups ($<$ 15 subjects per treatment group), and internally inconsistent methods of data collection. In many recent

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studies, researchers have attempted to gain a deeper understanding of SOCE through surveys, case studies, clinical observations, and descriptive reports with convenience-sampled populations from religiously affiliated organizations, where conflict and distress remain high despite increasing social acceptance of LGBTQ individuals (e.g., Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Silverstein, 2003; Spitzer, 2003). A recent review of this literature by an APA (2009) task force on SOCE efforts showed that individuals reported varied rationale for SOCE (also see Morrow & Beckstead, 2004). For example, telephone interviews with 200 self-selected individuals claiming success in sexual orientation change cited personal, emotional, religious, and/or marriage-related issues as reasons for seeking change (Spitzer, 2003).

The APA (2009) also reported widely varied SOCE strategies. A survey of 206 licensed mental health professionals who practice sexual orientation change therapy reported providing individual psychotherapy, psychiatry, group therapy, or a combination of individual and group therapies to address clients' reported desire to change sexual orientation (Nicolosi et al., 2000). Many individuals have attempted sexual orientation change with the help of nonprofessional individuals or organizations, which are often religiously or politically motivated (e.g., Evergreen International, Exodus International, Focus on the Family, Jews Offering New Alternatives for Healing; cf. Besen, 2012; Drescher, 2009). Such efforts range from one-on-one pastoral counseling to group conferences or retreats and can include such practices as confession, repentance, and self-control, as well as cognitive behavioral approaches (Ponticelli, 1999). Individuals may also engage in personal efforts to change sexual orientation. One recent qualitative study of sexual and religious identity conflict among late adolescents and young adults reported heightened efforts to be faithful, bargains with God, prayer, fasting, and increased church involvement as commonly self-reported individual efforts to "overcome" SSA (Dahl & Galliher, 2012). The outcomes of these private and religious efforts, however, remain almost completely unstudied.

Finally, qualitative reports have suggested that individuals who engaged in SOCE reported a variety of perceived benefits and harms (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Shidlo & Schroeder, 2002). Based on a comprehensive review of this work, the APA (2009) SOCE task force concluded that no study to date has demonstrated adequate scientific rigor to provide a clear picture of the prevalence or frequency of either beneficial or harmful outcomes. More recent studies claiming benefits and/or harm have done little to ameliorate this concern (e.g., Jones & Yarhouse, 2011; Karten & Wade, 2010).

Limitations of Previous Work

Experimental, quasi-experimental, correlational, and qualitative SOCE studies are limited in scope, methodological rigor, and comprehensiveness (APA, 2009). Previous studies have employed problematic sampling procedures, including biased subjects, small samples sizes, and a lack of female participants (e.g., McCrady, 1973; Mintz, 1966; Nicolosi et al., 2000; Spitzer, 2003). Virtually all studies to date have relied on convenience sampling, without any attempt to draw from nonbiased sources (Silverstein, 2003). Many researchers have drawn directly from those who were previously enrolled in therapeutic religious programs intended to change sexual orientation—participants who may be under cultural, religious, or personal pressure to make a positive self-report (e.g., Maccio, 2011; Nicolosi et al., 2000; Spitzer, 2003). Furthermore, previous studies have lacked consistency in the definitions of sexual orientation and sexual orientation change, making it difficult to compare across studies (Savin-Williams, 2006).

The frequency and rate of SOCE in SSA populations remain unknown (see Morrow & Beckstead, 2004, for a discussion). No known study to date has drawn from a representative sample of sufficient size to draw conclusions about the experience of those who have attempted SOCE. Furthermore, no known study to date has provided a comprehensive assessment of basic demographic information, psychosocial well-being, and religiosity, which would be required to understand the effectiveness, benefits, and/or harm caused by SOCE. Most studies have focused on the outcome of interventions led by licensed mental health professionals, while neglecting to directly assess the effectiveness or potential harm of self-help, religious, or nonlicensed efforts to change, understand, or accept sexual orientation. Finally, in spite of the APA's 2009 report on SOCE, considerable debate continues about the meaning of the report (cf. Hancock, Gock, & Haldeman, 2012; Rosik, Jones, & Byrd, 2012), focusing specifically around the lack of more conclusive SOCE-related outcome research.

The LDS Church and Same-Sex Attraction

The Church of Jesus Christ of Latter-day Saints is a U.S.-based Christian religious denomination claiming more than 14 million members worldwide (Church of Jesus Christ of Latter-day Saints, 2013). The LDS church claims the Holy Bible as scripture and, through traditional Biblical interpretations, has historically both condemned same-sex sexuality as sinful (cf. Kimball, 1969; O'Donovan, 1994) and explicitly encouraged its lesbian, gay, bisexual, transgender, and queer (LGBTQ) members to attempt sexual orientation change (Byrd, 1999; Faust, 1995; Packer, 2003; Pyrah, 2010). While the LDS church has somewhat softened its stance toward LGBTQ individuals in recent years (Church of Jesus Christ of Latter-day Saints Church, 2012), it continues to communicate to its LGBTQ members that sexual orientation change is possible through various means including prayer, personal righteousness, faith in Jesus Christ, psychotherapy, group therapy, and group retreats (e.g., Holland, 2007; Mansfield, 2011). In these respects, the LDS church's approach to SSA has closely paralleled other religious traditions including Orthodox Judaism, evangelical Christianity, and Roman Catholicism (Michaelson, 2012).

The Present Study

In the current study, we aimed to build on previous work to present a comprehensive analysis of the (a) prevalence of SOCE in a sample of SSA Mormons, (b) most commonly pursued SOCE methods, (c) demographic and developmental factors associated with increased likelihood to engage in SOCE, (d) effectiveness of SOCE, and (e) extent to which SOCE treatments have led to reported positive or iatrogenic effects. Our sample included sufficient numbers of men and women so that gender can be included as a factor in analyses, allowing for a more nuanced assessment of gendered SOCE processes. We sought to overcome many of the limitations of previous work by reporting from a large, interna-

tional, demographically diverse sample and by employing a large battery of qualitative and quantitative measures of demographic information, psychosocial well-being, mental health, sexuality, and religiosity. We also believed that the LDS church's long-standing opposition to same-sex sexuality, along with its continued support of SOCE in various forms, made the LDS SSA population ideal for a deeper study of these issues—one that could also inform our understanding of SOCE within other religious traditions.

Method

Research Team

Given the controversial nature of SOCE research, we feel it is important to engage transparently in our research dissemination. All authors self-identify as LGBTQ allies and also affirm the position of the American Psychological Association on the importance of affirming and supporting religious beliefs and practices (American Psychological Association, 2010). All authors have been active in supporting the LGBTQ community through campus, community, online, and national/international engagement. Four of the five authors were raised LDS, and two remain active LDS church participants. All authors work closely with LGBTQ Mormons in their professional and/or personal roles.

Participants

Participants were recruited for a web-based survey entitled "Exploration of Experiences of and Resources for Same-Sex-Attracted Latter-day Saints." Inclusion criteria were as follows: Participants had to (a) be 18 years of age or older, (b) have experienced SSA at some point in their life, (c) have been baptized a member of the LDS church, and (d) have completed at least a majority of survey items (i.e., the basic demographics, relevant sexual history, and psychosocial measures sections).

Data management. The LimeSurvey online survey software (Schmitz & LimeSurvey Project Team, 2011) marked 1,588 responses as "completed." Of these responses, 40 were excluded because the respondents failed to meeting participation criteria in the following ways: underage ($n = 8$), no indication of LDS membership ($n = 3$), no indication of ever experiencing same-sex attraction ($n = 17$), and leaving the majority of the survey blank (i.e., nothing beyond the demographic information, $n = 12$). Data for one participant was lost during downloading and data cleaning. Of the records designated as "not completed" by Limesurvey, 65 were included because they met the aforementioned inclusion criteria. This process left 1,612 respondents in the final data set.

Demographic information. Seventy-six percent of the sample reported to be biologically male and 24% reported to be biologically female. Regarding gender, the following responses were reported: "male" (74.5%), "female" (22.2%), "female to male" (0.3%), "male to female" (0.6%), "neither male nor female" (0.5%), and "both male and female" (1.9%). The mean sample age was 36.9 years ($SD = 12.58$). Approximately 94% reported residing in the United States, with 6% residing in one of 22 other countries (Canada being the next most common, at 2.8%). Of those residing in the United States, 44.7% reported residing in Utah, with the remainder residing across 47 other states and the District of Columbia. Regarding race/ethnicity, 91.1% identified as exclusively White, 4.5% as multiracial, 2.2% as Latino/a, and the remainder as either Asian, Black, Native American, Pacific Islander, or other.

Regarding educational status, 97.2% reported at least some college education, with 63.7% reporting to be college graduates. Sexual orientation self-labeling indicated that 75.5% identified as gay or lesbian, 14.5% as bisexual, and 4.9% as heterosexual, with the remaining 5.1% identifying as queer, pansexual, asexual, same-sex or same-gender attracted, or other. Relationship status was reported as 40.8% single, 22.7% unmarried but committed to a same-sex partner, 16.9% married or committed to heterosexual relationships, 12.6% in a marriage, civil union, or domestic partnership with a same-sex partner, and 5.8% divorced, separated, or widowed. Regarding LDS church affiliation, participants described themselves as follows: 28.8% as active (i.e., attending the LDS church at least once per month), 36.3% as inactive (i.e., attending the LDS church less than once per month), 25.2% as having resigned their LDS church membership, 6.7% as having been excommunicated from the LDS church, and 3.0% as having been disfellowshipped (i.e., placed on probationary status) from the LDS church.

Measures

The survey included items developed specifically for this study and a number of pre-existing measures assessing psychosocial health and sexual identity development. Major survey sections included demographics; sexual identity development history; measures of psychosocial functioning; an exploration of various methods to accept, cope with, or change sexual orientation; and religiosity. The larger study yielded data for a number of research questions; only measures relevant for the current study are described in the following sections. Specifically, measures for this study focus on methods related to SOCE and on a number of outcome variables related to sexual identity development (i.e., sexual identity distress) and positive psychosocial functioning (self-esteem and quality of life) that allowed us to assess SOCE correlates related to general well-being.

Sexual orientation identity, history, and religiosity. Participants answered several questions about their sexual orientation identity, history, sexual development milestones, disclosure experiences, and religiosity. Participants rated levels of family and community support for LGBTQ identities via a 6-point Likert-type scale from 0 (*closed or nonsupportive*) to 5 (*very open or supportive*). Participants rated their sexual behavior/experience, feelings of sexual attraction, and self-declared sexual identity on a 7-point Likert-type scale (modeled after the one-item Kinsey scale), ranging from 0 (*exclusively opposite sex*) to 6 (*exclusively same sex*), with the additional option of asexual also provided (Kinsey, Pomeroy, & Martin, 1948). Participants rated early and current religious orthodoxy on a 6-point Likert-type scale from 0 (*orthodox*—a traditional, conservative believer) to 5 (*unorthodox*—more liberal and questioning).

Attempts to cope with same-sex attraction. Participants were asked which of several activities they had engaged in to "understand, cope with, or change" their sexual orientation. Options included: (a) individual effort (e.g., introspection, private study, mental suppression, dating the opposite sex, viewing

opposite-sex pornography), (b) personal righteousness (e.g., fasting, prayer, scripture study), (c) psychotherapy, (d) psychiatry (medication for depression, anxiety, sleep problems, somatic complaints, and so forth), (e) group therapy, (f) group retreats, (g) support groups, (h) church counseling (e.g., LDS bishops), and (i) family therapy. These options were developed by the research team based on several sources, including direct clinical practice with LDS LGBTQ individuals, familiarity with LDS culture/practice and doctrine (Holland, 2007; Mansfield, 2011), and the psychology LGBTQ literature (APA, 2009). For each option, participants were asked to provide their ages when the effort began, the duration (in years), and a rating of the perceived effectiveness of each method (effort: 1 = *highly effective*, 2 = *moderately effective*, 3 = *not effective*, 4 = *moderately harmful*, 5 = *severely harmful*). These variables were later reversed scored to ease interpretation, such that 1 = *severely harmful*, 2 = *moderately harmful*, 3 = *not effective*, 4 = *moderately effective*, and 5 = *highly effective*. Participants were also provided an open-ended field to describe each effort in their own words.

Participants were asked to indicate their original goals for each effort, along with what was actually worked on (e.g., "desire to change same-sex attraction," "desire to accept same-sex attraction"). Participants were grouped into two categories: "SOCE reported" and "SOCE not reported." The participants in the SOCE-reported group consisted of those who checked the "desire to change same-sex attraction" box for at least one method or who responded affirmatively to one of the following two questions: (a) "My therapist(s) actively worked with me to reconsider my same-sex sexual behavior and thought patterns in order to alter or change my same-sex attraction," and/or (b) "My therapist(s) used aversive conditioning approaches (i.e., exposure to same-sex romantic or sexual material while simultaneously being subjected to some form of discomfort) in attempts to alter my attraction to members of my same-sex." All other participants were categorized as SOCE not reported.

Sexual Identity Distress Scale. The Sexual Identity Distress Scale (SID; Wright & Perry, 2006) is a seven-item measure assessing sexual-orientation-related identity distress. SID scores are obtained by reverse scoring the negative items and summing the scores. Higher scores indicate greater identity distress. According to its authors, the SID has demonstrated high internal consistency (α = .83), test–retest reliability, and strong criterion validity (Wright & Perry, 2006). Cronbach's alpha for the current sample was .91.

Rosenberg Self-Esteem Scale. The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a 10-item measure of self-esteem developed for adolescents but used with samples across the developmental spectrum. The RSES uses a Likert-type scale (1–4), with higher scores indicating higher self-esteem (reverse scoring required). The RSES demonstrated test–retest reliability of .85 and has demonstrated good validity. Cronbach's alpha for the current sample was .92. Total scores are calculated as the average across items.

Quality of Life Scale (QOLS). The QOLS (Burckhardt, Woods, Schultz, & Ziebarth, 1989) is a 16-item instrument measuring six domains of quality of life: material and physical well-being; relationships with other people; social, community and civic activities; personal development and fulfillment; recreation; and independence. The average total score for "healthy populations" is about 90. Average scores for various less-healthy groups range between Israeli patients with posttraumatic stress disorder (61) and young adults with juvenile rheumatoid arthritis (92). Evaluations from various studies indicate that the QOLS has demonstrated internal consistency (αs = from .82 to .92) and high test–retest reliability (*r*s = from .78 to .84; Anderson, 1995; Wahl, Burckhardt, Wiklund, & Hanestad, 1998). Cronbach's alpha for the current sample was .90.

Procedures

Data collection and recruitment. This study was approved by the institutional review board at Utah State University. It was released as an online web survey from July 12 through September 29, 2011, and required both informed consent and confirmation that the respondents had only completed the survey once. Participants were given the option of providing their names, e-mail addresses, and phone numbers in order to receive study results and/or be contacted for future studies; approximately 70% of the respondents voluntarily provided this information.

Since past SOCE outcome studies have been criticized for either small or biased samples, considerable efforts were made to obtain a large and diverse sample, especially with regard to ideological positions toward SOCE. Journalists in the online and print media were contacted about this study as it was released. Because of feature coverage by the Associated Press, articles about this study appeared in over 100 online and print publications worldwide, including the Huffington Post, ReligionDispatches.org, *Salt Lake Tribune*, *San Francisco Chronicle*, *Houston Chronicle*, *Q-Salt Lake*, and KSL.com. In all, 21% of respondents indicated that they heard about the study directly through one of these sources or through direct Internet search.

Leaders of major LDS-affiliated LGBTQ support groups were also contacted and asked to advertise this study within their respective organizations (e.g., Affirmation, Cor Invictus, Disciples, Evergreen International, LDS Family Fellowship, Gay Mormon Fathers, North Star, and Understanding Same-Gender Attraction). In total, 21% of respondents indicated learning about the survey from one of these groups. Careful attention was paid to include all known groups and to ensure inclusion across the spectrum of varying LDS belief and orthodoxy (to avoid claims of selection/recruitment bias). Special emphasis was made to reach out directly and in multiple ways to conservative LDS LGBTQ support groups such as Evergreen and North Star. Only Evergreen International refused to advertise, although many among our respondents acknowledged either current or past Evergreen affiliation.

Nonreligiously affiliated LGBTQ support organizations (e.g., Equality Utah, Salt Lake City Pride Center) were also helpful in promoting awareness about this survey. In total, 5% of respondents indicated learning about the survey from one of these sources. Once the survey was promoted through the previously described venues, a sizable portion of survey respondents (47%) indicated learning about the survey through word of mouth, including e-mail, Facebook, blogs, online forums, or other web sites.

Missing data. An analysis of missing data for the variables hypothesized to be associated with SOCE (family and community support, early religious orthodoxy, Kinsey scores, and the SID, RSES, and QOLS measures) revealed that 373 of the 1,612 cases (23.1%) contained at least some missing data across these vari-

ables, with 693 of the 62,175 fields overall (1.1%) being left blank. To account for potential bias in our statistical analyses arising from these missing data, we conducted a multiple imputation analysis using SPSS Statistics Version 20 to test the robustness of our findings with respect to the group comparisons using these measures. In SPSS, the imputation method was set to "automatic," and the number of imputations was set to five. When comparing the pooled imputed results with the original analyses, we found significance levels remained unchanged (with one exception noted in a later discussion), and *t* values changed minimally. Consequently, all statistical analyses reported are based on the original, nonimputed data.

Results

SOCE Prevalence, Methods, and Effectiveness

SOCE prevalence. Overall, 73% of men ($n = 894$) and 43% of women ($n = 166$) reported engaging in at least one form of SOCE, $\chi^2(1, n = 1{,}610) = 120.81$, $\Phi = .274$, $p < .001$. Of those who did attempt sexual orientation change, participants averaged 2.62 ($SD = 1.60$) different SOCE methods (maximum of eight, and minimum of one). Men reported utilizing a higher number of different SOCE types ($M = 2.76$, $SD = 1.63$) than did women ($M = 1.93$, $SD = 1.22$), t (adjusted $df = 286$) $= -7.58$, $p < .001$, $d = 0.58$.

Most common SOCE methods. Personal righteousness was reported by both men and women as the most commonly used SOCE method with the longest average duration, followed by individual effort, church counseling, and psychotherapy. Some of the most common personal righteousness methods mentioned included increased prayer, fasting, scripture study, focus on improving relationship with Jesus Christ, and temple attendance. Some of the most common individual effort methods mentioned included cognitive efforts (e.g., introspection, personal study, journaling), avoidance (e.g., suppression, self-punishment), seeking advice from others, seeking to eliminate or reverse same-sex erotic feelings (e.g., date the opposite sex, view opposite-sex pornography, emphasize gender-conforming appearance or behavior), and exploration in the LGBTQ community. A full list of prevalence rates, average durations, and effectiveness ratings for the nine SOCE methods is provided in Table 1. As a group, religious and private efforts (personal righteousness, ecclesiastical counseling, and individual efforts) were by far the most commonly used change methods (use exceeding 85% by those attempting change), with

Table 1
Sexual Orientation Change Efforts (SOCE) Method Prevalence, Starting Age, Duration, and Effectiveness Ratings by Sex

SOCE method	Count/%		Age began SOCE method (yrs.)		Method duration (yrs.)		SOCE method effectiveness		Method effectiveness w/out SOCE			Effect size
	n	%	*M*	*SD*	*M*	*SD*	*M*	*SD*	*n*	*M*	*SD*	*d*
Personal righteousness												
Men	688	77	16.65	6.91	12.40	9.73	2.57	1.21	218	3.39	1.26	−0.66
Women	114	68.7	17.55	6.75	8.18	8.14	2.37	1.09	91	3.33	1.15	−0.86
Individual effort												
Men	520	58.2	17.45	6.78	11.24	9.25	2.88	1.18	376	3.93	0.98	−0.97
Women	62	37.3	19.28	6.33	8.07	6.88	2.97	1.12	176	4.09	0.93	−1.09
Church counseling												
Men	448	50.1	21.10	7.86	7.34	8.65	2.58	1.15	161	3.06	1.22	−0.41
Women	54	32.5	21.61	7.25	6.34	6.89	2.59	1.11	33	2.45	1.20	0.12
Psychotherapy												
Men	330	36.9	24.29	9.06	4.70	5.76	3.23	1.20	335	3.96	0.91	−0.68
Women	37	22.3	23.11	6.75	6.27	6.79	3.22	1.16	155	4.11	0.82	−0.89
Support Groups												
Men	138	15.4	28.34	10.16	3.61	4.65	3.24	1.06	202	4.22	0.81	−1.04
Women	7	4.2	26.29	6.55	4.86	6.50	3.71	0.95	50	4.14	0.97	−0.45
Group therapy												
Men	126	14.1	27.93	10.44	2.71	3.38	3.16	1.18	111	4.04	0.85	−0.85
Women	6	3.6	32.00	9.10	1.58	0.80	3.00	1.79	31	3.90	0.98	−0.62
Group Retreats												
Males	56	6.3	29.88	11.18	2.45	3.84	3.45	1.24	53	4.36	0.83	−0.86
Females	3	1.8	26.33	3.51	0.70	0.52	2.67	1.53	4	4.50	1.00	−1.42
Psychiatry												
Men	33	3.7	25.52	10.73	8.38	9.42	3.06	1.30	276	3.91	0.90	−0.76
Women	2	1.2	25.50	3.54	17.00	5.66	4.50	0.71	115	3.95	0.98	0.64
Family therapy												
Men	34	3.8	24.42	9.21	4.37	6.40	2.88	1.07	65	3.65	1.02	−0.74
Women	1	0.6	21.00	N/A	0.25	N/A	N/A	N/A	12	3.58	0.67	N/A

Note. The % column indicates, out of the total number (by sex) who attempted to change, the percentage who used each method. Method effectiveness: ratings: 1 = *severely harmful,* 2 = *moderately harmful,* 3 = *not effective,* 4 = *moderately effective*, 5 = *highly effective*. The "method effectiveness w/out SOCE" columns represent those who engaged in the respective method without attempting to change their sexual orientation. Regarding comparisons of method effectiveness with and without SOCE, *t* values ranged from −0.5 to 14.5; *p* values ranged from .59 to < .001. Effect size (*d*) reflects differences between SOCE-focused methods and non-SOCE-focused methods.

therapist-led (40.4%) and group-involved (20.8%) change efforts trailing significantly in prevalence. Finally, 31.1% of participants reported engaging exclusively in private forms of SOCE, not indicating any effort that involved external support.

Method effectiveness/harm ratings. As detailed in Table 1, when sexual orientation change was not reported as a method objective, participants rated all but one of the methods as at least moderately effective (scores between 3.0 and 4.0), with a few methods (support groups, group therapy, group retreats, psychotherapy, psychiatry, individual effort) approaching or exceeding highly effective status (4.0 and above). Conversely, when sexual orientation change was reported as a method objective, in almost all cases reported method effectiveness was significantly lower (i.e., more harmful), with medium to large Cohen's *d* effect sizes (see Table 1 for exact effect sizes). Several SOCE methods including personal righteousness, individual effort, church counseling, and family therapy received average effectiveness ratings below 3.0 (more harmful than helpful). As shown in Figure 1, the SOCE methods most frequently rated as either ineffective or harmful were individual effort, church counseling, personal righteousness, and family therapy. The SOCE methods most frequently rated as effective were support groups, group retreats, psychotherapy, psychiatry, and group therapy. Ironically, methods most frequently rated as "effective" tended to be used the least and for the shortest duration, while methods rated most often as "ineffective" or "harmful" tended to be used most frequently and for the longest duration.

Developmental Factors Linked to SOCE

As reported in Table 2, some developmental factors that appear to be associated with SOCE included less family and community support for LGBTQ identities (for men only) and high levels of religious orthodoxy prior to acknowledging SSA (for both men and women; highly significant with a Bonferroni corrected $\alpha = .008$). Those who reported growing up in a rural community were more likely to engage in SOCE (71.0%) than those who reported growing up in an urban (63.0%) or a suburban (64.4%) community, $\chi^2(2, n = 1{,}565) = 6.95, \Phi = .067, p = .03$.

Effectiveness of Change Efforts

Reported changes in sexual identity. With regard to self-reported sexual attraction and identity ratings, only one participant out of 1,019 (.1%) who engaged in SOCE reported both a heterosexual identity label and a Kinsey attraction score of zero (exclusively attracted to the opposite sex). As shown in Table 2, the mean Kinsey attraction, behavior, and identity scores of those reporting SOCE attempts were not statistically different from those who did not indicate an SOCE attempt. Multiple imputation procedures to account for missing data yielded only one significant change in outcome; the statistical difference in Kinsey attraction scores between women who reported engaging in SOCE versus those who did not was found to be significant for the pooled imputation results at $t = -2.0, p = .045$ (vs. $t = -1.75, p = .08$ in the original analysis)—indicating that women who reported

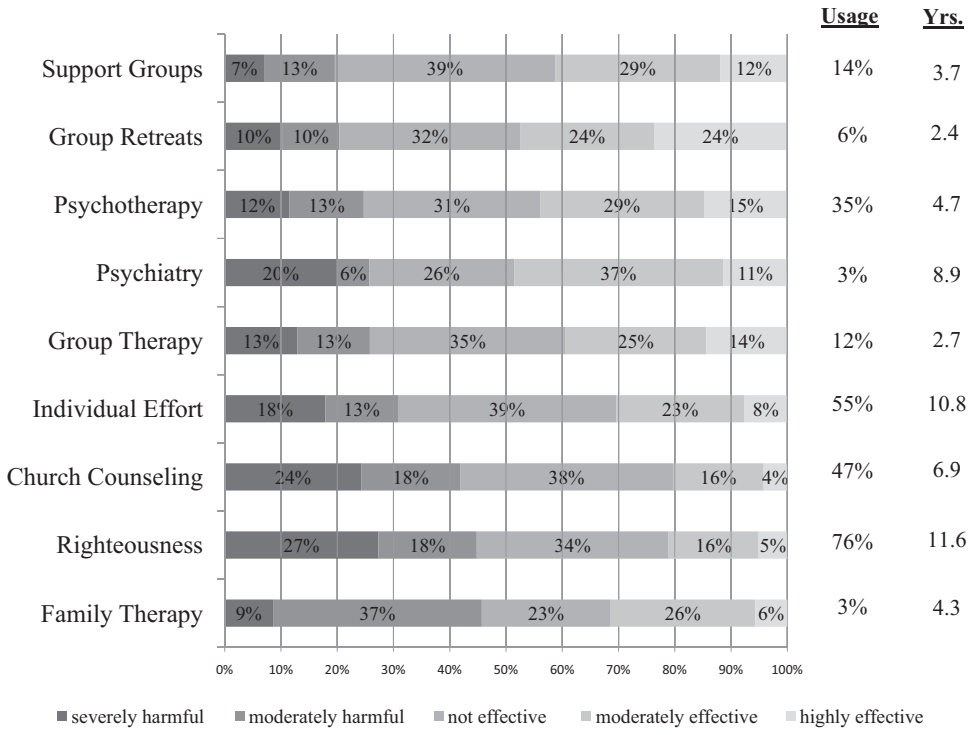

Figure 1. Graph displaying nine sexual orientation change effort (SOCE) methods, participant ratings of each method's effectiveness or harmfulness, percentages of participants who used each method, and the average number of years each method was employed.

Table 2
Developmental Factors, Kinsey Scores, and Psychosocial Health by Sexual Orientation Change Efforts (SOCE) Involvement

Variable	SOCE reported			SOCE not reported						
	n	*M*	*SD*	*n*	*M*	*SD*	*t*	*df*	*p*	*d*
Developmental factors by sex										
Men										
Family LGBTQ support	879	0.89	1.31	323	1.33	1.63	4.4	483[a]	<.001	0.30
Community LGBTQ support	881	0.96	1.32	325	1.33	1.6	3.73	495[a]	<.001	0.25
Religious orthodoxy before acknowledging SSA	874	1.22	1.61	293	2.46	1.94	9.89	435[a]	<.001	0.70
Women										
Family supportive growing up	165	0.84	1.23	218	1.00	1.42	1.11	381	.268	0.12
Community supportive growing up	164	1.09	1.41	221	1.23	1.43	0.95	383	.343	0.10
Religious orthodoxy before acknowledging SSA	165	1.51	1.73	213	2.77	1.95	6.66	369[a]	<.001	0.68
Kinsey scores by sex										
Men										
Feelings of sexual attraction	858	5.12	1.28	315	4.93	1.62	−1.88	466[a]	.061	0.13
Sexual behavior/experience	849	4.49	2.00	306	4.72	1.89	1.71	1153	.088	0.12
Sexual identity	845	4.82	1.98	308	4.87	1.98	0.37	1151	.709	0.03
Women										
Feelings of sexual attraction[b]	161	4.45	1.57	209	4.15	1.62	−1.75	368	.08	0.19
Sexual behavior/experience	157	3.76	2.09	206	3.32	2.15	−1.97	361	.05	0.21
Sexual identity	154	4.47	2.02	204	4.09	2.04	−1.76	356	.08	0.19
Psychosocial health by sex										
Men										
Quality of life	894	82.28	14.3	326	82.48	14.74	0.21	1218	0.834	0.01
Sexual identity distress	894	10.16	7.61	325	7.01	6.23	−7.35	697[a]	<.001	0.45
Self-esteem	894	3.15	0.64	328	3.29	0.61	3.38	1220	0.001	0.22
Women										
Quality of life	166	81.9	13.2	222	83.01	13.81	0.79	386	0.428	0.08
Sexual identity distress	166	9.49	7	221	7.04	5.91	−3.65	320[a]	<.001	0.38
Self-esteem	166	3.13	0.64	222	3.21	0.66	1.22	386	0.220	0.12

Note. LGBTQ = lesbian, gay, bisexual, transgender, and queer; SSA = same-sex-attracted.
[a] Corrected degrees of freedom. [b] Multiple imputation analyses conducted to account for missing data found a statistical difference in Kinsey attraction scores (from 0, *exclusively opposite sex* to 6, *exclusively same sex*) between women who reported engaging in SOCE vs. those who did not at $t = -2.0$, $p = .045$. Also, those who self-rated as "asexual" (i.e., rating of 7) were not included in the Kinsey analyses so as to not alter the commonly accepted interpretations of Kinsey scores.

engaging in SOCE reported significantly higher Kinsey attraction scores than women who did not report engaging in SOCE.

With regard to sexual identity (Table 3), more than 95% of both men and women who engaged in some form of SOCE identified as nonheterosexual. Men who did and did not report engaging in SOCE did not differ from each other statistically in terms of current sexual identity labels. Women who reported engaging in SOCE were significantly more likely to self-identify as lesbian than were those who did not engage in SOCE. SOCE participants currently self-identifying as heterosexual reported a mean Kinsey attraction score of 3.02 ($SD = 1.42$), which is commonly associated with bisexuality.

Reports and explanations of successful change. Participants were provided the option to describe their various change efforts in their own words. A review of these narratives yielded 32 participants (3.1% of those attempting change) who indicated some type of SSA change. Of these 32 participants, 15 described a decrease in the frequency and/or intensity of their SSA, without mentioning a cessation of SSA. As an example, one participant wrote, "While the same-sex attraction is still stronger than heterosexual attractions, the frequency and intensity and duration of those attractions have lessened." Twelve of the 32 narratives did not mention attraction at all but instead mentioned either a decrease or a cessation of same-sex sexual behavior, as exemplified in this narrative: "I feel like I have been forgiven for my sexual behavior. I think of a same-sex relationship every day, but I don't act on it." Five of the narratives reported an increase in other-sex attractions, two of the narratives reported a reduction in anxiety about the SSA, and five indicated some sort of change that was unclear or vague (e.g., "I have felt so much strength from God to control myself"). Finally, it should be noted that some participants fit into more than one of these categories and that none of the 32 participants indicated an elimination of SSA.

Perceived Benefits and Harm Associated With SOCE

Perceived benefits. Open-ended narratives were also reviewed to provide further insight into the perceived effectiveness summarized in Table 1 and Figure 1. Based on this review, methods rated as effective did not appear to generally reflect any changes in sexual orientation but instead referred to several other benefits, such as ultimate acceptance of sexual orientation, a decrease in depressive or anxiety symptoms, and improved family relationships. One such example from the personal righteousness narratives illustrates this point: "Instead of meeting original goals, the direction of the goals changed as I learned to accept and love myself as I am—as God created me." Another participant who attempted SOCE through a psychotherapist added,

> My therapist wanted to treat what he called the "underlying factors" that could lead to my same-gender attraction. He wanted to help with

Table 3
Current Sexual Identity Status Differences by Sex and by Sexual Orientation Change Efforts (SOCE) Involvement

Variable	SOCE reported		SOCE not reported	
	n	%	*n*	%
Men[a]				
Gay	717	80.30	267	81.40
Bisexual	96	10.80	37	11.30
Heterosexual	41	4.60	14	4.30
Same-sex- or gender-attracted	20	2.20	0	0.00
Other	19	2.10	10	3.00
Subtotal	893		328	
Women[b]				
Lesbian	109	65.70	109	49.10
Bisexual	32	19.30	69	31.10
Heterosexual	7	4.20	17	7.70
Other	18	10.80	27	12.20
Subtotal	166		222	

[a] Male differences are not statistically significant. [b] Female differences are significant at $\chi^2(3, n = 388) = 11.68, \phi = .174, p < .01$.

> depression and other things he was qualified to do. It did help, and the therapy helped with coping but did not really treat the underlying cause. In fact, because of talking, I resolved to accept it.

Perceived harm. As shown in Table 2, comparisons of psychosocial health were made between those who reported SOCE attempts and those who did not. Overall, no significant difference (Bonferroni corrected $\alpha = .008$) in quality of life for men or women was found between the two groups, though participants who reported engaging in SOCE had significantly higher sexual identity distress (men and women) and lower self-esteem (men only).

A similar review of the open-ended narratives also provides additional insight into the harmful ratings assigned to the various methods. Reportedly damaging aspects of SOCE included decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality. One example from the personal righteousness narratives illustrates: "Therapy, meeting with the bishop, meeting with stake president, praying, fasting, etc. Nothing worked. I felt that God wasn't listening, or wanted me to suffer. I felt horrible until I changed my outlook."

A narrative from the ecclesiastical counseling narratives further illustrates:

> After first being told to go on a mission to be cleansed of these feelings (resulting in relationships that intensified my same-sex activity) and then being told to get married and have children, and the feelings would go away—I buried myself emotionally and spiritually.

Another participant wrote, "My Bishop gave me a blessing promising me that I could change. Every day I didn't change, I thought I was more a failure, more of a monster."

Discussion

The purpose of this study was to better understand the demographics, prevalence, variety, perceived effectiveness, and potential benefit/harm of sexual orientation change efforts (SOCE) among current and former LDS church members through the recruitment of a large, demographically diverse sample. Our findings suggest that the majority of participants engaged in SOCE via multiple avenues for over a decade (on average). Almost no evidence of SSA being eliminated via SOCE could be found in this sample, and minimal evidence supported successful change in sexual orientation. SOCE participants in this sample showed no differences in quality of life from those who had not engaged in SOCE, but psychosocial function was lower in those who had engaged in SOCE. Participants reported a number of positive and negative outcomes of change efforts; perceived effectiveness ratings varied substantially, depending on the particular method and the reported goals.

The Nature of SOCE

LDS SOCE demographics. Highly religious LDS men from unsupportive families and communities were most likely to report having engaged in SOCE, while LDS women were somewhat less likely to do so. These findings confirm previous research that SOCE efforts most often arise from religious and/or social pressure (APA, 2009). The finding that same-sex-attracted LDS women were less likely to engage in SOCE seems noteworthy, though the exact reasons for this are still unknown. Same-sex-attracted LDS women may feel less pressure to engage in SOCE because of the greater sexual fluidity afforded women within the constraints of socialized gender roles (Diamond, 2009); U.S. male culture tends to stigmatize male homosexuality more than female homosexuality or bisexuality (Herek, 2002). The role of LDS cultural factors, such as the church's historical emphasis on missionary service for 19-year-old men with an accompanying requirement for sexual worthiness also warrants investigation.

Prevalence of SOCE types. Although the psychology literature to date has focused almost exclusively on therapist-led SOCE (APA, 2009), religious and private forms of SOCE were far more prevalent in our sample. To illustrate, while more than 85% of SOCE participants reported engaging in either religious or individual SOCE efforts, only 44% reported some form of therapist or group-led SOCE. Personal righteousness (e.g., prayer, fasting, scripture study, improved relationship with Jesus Christ) as a form of SOCE was reported by our sample to be (a) by far the most prevalent method used to change sexual orientation (more than twice as common as psychotherapy), (b) initiated at the earliest average ages (16–18 years), and (c) utilized for the longest average duration of any SOCE method (more than12 years on average for men and eight years for women). Church counseling (e.g., with LDS bishops) and individual efforts also yielded significantly higher prevalence and duration rates than most other SOCE forms. These findings generally held true for both men and women, though LDS women reported engaging in church counseling, individual-based, and group-based SOCE at considerably lower rates than LDS men.

We recognize, from the age of onset and duration of effort data, that many of our participants were still actively engaged in efforts to understand, cope with, or change their orientation and that the efforts have been carried out across varying developmental stages and historical contexts (i.e., our participants ranged in age from 18–70 years). Thus, while our "snapshot in time" yields important information about the experiences of SOCE at a broad and com-

prehensive level, we look forward to more detailed assessment of the ways that SOCE are developmentally, historically, and culturally contextualized.

Effectiveness/Harm Rates of SOCE

The evidence from this study—based on multiple criteria including Kinsey-style self-ratings of attraction, sexual identity self-labels, method effectiveness ratings, and open-ended responses—suggests that for this sample, sexual orientation was minimally amenable to explicit change attempts. The literature supports these findings (APA, 2009; Beckstead, 2012). It is notable that zero open-ended narratives could be found indicating complete elimination of SSA via SOCE and that only a small percentage of our sample (3.2%) indicated even slight changes in sexual orientation. When survey participants did report experiencing sexual orientation change, the most common descriptions involved slight to moderate decreases in SSA, slight to moderate increases in other-sex attraction, and/or a reduction in same-sex sexual activity. As Beckstead (2012) noted, it is unclear if the decreased frequency and intensity of SSA are due to a reduction of sexual attraction or due to avoidance behaviors and/or a decrease of intense feelings, such as anxiety and shame, associated with SSA. Instead of fundamental changes in core sexual orientation, accommodation and acceptance of one's SSA were the most common themes. While these findings seem consistent with the larger literature and broad professional consensus, we are compelled by the fact that we have observed these patterns within a population that may be among the most likely to embrace and support change efforts.

We note that all nine methods utilized by participants to understand, cope with, or change SSA (with the exception of church counseling for women) were rated as effective (on average) when sexual orientation change was not listed as a goal. However, when sexual orientation change was listed as a goal, a majority of methods decreased in reported effectiveness—often with large effect sizes. Personal righteousness was rated as the most "severely harmful" of all SOCE methods for our sample, particularly noteworthy given that it was also rated as the most commonly used SOCE method (76%) for the longest average duration (12 years for men, eight years for women). Church counseling and individual efforts were rated as the next most "severely damaging" SOCE methods for our sample, with church counseling being rated as only slightly less damaging than personal righteousness. Significantly higher sexual identity distress (in men and women) and lower self-esteem (in men) were associated with prior participation in SOCE, although we do not know distress and self-esteem levels prior to SOCE participation, and thus cannot determine causality.

Additional study is warranted to provide better understanding of why religious methods were simultaneously used so frequently, yet rated as most ineffective/harmful. We theorize that the high prevalence of religious SOCE is due in large part to the LDS church's continued emphasis on prayer, fasting, scripture study, improved relationship with Jesus Christ, and consulting with church leaders (e.g., bishops) as primary ways to deal with SSA (Holland, 2007; Kimball, 1969; Mansfield, 2011). We also speculate that highly religious individuals in our sample were more likely keep their SSA private due to social stigma and thus more likely to favor/trust religious or private efforts over secular ones. In addition, most licensed therapists are likely to refuse to engage in SOCE—all of which could explain the increased prevalence of private and religious forms of SOCE in this sample.

Based on our review of the open-ended responses, we also speculate that when religious SOCE did not result in the desired outcomes, it may have damaged many of our participants' faith and confidence in God, prayer, the church, and its leaders. Consequently, failed SOCE often led to high levels of self-shame, feelings of unworthiness, rejection and abandonment by God, and self-loathing, as well as "spiritual struggles" for many of our respondents (Bradshaw, Dehlin, Galliher, Crowell, & Bradshaw, 2013; Dahl & Galliher, 2012; McConnell, Pargament, Ellison, & Flannelly, 2006). This pattern of findings does emphasize the importance of ensuring that LDS church leaders are adequately trained to deal with LGBTQ issues and addressing culturally inherited leadership beliefs and practices that might be contributing to these deleterious effects.

Effectiveness. In terms of effectiveness, group-related and therapist-led methods tended to be rated by participants as the most effective and least damaging. While therapist-led SOCE were reportedly used less frequently than individual and religious methods, they were surprisingly common, given the general denunciation of SOCE by all of the major mental health professional organizations. A review of the open-ended descriptions for the various methods indicated that for the majority of participants, a rating of "effective" for therapist-led methods did not signify successful change in sexual orientation but instead indicated other outcomes such as acceptance of sexual orientation (even when change was an original goal), a decrease in anxiety or depression, and/or improvements in family relationships. These findings appear to align with APA (2009) conclusions that the secondary benefits found in SOCE can be found in other approaches that do not attempt to change sexual orientation.

Implications for Counseling

Our results present several possible implications for therapist-led and church-affiliated LGBTQ counseling. First and most obvious, these findings lend additional support to the strong positions already taken by most mental health professional organizations that therapist-led SOCE treatments are not likely to be successful—although our data indicate that such interventions are ongoing among the LDS population. Consequently, LDS-affiliated therapists, support group/retreat leaders, and ecclesiastical leaders who encourage or facilitate SOCE (whether therapist-led, religious, or group-based) might consider amending their approaches in light of these findings. LDS therapists, group, and ecclesiastical leaders might also consider providing evidence-based psychoeducation about reported SOCE effectiveness rates to their LDS LGBTQ clients, family, and fellow congregants.

Given the high prevalence and reported ineffectiveness/harm rates of religious SOCE in particular, counselors and church leaders who work with LDS LGBTQ populations might consider explicitly assessing for and exploring histories of religious SOCE with LDS LGBTQ clients. In addition, group-based methods such as support groups, group therapy, and group retreats (that do not encourage SOCE) should potentially be recommended with increased frequency, along with psychiatry (where depression/anxiety is particularly notable)—based on their reported relative effectiveness compared with other methods. Finally, as noted in Bradshaw et al. (2013), LDS-affiliated

therapists should duly consider the finding that acceptance-based forms of therapy are likely to be rated as significantly more effective and less harmful by LDS LGBTQ individuals than are change-based forms of therapy. Ultimately, these suggestions align well with the therapeutic recommendations offered by the APA (2009).

Summary and Limitations

The major findings from this study are as follows: (a) the majority of same-sex-attracted current and former LDS church members reported engaging in SOCE for mean durations as long as 10–15 years, (b) religious and private SOCE were reported to be by far the most commonly used SOCE methods for the longest average durations and were rated as the most ineffective/damaging of all SOCE methods, and (c) most LDS SOCE participants reported little to no sexual orientation change as a result of these efforts and instead reported considerable harm.

Our reliance on convenience sampling limits our ability to generalize our findings to the entire population of same-sex-attracted current and former LDS church members. For example, our sample almost certainly overrepresents men, Whites, and U. S. residents, along with those who are more highly educated and affluent, and who either read the newspaper or are Internet-connected. Because of the highly distressing, stigmatizing, and/or controversial nature of being both same-sex-attracted and LDS, it is probable that a significant number of both highly devout and highly disaffected current and former LDS church members did not become aware of or feel comfortable participating in this study.

The extent to which these findings generalize to the broader, non-LDS LGBTQ religious population is uncertain. While we acknowledge that the LDS church is distinctive in many ways from other more LGBTQ-affirming religious institutions (e.g., Reform and Reconstructionist Judaism, Unitarian Universalism, and Episcopalian), there is some evidence to suggest that the societal and theological pressures experienced by LDS LGBTQ individuals are similar to those in other conservative religious traditions (e.g., Orthodox Judaism, Catholicism, evangelical Christianity, and Islam; APA, 2009; Michaelson, 2012). Though no known research has been conducted to compare SOCE experiences across religious denominations, the APA's report on SOCE seems to acknowledge several commonalities in LGBTQ/SOCE experiences between LDS church members and those of other religious traditions, which include (a) church-based doctrinal and administrative opposition toward same-sex sexuality, (b) no known role for same-sex relationships within church structure, (c) the possible threat of expulsion for assuming an open LGBTQ identity, (d) considerable church-related familial and social pressure to eschew an LGBTQ identity and to engage in SOCE, (e) ostracizing of LGBTQ individuals at church/temple/synagogue/mosque, and (f) considerable psychological distress for religious LGBTQ individuals due to identity conflict. In addition, several studies with samples drawn from Christian reparative therapy conferences (e.g., Exodus International) have explicitly noted the participation of LDS church members, suggesting possible similarities between LDS LGBTQ experiences and those of other religious traditions (Beckstead & Morrow, 2004; Morrow & Beckstead, 2004). We are hopeful that additional research will be conducted to further assess similarities and differences in SOCE experiences between religious traditions.

Because our survey relied heavily on both self-report and participant memory, responses are likely to be impacted accordingly. Also, while we are able to provide some correlational data relative to findings such as factors associated with the likelihood of SOCE participation, average Kinsey scores of those who did and did not engage in SOCE, and a relationship between SOCE and well-being, it is not possible to determine causality and directionality of these relationships without the use of methodologies such as randomized clinical trials or longitudinal studies. For example, regarding our finding that women who have engaged in SOCE were more likely to identify as lesbian than those who did not engage in SOCE, it is difficult to ascertain from our data whether women who are more likely to identify as lesbian are also more likely to engage in SOCE, or if the process of engaging in SOCE might make one's nonheterosexual identity more salient. Finally, it should be noted that participants were not always consistent and coherent in their reports. For example, a number of participants described SOCE in their open-ended responses, even though they had not indicated "change" as either a goal or as something worked on during the methods earlier in the survey. In order to retain a more parsimonious set of classification criteria, we elected to use more conservative inclusion criteria and did not include participants in the SOCE-reported group based on open-ended responses only. Consequently, it is likely that SOCE rates are underreported in our sample.

In summary, this study contributes to the literature by demonstrating significantly greater prevalence of religious and private SOCE versus therapist-led SOCE, no meaningful evidence of reported SOCE effectiveness, and considerable evidence of SOCE-related harm—all via a large, diverse sample. Despite our results being limited to one particular faith tradition, the observed motivations, correlates, and outcomes of SOCE are likely relevant in other conservative religious contexts, and we look forward to additional research on this topic.

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